OKLAHOMA'S MEDICALLY FRAGILE WAIVER

Long Term Services and Supports

OKLAHOMA'S MEDICALLY FRAGILE WAIVER

- A medically fragile condition is defined as a chronic physical condition which results in prolonged dependency on medical care:

- Oklahoma Health Care Authority & ADvantage collaborated to create the Medically Fragile Waiver to address the needs of members whose care could not be managed in another waiver program.

- Medically Fragile was approved in July 2010 and the first member was enrolled in August 2010.

- In 2010, 31 slots were approved for the first year. Currently, the waiver is approved for 129 slots.

HOW TO MAKE A REFERRAL

- A referral form can be completed by anyone via phone, fax, email or on the OHCA website.
- Phone: 888-287-2443
- Fax: 405-530-7265
- Website: www.okhca.org/ltss
- Email: medicallyfragilewaiver@okhca.org

Who We Serve

EPSDT

- Early, Periodic, Screening, Diagnostic Treatment (EPSDT)
- Age Out

ADvantage

- Unmet needs

Community Members

- No services

ELIGIBILITY REQUIREMENTS

- 19 years of age or older
- Financial eligibility determined through DHS county offices
- Currently reside in a community setting of their choosing

PROGRAM CRITERIA

- Meet hospital or skilled nursing facility level of care, AND
- A life threatening condition; requires frequent medical supervision, OR
- Frequent administration of specialized treatment, OR
- Dependent on medical technology

MEDICALLY FRAGILE WAVIER QUICK TIPS

- 485 –
  - Members that receive Private Duty Nursing (PDN) require a 485.
  - The 485 is requested by the nursing agency to the member's physician.
  - The 485 is current for 60 days at a time.
  - When case managers send in an initial plan, reassessment or addendum to add, increase or decrease PDN, a current signed 485 is required. If the nursing agency does not have the current signed 485, please send the most recent 485 and once the current signed 485 is received, that copy should be sent in to OHCA.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- 485 –
    - A 485 must be signed by the physician.
    - When submitting goals on the service plan for a member who has a 485, the CM can write please see 485 in the goals section, but must also list the amount of hours in the goals (I.E. 8 hours a day 5 days per week of PDN) and the units as well as the frequency on the service plan.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Institutional/Transitional Case Management/Transitional RN Evaluation –
    - Institutional CM will be requested when a member is placed in a hospital or NF for an extended but temporary time in which the CM is following the member's process to be placed back in the community. Please submit an addendum once the member has been discharged from the facility. The addendum must include all CM notes during the timeframe. Please do not bill for regular CM during this time.
    - Transitional CM will be requested when the CM agency takes a new case.
    - Transitional CM covers the time it took to have an IDT meeting and create the initial service plan. The request will be added to the member's service plan with the CM notes during that time.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Institutional/Transitional Case Management/Transitional RN Evaluation –
  - Transitional RN Evaluation – This service will be requested during an initial plan as the agency will go on during the IDT meeting. The CM will request 5 units on the initial plan with the RN eval. The CM will request 10 regular units for the remainder of the plan year.
  - The approved PAs will be created for 1 day (the start date of the plan or the day the member was discharged from the facility).
  - Please see the rate sheet for the correct codes.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- UCAT and Service Plan Information –
  - Record the member's primary and secondary diagnosis codes on the UCAT.
  - Where asked on the forms, include the supervisor's signature.
  - Provide the contact information of the case manager on the service plan checklist.
  - Please submit all packets to the waiver fax: 405-530-7265 or the waiver email: medicallyfragilewaiver@okhca.org (waiver staff may use their personal fax or email to send approvals but CMs are to use the general fax or email when sending in documents).

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- UCAT and Service Plan Information –
    - Legal Guardianship and/or Power of Attorney documents are required on a yearly bases.
    - Please complete the Consents and Rights form in its entirety on a yearly bases.
    - PCA/ASR goals must be detailed and list out on the service plan and the goals section.
    - Medically Fragile is the payer of last resort.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- UCAT and Service Plan Information –
    - Please ensure the correct codes are listed when making requests.
    - T1999 or E1399 should NO LONGER be used. Please use ***T2028*** for any specialty DME item.
    - Please ensure the correct rate sheet is being used when submitting requests (most current reads: 10.01.2019).

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Request for PDN with PCA/ASR –
  - Members who are receiving PDN services but are unstaffed may be eligible for PCA and/or ASR services.
  - Members with no staffing or partial staffing for PDN puts a lot of responsibility on the informal support, which puts the caregivers in risk of burn out.
  - If you have members who are in a situation in which they have no staffing or are receiving less than 50% of the approved hours, please contact the waiver staff so that we can consult with you on the best recommendation.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Request for PDN with PCA/ASR –
    - At that time, we may request an addendum temporarily to assist the family with the members' needs. If the goal is for the member to have PDN services that is our true end goal. Approval of PCA/ASR will be approved within the scope of the service and needs of the member.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Monthly Monitoring Reports (MMR) –
    - MMRs should be sent into the waiver staff no later than the 5th of the month. If the 5th of the month falls on a weekend/holiday, please send the MMR on the next business day.
    - When completing the MMR, please refer to the goals listed in the service plan or 485 and address each goal during your visit. If additional documentation is needed, please attach the notes to the MMR.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Monthly Monitoring Reports (MMR) –

  - If a member is unstaffed, weekly provider calls are required. If the member is staffed less than 50% of the time, monthly provider calls are required. The provider calls are to inquire about staffing the member 100% of the time as approved in the plan.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- DME –
  - All DME requests require a signed prescription from the members' doctor.
  - Incontinent supplies can be listed on the same signed prescription unless the request is for a specialty item.
  - Supplement requests must include the supplement request form, addendum and a separate signed prescription to include to the date, type, amount, frequency and refills.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- DME –
  - Feeding kits and other DME items will also require a separate signed prescription.
  - High cost DME items and Environmental Modifications require an addendum, invoices, pictures of the items, prescriptions for each item and 3 bids (if the CM cannot retrieve 3 bids, the CM will need a letter from the provider to support why the provider could not provide a bid).
  - Please ensure that DME requests are listed under the correct payer source. The information can be provided by the DME company.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Specialty DME –
    - Mickey Button requests should be for no more than 2 units unless the members' doctor has provided a detail order for additional units.
    - CMs are to review the dates of the approved supplement and other services as the dates and/or units may have changed during the authorization process.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Supervisor Notes –
    - Supervisors are to review all plans and requests that come to the waiver program.
    - When asked, supervisors are to sign the requested documents.
    - The waiver does not pay CMs for corrections; when additional documents are needed or corrections requested, the CM units will be placed in pending status.

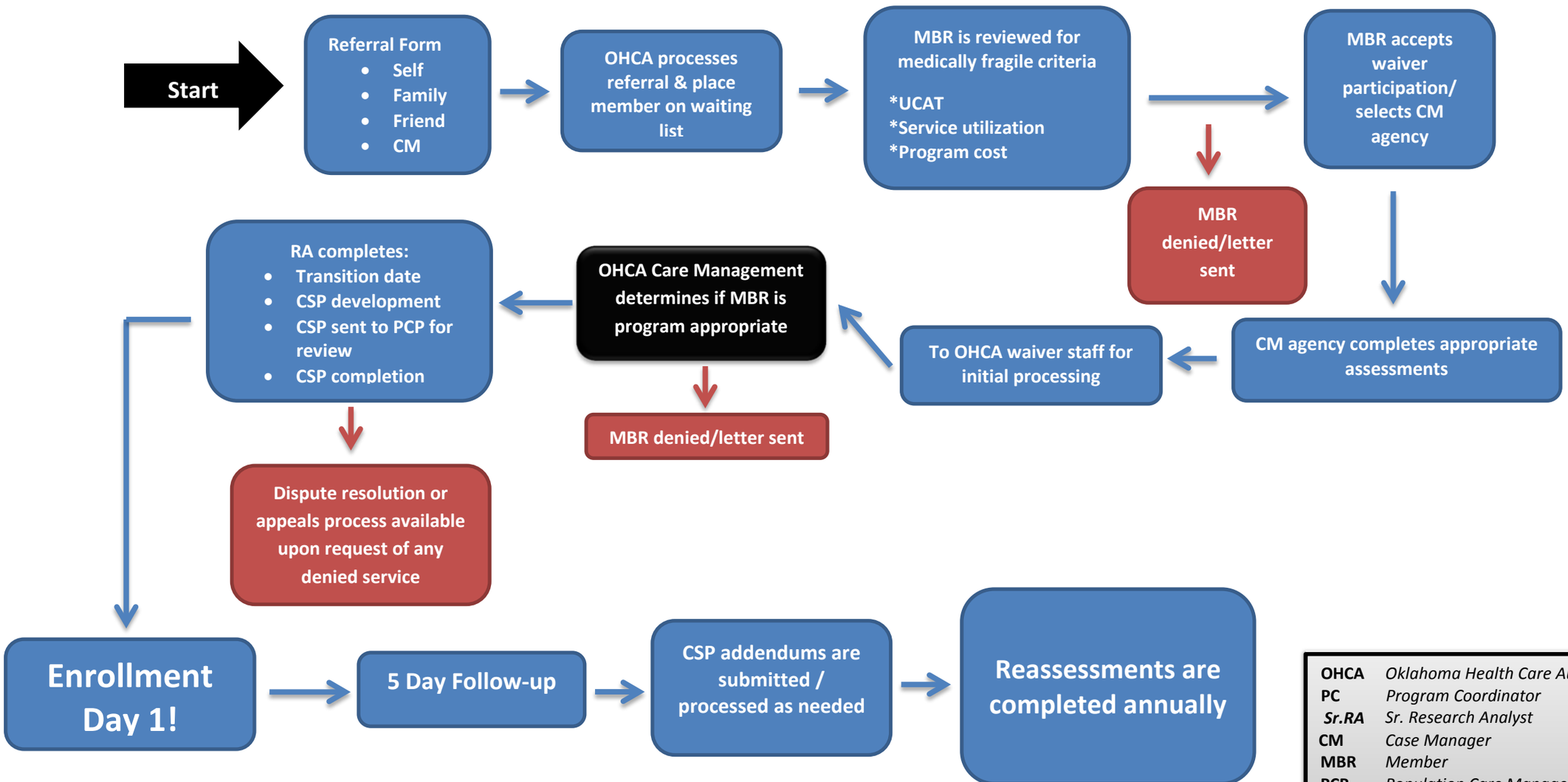
MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Supervisor Notes –
    - When CM units are in pending status, the CM is still responsible for providing CM services. If there is a time in which the CM has tried to retrieve the documents requested but has not received the information, please have the CM staff the issue with the waiver program.
    - The 6g provides information in which all providers are paid.
    - The CM is responsible for reviewing the 6g for their knowledge as well as reviewing the 6g with the family.

MEDICALLY FRAGILE WAVIER QUICK TIPS CONT..

- Supervisor Notes –
  - The CM is also responsible for sending the specific 6g to each provider listed on the plan.
  - Most of our members' parents are accustomed to requesting their DME needs directly through the DME company, CMs should check in with the family during the monthly visit to inquire if supplies were sent to the home.

Medically Fragile Enrollment Process



OHCA	*Oklahoma Health Care Authority*
PC	*Program Coordinator*
Sr.RA	*Sr. Research Analyst*
CM	*Case Manager*
MBR	*Member*
PCP	*Population Care Management*
ROI	*Release of Information*
UCAT	*Uniform Comprehensive Assessment Tool*
CSP	*Community Service Plan*
IDT	*Inter-Disciplinary Team*

Medically Fragile Services

- Advanced supportive/restorative assistance
- Case management
  - Institutional transition case management
  - Transitional case management
- Environmental modifications
- Home-delivered meals
- Hospice care
- Personal care
- Prescription drugs
- Personal emergency response system (PERS)
- Respite care
- Skilled nursing
- Private duty nursing
- Self-Direction Services:
  - Personal Care
  - Advanced Supportive/Restorative
  - Respite
  - Self-Directed Goods and Services (SD-GS)
- Specialized medical equipment and supplies
- Therapy services: Occupational
- Therapy services: Physical
- Therapy services: Respiratory
- Therapy services: Speech

Reimbursement Rates for Services
Medically Fragile Waiver Program

Medically Fragile					
Waiver Services	**Unit of Service**	**Unit Rate**	**Service Code**	**Modifier 1**	**Modifier 2**
Advanced Supportive/Restorative	15 minutes	$4.57	T1019	**TF**	-
Case Management S	15 minutes	$15.41	T1016	-	-
Case Management VR	15 minutes	$22.06	T1016	**TN**	-
Institutional Transition Case Management S	15 minutes	$15.41	T1016	**U7**	-
Institutional Transition Case Management VR	15 minutes	$20.06	T1016	**U7**	**TN**
Transition Case Management S	15 minutes	$15.41	T1016	**U3**	-
Transition Case Management VR	15 minutes	$22.06	T1016	**U3**	**TN**
Environmental Modifications	As Billed	As Prior Authorized	S5165	-	-
Home Delivered Meals	1 Meal	$5.41	S5170	-	-
Hospice Care	1 Day	$128.80	S9126	-	-
In-home Extended Respite (8+hrs)	1 Day	$179.40	S9125	-	-
In-home Respite (2-7 hours)	15 minutes	$4.24	T1005	-	-
NF Extended Respite (8+ hours)	1 day	Varies	UB120	-	-
Personal Care	15 minutes	$4.24	T1019	-	-
Personal Emergency Response *Install*	1 Time	As Prior Authorized	S5160	-	-
Personal Emergency Response *Monthly*	Monthly	As Prior Authorized	S5161	-	-
Prescriptions (maximum of 7 units only)	As Ordered	Avg. $76.40 each	W1111	-	-
Private Duty Nursing	15 minutes	$8.17	T1000	-	-
RN Assessment/Evaluation	15 minutes	$14.61	T1002	-	-
RN Assessment/Evaluation - Transitional	15 minutes	$14.61	T1002	**U3**	-
Skilled Nursing – Home Health Setting (LPN)	15 minutes	$14.61	G0300	-	-
Skilled Nursing – Home Health Setting (RN)	15 minutes	$14.61	G0299	-	-
Specialized Medical Equipment and Supplies	As Billed	As Prior Authorized	HCPCS	-	-
Therapy Services					
Therapy – Occupational	15 minutes	$21.63	G0152	-	-
Therapy – Physical	15 minutes	$21.63	G0151	-	-
Therapy – Respiratory	15 minutes	$15.41	G0237	-	-
Therapy – Speech/Language	15 minutes	$21.63	G0153	-	-

Self-Directed Services					
Advanced Supportive/Restorative	15 minutes	$4.57	S5125	**TF**	-
Personal Care	15 minutes	$4.24	S5125	-	-
In-home Respite (2-7 hours)	15 minutes	$4.24	T1005	**U4**	-
In-home Extended Respite (8+hrs)	1 day	$179.40	S9125	**U4**	-
Incontinence Supplies					
Adult Small Brief	Each	$.80	T4521	-	-
Adult Medium Brief	Each	$.88	T4522	-	-
Adult Large Brief	Each	$.99	T4523	-	-
Adult Extra Large Brief	Each	$1.16	T4524	-	-
Adult Small Underwear	Each	$.89	T4525	-	-
Adult Medium Underwear	Each	$1.04	T4526	-	-
Adult Large Underwear	Each	$1.13	T4527	-	-
Adult Extra Large Underwear	Each	$1.29	T4528	-	-
Disposable/Guard Liner	Each	$.61	T4535	-	-
Any Size Reusable Underpad	Each	$13.91	T4537	-	-
Chair Size Reusable Underpad	Each	$14.83	T4540	-	-
Large Disposable Underpad	Each	$.60	T4541	-	-
Small Disposable Underpad	Each	$.39	T4542	-	-

CLINICAL

OKLAHOMA Human Services

Uniform Comprehensive Assessment
Part III Medical Assessment

Assessment Information

(Assessor) Attach completed Form 02HM001E, Uniform Comprehensive Assessment, Part I, Intake and Referral.

Applicant/Member name _____ Date _____

Social security number _____ Case number _____ Unique ID number _____

Location of: ☐ assessment ☐ reassessment

☐ applicant's/member's residence ☐ relative's home ☐ nursing home ☐ hospital

☐ remotely (phone, video, etc.) ☐ other, specify: _____

Mental Status Questionnaire (MSQ)

(Assessor) Write responses to questions. Do not score until section is completed. Count one error for each incorrect response up to the maximum errors for the item. No response is counted as an incorrect response.

(Say) I'm going to ask you a list of questions. These are questions often asked in interviews like this and we are asking them the same way to everyone. Some may be easy, and some may be difficult. Let's start with the current year.

Question	Answer	Maximum errors	Score	Weight	Weighted score
What year is it now?		1		X 4 =	0
What month is it now?		1		X 3 =	0

(Say) I'm going to give you a man's name and address to memorize and you will be asked to repeat the phrase later.

Memory phrase: **John Brown, 42 Market Street, Chicago**

Elicit three correct repetitions, phrase by phrase or word by word, if necessary, before continuing.

(Ask) Without looking at a clock, what time is it? (within one hour)

Time is:	Response:		1		X 3 =	0

(Say) Count backwards from 20 to 1.

Indicate missed or out of order numbers in boxes. Mark / for correct and x for incorrect.

		2		X 2 =	0	

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

(Say) Say the months in reverse order.

For ease in scoring, start with the month of December. Indicate missed or out of order months in boxes. Mark / for correct and x for incorrect.

2		X 2 =	0

Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan

(Say) Now, repeat the memory phrase.

Prompt if necessary: **It was John Brown...**

Write response on the line below to score.

Error points	John	Brown	42	Market Street	Chicago
	(1)	(1)	(1)	(1)	(1)

Response: _____

5		X 2 =	0

Maximum weighted error score = 28 **Total weighted error score:** 0

Health Assessment

Check source of information used for health assessment:

☐ Applicant ☐ Member ☐ Record review ☐ Other, specify: _____

Health Conditions

(Ask) Do you have any health conditions, or symptoms of health conditions, and how do they affect you?

For instance, has a doctor told you that you have any of the following health problems?

Read each health condition.

Reviewed	Health condition	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	Allergies (drug/skin/etc.), type:	☐	☐	☐	
☐	Amputation, site:	☐	☐	☐	
☐	Anemia (iron deficiency, hemolytic, pernicious, sickle cell, etc.), type:	☐	☐	☐	
☐	Arthritis (osteo, rheumatoid, psoriatic, etc.), type:	☐	☐	☐	

Reviewed	Health condition	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	Asthma, type:	☐	☐	☐	
☐	Bed sore(s)/pressure ulcer, decubitus stage:	☐	☐	☐	
☐	Bladder/kidney problems (UTI, urgency, incontinence, kidney failure, etc.), type:	☐	☐	☐	
☐	Blood disorder (hemophilia, leukemia, leukopenia, clotting disorder, etc.), type:	☐	☐	☐	
☐	Blood pressure (hypertension, hypotension, orthostatic hypotension, etc.), type:	☐	☐	☐	
☐	Brain injury, type:	☐	☐	☐	
☐	Broken bones, type/site:	☐	☐	☐	
☐	Cancer, type:	☐	☐	☐	
☐	Dehydration	☐	☐	☐	
☐	Dementia (Alzheimer's, vascular, Lewy body, organic brain syndrome, Parkinson's related, etc.), type:	☐	☐	☐	
☐	Developmental disability (autism, cerebral palsy, cystic fibrosis, muscular dystrophy, Fetal Alcohol Spectrum Disorders, Fragile X Syndrome, intellectual disability, Spina bifida, etc.), type:	☐	☐	☐	
☐	Dialysis (hemodialysis, peritoneal, etc.), type:	☐	☐	☐	

Reviewed	Health condition	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	Diabetes, type:	☐	☐	☐	
☐	Dizziness	☐	☐	☐	
☐	Eating disorder, type:	☐	☐	☐	
☐	Emphysema (COPD, etc.)	☐	☐	☐	
☐	Falls, indicate if falls with/without injury (past six months):	☐	☐	☐	
☐	Gall bladder problems (gallstones, etc.)	☐	☐	☐	
☐	Hearing problems Date of last hearing exam:	☐	☐	☐	
☐	Heart problems (CHF, MI, CAD, angina, arrhythmia, etc.), type:	☐	☐	☐	
☐	HIV/AIDS	☐	☐	☐	
☐	Hormonal disorder (Cushing's syndrome, acromegaly, hypogonadism, dwarfism, etc.), type:	☐	☐	☐	
☐	Intestinal disorder (IBS, diverticulitis, chronic constipation/diarrhea, Crohn's, colitis, gastric ulcer, etc.), specify:	☐	☐	☐	
☐	Learning disability (issues with reading, writing, math, etc.)	☐	☐	☐	
☐	Liver problems (cirrhosis, hepatitis, failure, etc.), type:	☐	☐	☐	
☐	Lupus	☐	☐	☐	

Reviewed	Health condition	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	Mental illness, type:	☐	☐	☐	
☐	Migraine headaches	☐	☐	☐	
☐	Mood or behavior problems	☐	☐	☐	
☐	Multiple sclerosis	☐	☐	☐	
☐	Osteoporosis	☐	☐	☐	
☐	Paralysis, site:	☐	☐	☐	
☐	Parkinson's disease	☐	☐	☐	
☐	Pneumonia	☐	☐	☐	
☐	Polio/post-polio syndrome	☐	☐	☐	
☐	Potassium/sodium imbalance (electrolytes)	☐	☐	☐	
☐	Seizure disorders (epilepsy, etc.)	☐	☐	☐	
☐	Skin disease (psoriasis, eczema, contact dermatitis, hives, statis ulcer, etc.), specify:	☐	☐	☐	
☐	Sleep problems (insomnia, narcolepsy, etc.), type:	☐	☐	☐	
☐	Spinal cord injury, level:	☐	☐	☐	
☐	Stroke	☐	☐	☐	
☐	Thyroid problems (Graves, myxedema, etc.), type:	☐	☐	☐	

Reviewed	Health condition	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	Transplant (candidate, waiting list, recipient, etc.), specify:	☐	☐	☐	
☐	Tuberculosis	☐	☐	☐	
☐	Virus (shingles, herpes, COVID, influenza, etc,), type:	☐	☐	☐	
☐	Vision problems (cataracts, glaucoma, diabetic retinopathy, macular degeneration, etc.), type: Date of last vision test:	☐	☐	☐	
☐	Other (health conditions not listed, significant surgeries, etc.), specify:	☐	☐	☐	

Notes/comments:

Tobacco, Alcohol, and Substance Use/Abuse

(Ask) Do you smoke, chew, or dip tobacco?

☐ Yes **(Ask)** How much do you use per day? _____

☐ No

☐ Used tobacco in the past. Specify when quit. _____

(Ask) Do you drink any alcoholic beverages, including beer and wine?

☐ Drinks alcohol. **(Ask)** On average, how much beer, wine, and other alcoholic beverages do you drink?
Specify frequency: _____

☐ Never drinks alcohol.

☐ Used alcohol in the past. Specify when quit. _____

(Ask) Do you use a recreational substance? For example, methamphetamine, marijuana, LSD, cocaine, heroin, barbiturates, bath salts, ecstasy, pink, spice, inhalants, etc.

☐ Uses **(Ask)** Specify frequency: _____

☐ Does not use.

☐ Used in the past. Specify when quit. _____

(Assessor) Does assessor have concerns about tobacco, alcohol, or substance use/abuse? ☐ Yes ☐ No

Describe why:

Comments and conditions pertaining to health conditions through tobacco, alcohol, and substance use/abuse sections:

Medication Use

Current medicines, refrigerated medicines, and non-prescription drugs such as aspirin, vitamins, laxatives, home remedies, herbal products, and birth control.

Name	Dosage	Frequency	Physician	Date filled

+ -

(Ask) Do you have a medical marijuana license? ☐ Yes ☐ No

Comments:

Pharmacy Information. If more than one, note others in comments.

Pharmacy name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

(Ask) How do you remember to take your medications? **Do not read list. Check answer and specify who gives or fills.**

- ☐ Caregiver gives meds _____
- ☐ Follow directions on label or doctor order _____
- ☐ Plastic pill minder _____
- ☐ Calendar or log _____
- ☐ Egg carton, envelopes _____
- ☐ Other, specify _____

(Assessor) Does assessor have concerns with any of the following? (Check if yes.)

Applicant/member is:

- ☐ not taking meds on time
- ☐ not taking proper number of meds

- ☐ taking meds prescribed for others
- ☐ not getting Rx properly filled
- ☐ not getting med needs re-evaluated
- ☐ not getting meds due to cost
- ☐ affected by drug side effects
- ☐ taking prescriptions from too many physicians
- ☐ using outdated meds
- ☐ refusing to take meds
- ☐ having other medication problems, specify:

Comments and service plan implications:

Medical Utilization

(Ask) In the PAST SIX MONTHS, have you gone to an emergency room, been admitted to a hospital, or seen a doctor (physician's assistant or nurse practitioner, eye doctor, foot doctor, dentist, or hearing exam)?

☐ Yes, complete below
☐ No ☐ Don't know

Name of physician/hospital/ER	Date	How long?	Reason for visit/admission

+ -

(Ask) Were you ever a resident of a nursing home, residential care facility (RCF), or similar place?

☐ Yes, complete below
☐ No ☐ Don't know

Name of facility (RCF, NF, SNF, ICF)	Admit date	Discharge date	Reason for admission

+ -

Special Equipment and Assistive Devices

(Ask) Do you have or need any of the following special equipment or aids?

Equipment/assistive device	Has and uses	Has, but doesn't use	Needs but doesn't have	
Prosthesis, type:	☐	☐	☐	
Cane, type (straight, quad, etc.):	☐	☐	☐	
Walker, type (standard, wheeled, etc.):	☐	☐	☐	

Equipment/assistive device	Has and uses	Has, but doesn't use	Needs but doesn't have	
Wheelchair, type:	☐	☐	☐	
Brace, type (arm, leg, back, etc.):	☐	☐	☐	
Hearing aid(s)	☐	☐	☐	
Glasses	☐	☐	☐	
Contact lenses	☐	☐	☐	
Dentures	☐	☐	☐	
Personal Emergency Response System (PERS)	☐	☐	☐	
Hospital bed	☐	☐	☐	
Toileting equipment, type (bedside commode, toilet rails, elevated toilet seat, etc.):	☐	☐	☐	
Bathing equipment, type (shower chair, tub, transfer bench, hand-held shower, grab bar, etc.)	☐	☐	☐	
Transfer equipment, type (gait belt, slide board, Hoyer lift, etc.):	☐	☐	☐	
Adaptive eating equipment	☐	☐	☐	
Disposal medical supplies, type (ostomy, glucose monitoring, insulin administration, wound care, gloves, etc.):	☐	☐	☐	

Equipment/assistive device	Has and uses	Has, but doesn't use	Needs but doesn't have	
Incontinence supplies, type (pull-up, pads, disposable bed/chair pads, reusable bed/chair pads, etc.):	☐	☐	☐	
Size:				
Other, specify:	☐	☐	☐	

Comments and service plan implications:

Medical Treatments and Therapies

(Ask) Do you regularly receive any of the following medical treatments?

Medical treatment	Yes	No	Frequency/comment
Bedsores treatment	☐	☐	
Blood glucose monitoring	☐	☐	
Bowel/bladder rehab	☐	☐	
Bowel impaction therapy	☐	☐	
Catheter care, type:	☐	☐	
Dialysis, type:	☐	☐	
IV fluids	☐	☐	
IV medicines	☐	☐	
Insulin therapy	☐	☐	
Lesion irrigation	☐	☐	
Ostomy care, type:	☐	☐	
Oxygen treatment	☐	☐	
Respiratory treatment, type:	☐	☐	
Suctioning treatment	☐	☐	
Tube feeding, type:	☐	☐	
Physical therapy	☐	☐	
Occupational therapy	☐	☐	

Medical treatment	Yes	No	Frequency/comment
Speech therapy	☐	☐	
Respiratory therapy	☐	☐	
Wound/skin care dressing, type (aseptic, sterile, compression wrap, Unna boot, etc.):	☐	☐	
Other treatment, specify:	☐	☐	

Comments and service plan implications:

Nutrition

(Ask) Would you say that your appetite is good, fair, or poor?

Good (0) Fair (2) Poor (6) Score: _____

Current weight and height? Weight_____Height _____

(Ask) Have you gained or lost a significant amount of weight in the last six months?

Significant is defined as 10% *unintentional* weight loss or gain in the last six months.

Yes (4) ☐ Gain (10% unintentional last six months) _____pounds

Yes (4) ☐ Loss (10% unintentional last six months) _____pounds

No (0) ☐ Gain (Intentional or <10% unintentional last six months) _____pounds

No (0) ☐ Loss (Intentional or <10% unintentional last six months) _____pounds

Score: _____

(Ask) Do you have any problems that make it difficult to eat?

List score. For example, do you have:	Yes	No
tooth or mouth problems	(4)	(0)
swallowing problems	(4)	(0)
nausea or vomiting	(4)	(0)
taste problems	(0)	(0)
problems eating certain foods	(0)	(0)
food allergies	(0)	(0)
other problems eating, describe:	(0)	(0)
Total:		0

Comments and service plan implications:

(Ask) Has a doctor advised you to follow one or more special diet?

None (0) 1 diet (4) 2 or more diets (6) Score: _____

(Assessor) Check the diet(s) the applicant/member has been advised to follow:

- ☐ Low sodium (salt)
- ☐ Low fat/cholesterol
- ☐ Low sugar
- ☐ Calorie supplement
- ☐ Other prescribed special diet, specify: _____

(Ask) Are you following the diet? ☐ Yes ☐ No

(Ask) Does applicant/member take three or more prescribed or over-the-counter drugs daily?

Yes (2) No (0) Score: _____

Briefly describe what the applicant/member usually eats and drinks during a typical meal.

Meal/snack	Description of typical meal
Breakfast	
Lunch	
Dinner	
Snack	

Specify any religious or self-imposed diets practiced:

Comments and service plan implications:

Nutrition total score

Subjective Evaluation of Health

(Ask) Overall, how do you rate your health: excellent, good, fair, or poor?

Excellent (0) Good (5) Fair (15) Poor (25) Score: _____

(Ask) What makes you feel this way? **(Document answer)**

Subjective Evaluation of Health total score

Personal Goal

(Assessor) Engage the applicant/member in conversation about their life and continue to develop rapport. Talking points might include:

- "What did you do before you retired?"
- "How do you like to spend your time? What are your interests or hobbies?"
- "What are some of the things that are important to you?"
- "Tell me a few things you like people to know about you."

(Ask) What personal goals do you have for yourself? What are some things you would like to try, accomplish, learn, or do?

(Assessor) Rate speaking ability based on performance in the interview:

- ☐ Speaks clearly with others of the same language
- ☐ Some defect in speech/usually gets message across
- ☐ Unable to speak clearly/does not speak

(Assessor) Rate communication ability based on performance in the interview:

- ☐ Transmits/receives information
- ☐ Limited communication ability
- ☐ Nearly or totally unable to communicate

Health Assessment Clinical Judgment

(Related to Health Conditions, Tobacco/Alcohol/Substance Use/Abuse, Medication Use, Medical Utilization, Special Equipment and Assistive Devices, Medical Treatment and Therapies, and Nutrition)

The risk level must be supported by the information obtained in the health assessment. Clearly document the risk level selected. Include specific personal information related to the applicant/ member's health conditions and stability, control of symptoms, unmet needs, medical treatment and oversight, risk of nursing home admission and health management functional capacity as to why the risk level was chosen. *See Clinical Judgment Grid.

Check risk level and document why.

☐ Low risk (5) ☐ Moderate risk (15) ☐ High risk (25) Score: _____

Health Assessment - Clinical Judgment total score ☐

Functional Assessment - ADLs

Check sources of information used for Functional assessment section.

☐ Applicant ☐ Member ☐ Other, specify: _____

For initial assessment: List in the last column assistance needed in addition to what is already in place. Be specific about tasks needed and frequency.

For reassessment: Indicate in the last column if services need to be increased, decreased, or remain at the same level.

Read all choices.

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay
Level of help needed codes: 0 = No assistance 2 = Some assistance/supervision 3 = Can't do at all

Activities of Daily Living (ADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Dressing. Includes getting out clothes, putting them on, fastening them, and putting on shoes.								
Grooming. Includes combing hair, washing face, shaving, and brushing teeth.								
Bathing. Includes running the water, taking the bath or shower, and washing all parts of the body, including hair. Does not include transfers.								

Activities of Daily Living (ADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Eating. Includes eating, drinking from a cup, and cutting foods.								
Transferring. Includes getting in and out of a tub, shower, toilet, bedside commode, bed, chair, sofa, vehicle, etc.								
Mobility. Moving about, even with a cane or walker or using a wheelchair. Independence refers to the ability to walk or move yourself short distances, including to and from the toilet, bedside commode, living area, kitchen, bedroom, etc. Does not include using stairs or the act of transferring; may refer to history of falling that affects routine mobility and is not just a rare occurrence.								
Stairs. Ability to use any stairs that affect your daily activities **three or more times per week**, both in your home and community.								

Activities of Daily Living (ADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Toileting. How well can you manage using the toilet? Independence includes adjusting clothing, adequately wiping self, keeping yourself clean and dry, maintaining cleanliness of the toilet seat, properly disposing of soiled clothing/supplies, and the ability to wash hands following toileting. If reminders are needed, count as some assistance/ supervision. If accidents occur and person manages it alone, count as **NO** assistance. Does not include getting to or from the toilet or on/ off toilet (those tasks are assessed under Mobility and Transferring).								

Activities of Daily Living (ADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Bladder/bowel control. How often do you have bladder or bowel accidents? (See below) ☐ Never (0) ☐ Occasionally (2) ☐ Often (3) ☐ Always (4)	enter one score:			If accidents occur, must include type (bowel and/or bladder) and frequency of accidents per week to support assigned score.				

Definitions:

An accident is defined as the inability of the body to control evacuation of urine or feces severe enough to soak through undergarments, clothing, or bedding onto the skin with or without the use of an incontinence appliance or training program. Dribbling, leakage, or incontinence that does not soak through undergarments, clothing, bedding, or incontinence appliance does not indicate an "Accident." A person may have incontinence and use pads, briefs, or a catheter, however, if the appliance is able to contain the urine or feces, the occurrence is not counted as an accident.

- Never = Bladder and/or Bowel - Complete control or 0 accidents per week. Also count as 0 if control is achieved by an appliance or training program.
- Occasionally = Bladder - 1 or more accidents per week, but not daily. Bowel - 1 accident per week.
- Often = Bladder - 1 daily accident. Bowel - 2-3 accidents per week.
- Always = Bladder - 2 or more daily accidents. Bowel - 4 or more accidents per week.

Scoring note: Bladder/bowel control score is not included in the category totals but is included in the overall ADL score.

Activities of Daily Living (ADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Incontinence. Do you use incontinence products (pads, briefs, underpads, etc.), appliances (urinal, bedpan, bedside commode, catheter, ostomy, etc.) or training programs (scheduled reminders, intermittent use of catheters, enemas, irrigation, etc.)? ☐ Yes (ask question below) ☐ No (skip next question) ☐ Pad ☐ Brief ☐ Urinal/bedpan ☐ Catheter ☐ Training programs ☐ Ostomy ☐ Other:	☐ Training programs ☐ Catheter ☐ Urinal/bedpan Type and quantity per month: Comments:							

Activities of Daily Living (ADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Do you need assistance to change incontinence products, use appliances, or manage training programs?								
Totals	0							

ADL score 0 **ADL impairment count** 0

Functional Assessment - IADLs

For initial assessment: List in the last column assistance needed in addition to what is already in place. Be specific about tasks needed and frequency.

For reassessment: Indicate in the last column if services need to be increased, decreased, or remain at the same level.

Read all choices.

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay
Level of help needed codes: 0 = No assistance 2 = Some assistance/supervision 3 = Can't do at all

Instrumental Activities of Daily Living (IADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Answering the telephone. Ability to identify the signal, pick up the phone, connect, hear, and communicate effectively with the caller, etc. Includes the use of an amplifier or special equipment. (Assessor: Score as if a phone is available.)								
Making a telephone call. Ability to pick up the phone, look-up/ search/select and dial numbers to connect with desired parties, hear and/or communicate effectively with the respondent, etc. Includes the use of an amplifier, special equipment or programmed calling systems. (Assessor: Score as if a phone is available.)								
Shopping/errands. Shopping for food and other things you need. Includes making lists, selecting needed items, reading labels, reaching shelves, completing the								

Instrumental Activities of Daily Living (IADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
purchase, getting items into the home, etc. Does not include getting to and from store.								
Transportation ability. Arranging and using local transportation (without the assistance of an additional person) or driving to places beyond walking distance, to get to places you need to go.								
Prepare meals. Includes all activities involved in preparing foods for balanced, nutritious meals, which might include making sandwiches, cold or cooked meals, TV dinners, etc. May refer to prescribed dietary meals.								
Laundry. Using detergent, getting items in/out of washer or dryer, starting, and stopping the machine, or otherwise washing and drying, sorting, folding, putting away, etc.								

Instrumental Activities of Daily Living (IADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Light housekeeping. Includes dusting, vacuuming, sweeping, mopping, cleaning bathroom, changing sheets, etc. Does not include laundry or areas of the home not used by the applicant/ member.								
Heavy chores. Washing windows, changing light bulbs or smoke detector batteries, moving furniture, general home maintenance, yardwork.								
Taking medication. Ability to identify correct medication, set up, remember, and take your own medication in correct doses and methods.								

Instrumental Activities of Daily Living (IADLs) Do you need assistance with:	No assistance	Some assistance/ supervision	Can't do at all	Comment (Required to justify some assistance/ supervision or can't do at all)	Name and phone number of assistant	Assistant code	Frequency, hours, etc.	Assistance needed
Managing money. Ability to stay within your budget or financial resources, paying bills when due, balancing checkbook, etc. Refers to managing your own money.								
Totals	0							

IADL score 0 **IADL impairment count** 0

Applicant/Member Support and Social Resources

Check sources of information used for support and social resources.

☐ Applicant ☐ Member ☐ Other, specify: _____

For initial assessment: List in the last column assistance needed in addition to what is already in place. Be specific about tasks needed and frequency.

For reassessment: Indicate in the last column if services need to be increased, decreased, or remain at the same level.

Level of help needed codes: 0 = No assistance 2 = Some assistance/supervision 3 = Can't do at all

Applicant/Member Support **Do you receive assistance from a formal support not already identified in the ADL/IADL sections, such as:**	**Yes**	**No**	**Name and phone number of assistant**	**Frequency, hours, etc.**	**Assistance needed**
a health professional (RN, therapist, hospice, etc.), specify:	☐	☐	☐ Agency ☐ Church ☐ Private pay ☐ Other		
adult day health services	☐	☐	☐ Agency ☐ Church ☐ Private pay ☐ Other		
home-delivered meals	☐	☐	☐ Agency ☐ Church ☐ Private pay ☐ Other		
other assistance (respite, assisted living, etc.), specify:	☐	☐	☐ Agency ☐ Church ☐ Private pay ☐ Other		

Social Resources

The questions in this section help identify informal supports (family, friends, church, etc.) and activities that are important to the applicant/member.

(Assessor) Does applicant/member live alone? ____Yes (6)_____No (0)

(Ask) Is there someone who could stay with you if you needed help or if you were sick?

____Yes (0), complete below ____No (6)

Name	Relationship	Phone

If you could not continue to live in your present location, do you have any ideas about where you would live?

- ☐ Home
- ☐ Nursing home
- ☐ Assisted living
- ☐ Don't know
- ☐ Smaller home (apartment, mobile home)
- ☐ Relative's home, specify: _____
- ☐ Residential care facility or group home
- ☐ Other, specify: _____

Is there a person you can talk to when you have a problem?

____Yes (0), complete below ____No (4)

Name	Relationship

Do you have a pet or pets? ☐ Yes, specify: _____ ☐ No

How often do you talk to friends, relatives, or others on the phone or through another electronic device to communicate verbally or otherwise, either they contact you or you contact them?

- ____Once a day or more (0)
- ____2-6 times a week (1)
- ____Once a week (2)
- ____1-3 times a month (3)
- ____Less than once a month (4)
- ____No phone or communication device (4)

Name	Phone number

Comments:

How often do you spend time with someone who does not live with you? You go to see them, they come to visit you, or you do things together, in or out of the home?

____Once a day or more (0) ____1-3 times a month (3)
____2-6 times a week (1) ____Less than once a month (4)
____Once a week (2)

Name	Phone number

Comments:

What activities or interests do you enjoy?

Record the activities/interests in which the applicant/member currently participates. It is also helpful to ask if there are activities/interests he/she used to enjoy but is no longer able to do.

Are you able to attend services or practice your religious or spiritual beliefs as often as you would like? ☐ Yes ☐ No ☐ N/A

Name of church/synagogue/mosque, etc: _____

Contact person: _____

Notes (provide pertinent information such as why the applicant/member is unable to attend religious services or practice spiritual beliefs as desired):

Social resources total score

Comments and service plan implications:

Mental Health

As with the MSQ and Subjective Evaluation of Health, the Mental Health Assessment questions are answered by the applicant/member only. If other sources of information are present and contribute information, note the comments and the source to distinguish their information from that of the applicant/member. If it is not possible for the applicant/member to respond, document the reason in the comment box.

Check source of information used for mental health:

☐ Applicant ☐ Member ☐ Other, specify: _____

(Assessor) Is there any indication that the applicant/member has a current mental health problem? ☐ Yes ☐ No

If yes, describe:

(Ask) Are you currently, or have you previously, received mental health services or counseling?

☐ Yes, complete below ☐ No

Provider name _____ Phone _____

Comments:

Emotional Well-Being

(Say) Now I have some questions about how you have been feeling during the **past month**.

Are you satisfied with your life?	☐ Yes ☐ No
Have you been feeling in good spirits?	☐ Yes ☐ No
Have you been depressed or very unhappy?	☐ Yes ☐ No
Have you been very anxious or nervous?	☐ Yes ☐ No
Have you had difficulty sleeping due to a mental health condition?	☐ Yes ☐ No
Have you seen or heard things that other people didn't see or hear?	☐ Yes ☐ No
Have you had serious thoughts about harming anyone?	☐ Yes ☐ No
Have you had serious thoughts about harming or killing yourself?	☐ Yes ☐ No
Is anyone plotting against you?	☐ Yes ☐ No

Comments and service plan implications:

Memory Assessment

(Say) I'd like to ask you some questions about your memory and ability to find things. In the **past month**:

Have you had any problems with your memory?	☐ Yes ☐ No
Specify: _____	
Have you frequently lost items, such as your keys, purse, wallet, or glasses?	☐ Yes ☐ No
Have you had difficulty recognizing family members or friends?	☐ Yes ☐ No
Have you lost your way around the house? For example, couldn't find your bedroom or bathroom.	☐ Yes ☐ No
Have you forgotten to turn the stove off?	☐ Yes ☐ No

Comments and service plan implications:

(Assessor) In your judgment, does the applicant/member:

appear to be depressed, lonely, or dangerously isolated? ☐ Yes ☐ No

wander away from home for no apparent reason? ☐ Yes ☐ No

need supervision? If yes, specify how much, such as constant, at night only. ☐ Yes ☐ No

_____

pose a danger to self or others? ☐ Yes ☐ No

show suicidal ideation? ☐ Yes ☐ No

demonstrate significant memory problems? ☐ Yes ☐ No

exhibit other behavior problems? ☐ Yes ☐ No

Specify: _____

Comments and service plan implications:

Does the applicant/member require:

☐ Immediate intervention

Document why: _____

Document action taken: _____

☐ Immediate intervention

☐ Immediate intervention

Comments:

Environmental Assessment

Subjective Evaluation of Environment

(Ask applicant/member only) Are you concerned about your safety in your home or neighborhood? ☐ Yes ☐ No

If yes, comment required:

(Assessor) Indicate specific area in which there are potential safety or accessibility problems for the applicant/member. Scoring relates to physical barriers in this section (transfers and mobility are assessed in ADLs).

☐ Structural damage/dangerous floors

☐ Barriers to access, including steps and stairs

☐ Electrical hazards

☐ Fire hazards/safety equipment

- ☐ Unsanitary conditions/odors
- ☐ Insects or other pests
- ☐ Poor lighting
- ☐ Insufficient water/hot water
- ☐ Insufficient heat/air conditioning
- ☐ Shopping
- ☐ Transportation
- ☐ Telephone
- ☐ Neighborhood unsafe
- ☐ Unable to evacuate in emergency

Problem area:

Landlord name _____ Phone _____

Yardwork/home repair person _____ Phone _____

Environmental - Clinical Judgment

The Environmental Assessment Score is based upon the assessor's judgment of the applicant's/member's physical environment. Assessor's judgment should concern only items/situations that may threaten the applicant's/member's ability to live safely in the environment.

The physical environment is generally well equipped and supportive.	No risk (0) ____
The physical environment has a few negative aspects.	_____
The physical environment is negative.	Low risk (5) ____
The physical environment is strongly negative and hazardous.	Moderate risk (15) ____
	Environmental ~~total score~~ ____
	High risk (25) ____

Provide applicant/member specific justification for the level of risk selected:

Comments:

Caregiver Assessment

The intent of this section is to assess the primary informal caregiver's response to caregiving and to determine their capacity to continue. The primary informal caregiver is any individual, usually family or a friend, who provides care and support on a regular basis and who does not get paid for their assistance. If an informal individual is listed in the ADL or IADL section as providing assistance on a regular basis, that individual is considered to be a caregiver.

(Ask) Does an informal caregiver help you on a regular basis? ☐ Yes ☐ No

Comments:

Are you comfortable receiving assistance from [caregiver name]? ☐ Yes ☐ No

Comments:

☐ Caregiver assistance is present, complete this section.

☐ No caregiver assistance is present, go to Recommendations.

Informal caregiver name _____ Relationship _____

Address _____ Phone _____

Address the following questions to the caregiver alone:

(Ask) How long have you assisted **[name of applicant/member]**? ____years ____months

How often do you assist **[name of applicant/member]**? Would you say you assist:

☐ every day
☐ several times a week
☐ at least once a week
☐ less than once a week
☐ never
☐ don't know

What kind of assistance do you provide **[name of applicant/member]**?

If caregiver gave information in Section ADLs/IADLs and Applicant/Member Support and Social Resources, verify and note here and go to next section.

You help with:	Yes	No	Comments
Personal care - assistance with bathing, dressing, using the toilet, getting in and out of bath, and feeding	☐	☐	
Housekeeping - assistance with meal preparation, cleaning, and laundry	☐	☐	
Transportation	☐	☐	
Shopping/errands	☐	☐	

You help with:	Yes	No	Comments
Supervision for safety concerns	☐	☐	
Money management	☐	☐	
Other, specify (medications, heavy chores, etc.):	☐	☐	

Do other family members or friends also provide care to **[name of applicant/ member]**? ☐ Yes ☐ No

Comments:

Thinking of the help you get from family and/or friends in providing care, please identify the response that most closely describes your situation:

- ☐ I receive no help.
- ☐ I receive far less help than I need.
- ☐ I receive about what help I need.
- ☐ I don't need any help.

Are you employed? ☐ Full-time ☐ Part-time ☐ Not working at all

Has your employment status changed *because of caregiving duties*?

- ☐ No change ☐ Changed jobs ☐ Family/Medical leave
- ☐ Leave of absence ☐ Use of vacation time/personal leave
- ☐ Increased hours ☐ Decreased hours ☐ Early retirement
- ☐ Began working ☐ Quit job ☐ Laid off
- ☐ Terminated ☐ Other, specify: _____

If you were suddenly unable to provide care, who would take your place?

☐ No one ☐ Other, specify: _____

Would you say your health is: ☐ excellent ☐ good ☐ fair ☐ poor?

How often in the past six months have you had a medical exam or received treatment from a healthcare practitioner for physical health problems?

Comments:

Have you experienced anxiety or depression in the past twelve months? ☐ Yes ☐ No

If yes, describe:

In addition to caregiving, have you recently had a major stress in your life such as a death, job loss, or divorce? ☐ Yes ☐ No

If yes, describe:

Considering the assistance you provide, I would like to ask you if various aspects of your life have become better, stayed the same, or become worse since you began providing care. Let's start with…

	Better	Same	Worse	Don't know
Relationship with [name of applicant/member	☐	☐	☐	☐
Relationships with other family members	☐	☐	☐	☐
Relationships with friends	☐	☐	☐	☐
Your health	☐	☐	☐	☐
Your work, if applicable	☐	☐	☐	☐
Your emotional well-being	☐	☐	☐	☐

Is there anything that makes it difficult for you to manage the care you provide? ☐ Yes ☐ No

If yes, describe:

Do you need information about education or training on how to care for [name of applicant/member]? ☐ Yes ☐ No

If yes, describe:

Comments:

(Assessor) Has providing care to the applicant/member become a problem for the caregiver?

☐ Very much a problem ☐ Somewhat a problem ☐ Not a problem at all

(Assessor) How likely is it that [caregiver] will continue to provide care?

☐ Very likely ☐ Somewhat likely ☐ Unlikely

Comments on caregiver and service plan implications:

Applicant/Member Support - Clinical Judgment

(Related to Functional Assessment, Support and Social Resources, Mental Health, Environmental, and Caregiver Assessment.)

The intent of the Applicant/Member Support - Clinical Judgment is to rate the level of risk posed by the need for informal and formal supports and services. Once a risk level is determined, the assessor is required to document ***how*** an applicant/member meets the criteria for that risk level.

*See Clinical Judgment Grid.

On initial assessments for eligibility, the assessor may find dedicated family supports and rate as low risk. The task, however, is to analyze if there are service needs beyond what the current informal and formal resources can provide AND whether current supports are stable. If current supports are inadequate or fragile (meaning they cannot be sustained at the current level), and additional services are needed, the risk is at least moderate.

On reassessments, the assessor may mistakenly score the risk as low because services are in place and stable. The needs, however, may not have changed at all, indicating the assessor has rated the effectiveness of the services instead of the need for them. With reassessments, the assessor needs to ask, "If State Plan or ADvantage waiver services were not in place, would the needs be met?" If the answer is "no", the risk level is at least moderate. If the answer is "yes", then the Team may need to reevaluate program appropriateness.

Indicate the level of need for additional services:

_____ Very low (0)_____ Low (5)_____ Moderate (15)_____ High (25)

Applicant/member support total score ☐

Justify informal supports:

Justify formal supports:

Select a primary and secondary diagnosis and code that reflects the main reason that the applicant/member needs Home and Community Based Services. Codes that are procedure, aftercare, history, external cause, or status codes are not appropriate for Waiver billing and should not be used.

(Assessor) Record primary and secondary diagnosis and code.

Primary diagnosis _____ ICD code _____

Secondary diagnosis _____ ICD code _____

Summary: The summary section is typically completed last and away from the interview site to ensure deliverance of a holistic picture of the applicant/member and their circumstances. For individuals wishing to remain in their own home, it should be a synthesis of the health of the individual and a summary of the baseline services required to prevent premature institutionalization. At reassessment, the professional summary should note any changes, improvements or deterioration in condition, new treatments, etc.

Recommendations

Scoring matrix

Domain	Low range	Moderate range	High range	Score

Domain	Low range	Moderate range	High range	Score
Cognitive functioning (MSQ)	(0-6)	(7-11)	(12-28)	0
Nutrition	(0-8)	(9-11)	(12-30)	
Subjective evaluation of health	(0-5)	(15)	(25)	
Health assessment - clinical judgment	(5)	(15)	(25)	
Functional - ADL count: 0	(0-2)	(3-9)	(10-31)	0
Functional - IADL count: 0	(0-2)	(3-11)	(12-30)	0
Social resources	(0-6)	(7-14)	(15-24)	
Environmental - clinical judgment	(0-5)	(15)	(25)	
Applicant/member support - clinical judgment	(0-5)	(15)	(25)	
Total score				0

Overall risk score ranges, check one:

☐ Low (0-44) ☐ Moderate (45-116) ☐ High (117-243)

Is applicant/member homebound? ☐ Yes ☐ No

Should applicant/member be referred for:

physical health assessment/services? ☐ Yes ☐ No

mental health assessment/services? ☐ Yes ☐ No

Was assessor override used for any of the domains? ☐ Yes ☐ No

If yes, provide written justification:

Alternatives

What alternatives were discussed with the applicant/member/caregiver? (select all that apply)

☐ a. Home with services
☐ b. Home without services
☐ c. Assisted living, RCF
☐ d. Mental health residential facility
☐ e. Nursing home
☐ f. Short-term respite care
☐ g. Short-term nursing home stay with intent to return home with services
☐ h. Developmental services facility (ICF/ID)/waiver
☐ i. Applicant/Member refuses service - place in NF, SNF, ICF
☐ j. Applicant/Member refuses service - remains in community
☐ k. Adult day health services
☐ l. ADvantage
☐ m. Other: _____
☐ n. Undecided

Recommendations

In your judgment, the applicant/member:

- ☐ has community potential:
  - ☐ low
  - ☐ moderate
  - ☐ high
- ☐ requires care in a nursing home on a temporary basis but community potential exists
- ☐ requires care in a nursing home

Choose code from the Alternatives list above:

Applicant's/member's choice _____

Family/caregiver's choice: _____

Assessor's recommendation: _____

Assessor name	Agency/program	Date

☐ Living Choice ☐ Medically Fragile

COMMUNITY SERVICE PLAN AUTHORIZATION REQUEST CHECKLIST

Participant Name				SoonerCare ID	
	Last	*First*	*Middle*		

☐ A. INITIAL ASSESSMENT

Pre-assessment

_____ Participant Consents and Rights
_____ Release of Information
_____ UCAT I & III
_____ Quality of Life Survey (QOL)

Post-assessment

_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan

STOP
This Section only pertains to The Living Choice Demonstration Program

☐ B. INITIAL COMMUNITY SERVICE PLAN

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ IDT Meeting
_____ 485 & Scripts for Durable Medical Equipment
_____ RN Evaluation
_____ Conflict Free Case Management
_____ Other, only if necessary, for this plan (i.e., Nutritional Supplement, Environmental Mods)

☐ C. REASSESSMENT

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ IDT Meeting
_____ 485 & Scripts for Durable Medical Equipment
_____ RN Evaluation
_____ Conflict Free Case Management
_____ Other, only if necessary, for this plan (i.e., Nutritional Supplement, Environmental Mods)

☐ D. ADDENDUM

_____ Community Service Plan Addendum
_____ Revised Goal(s)
_____ Other, only if necessary, for this plan

SIGNATURES

Documentation marked above was sent:

TC/CM Agency	TC/CM Signature	Date

REQUEST FOR NUTRITIONAL SUPPLEMENT

☐ Living Choice ☒ Medically Fragile

Participant Name				
	Last	First	M.I.	SoonerCare ID

A. DESCRIPTION

Oral Nutritional Supplements provide medically necessary nutrient intake for individuals with special nutritional needs related to a specific medical condition for which the use of oral nutritional supplements is an accepted treatment. The participant must either have a medical condition requiring special nutrients or preventing him/her from obtaining sufficient nutrients with food alone, have a Body Mass Index below 21, or have experienced a significant weight loss.

B. TYPE OF REQUEST

☐ New Request ☒ Request for extension ☐ Request for change in authorized product and/or quantity

C. PRESCRIPTION

Physician's prescription must include specific product name, amount, frequency and related diagnosis.

☒ **Physician's prescription attached (required)** Product Name: _____

Amount & Frequency: 4- cans per day per peg with 500ML of water Related Diagnosis: 787.20/783.41

D. CURRENT RELATED MEDICAL CONDITIONS (Please check all that apply and indicate date of onset.)

Condition	Date of Onset	Condition	Date of Onset
☐ Renal Dialysis		☒ Other Shaken Baby	01/01/1991
☐ Chemotherapy Frequency: _____		☒ Other Cerebral Palsy	01/01/1991
☐ Radiation Frequency: _____		**Wounds**	**Date of Onset**
☐ Burns (within past 3 months) Location/Degree: _____		☐ Location: _____ Stage/Type: _____	
☐ Sepsis (within past 3 months) Type: _____		☐ Location: _____ Stage/Type: _____	
☐ Major Surgery (within past 3 months) Type/Location: _____		☐ Location: _____ Stage/Type: _____	
☐ Major Trauma (within past 3 months) Type: _____		☐ Location: _____ Stage/Type: _____	

LONG TERM CARE ADMINISTRATION

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COMMUNITY SERVICE PLAN ADDENDUM

Participant Name	Last	First	M.I.	SoonerCare ID	

REVISED SERVICES AND GOALS

Put Appropriate Amount for the Pay/Support Source: I=Informal; P=Private Pay; O=Other; M=Medicare; SP=State Plan; SC=Self Care

SERVICES/SUPPORT

Service line to be ended:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

Service line to be added:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program
B4150	Jevity	Preferred Pediatrics	360	Y	360	$ 2.02	10/30/2017	01/30/2018							2351.52

GOALS

Expected Outcome	Action Steps	Monitoring of Expected Outcome
has all nutritional needs met.	1. is NPO, All Nutrition is received through peg tube (Jevity). has no PO potential . 2. Preferred Pediatrics will deliver Jevity monthly paid for by Med-Frag. 3.Preferred Pediatrics will administer Jevity per Dr. orders. 4 cans per day per peg w/500ML of water. 4. will maintain a healthy weight and receive all needed nutrition. 5.CM/MD will assess weight, nutrition, and need for changes monthly and as needed.	How will outcome be monitored? RN/CM HOW OFTEN will monitoring occur? RN 2xyrly/CM monthly HOW LONG will monitoring continue? ☒ Plan Year ☐ Until Expected Outcome is met

Participant/Legal Representative Initials_____

NOTE: Full signature required on final page only. Initials required for all other pages.

OKHCA Revised 10-27-2015

E. HEIGHT/WEIGHT INFORMATION

1. Participant's current height/weight: 4'8 / 117 Date weighed: 09/01/2017
2. Participant's Body Mass Index (BMI): _____
   BMI below 21: ☐ Yes (skip to Section F – authorization guideline met) ☐ No (continue to #3 below)
3. Previously documented weight: 119 From: ☐ UCAT ☒ RN Eval ☐ Other _____
4. Date of previous weight: 06/28/2017 Total pounds lost: 2 % body weight lost: _____
5. Documented weight loss: ☐ 10% loss past 6 months ☐ 5% loss past 30 days ☒ Neither

F. CORRESPONDING GOALS

☒ **Corresponding goals attached (required)**

Corresponding goals must include the following information:
1) The nutritional outcome of the request (wound healing, increased weight, etc.);
2) What steps are to be taken to meet nutritional goals and by whom; and
3) How, how often, and by whom progress toward outcome will be assessed.

G. ADDITIONAL SUPPORTING DOCUMENTATION (Optional)

Member is NPO, All nutrition from peg tube (Jevity). Member has no po potential and will not change , most recent weight was from hospital stay.

Signature of Participant or Legal Agent (If Participant signs with a mark, two witnesses are required.)	Date	Signature of TCCM	Date
Signature of Witness	Date	Signature of Witness	Date

AUTHORIZATION GUIDELINES

Authorization for payment of oral nutritional supplement products requires documentation of medical necessity by the TC/CM. An Orally Administered Nutritional Supplement – Documentation of Need must be completed and signed by the Participant and the TC/CM. The TC/CM must document the medical need for which oral nutritional supplement is an accepted treatment, the nutritional outcome, action steps and monitoring plan. The TC/CM must submit:

1. a completed and signed Request for Nutritional Supplement form
2. a copy of physician's prescription The prescription must include specific product, amount, frequency, and related diagnosis for which the nutritional supplement is being prescribed)
3. the Plan or Plan Addendum for authorization (please indicate amount requested in monthly quantity).

COMMUNITY SERVICE PLAN ADDENDUM

Participant Name				SoonerCare ID #	
	Last	*First*	*M.I.*		

SERVICES/SUPPORT

Service line to be ended:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

Service line to be added:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

GOALS

Expected Outcome	Action Steps	Monitoring of Expected Outcome
		How will outcome be monitored? HOW OFTEN will monitoring occur? HOW LONG will monitoring continue? ☐ Plan Year ☐ Until Expected Outcome is met

Participant Agrees to Addendum: ☑ Yes ☐ No

Signature of Participant or Legal Agent **Date**
(If Participant signs with a mark, two witnesses are required.)

Witness Signature and Date:

Witness Signature and Date:

Supporting Documentation:

Date Submitted:

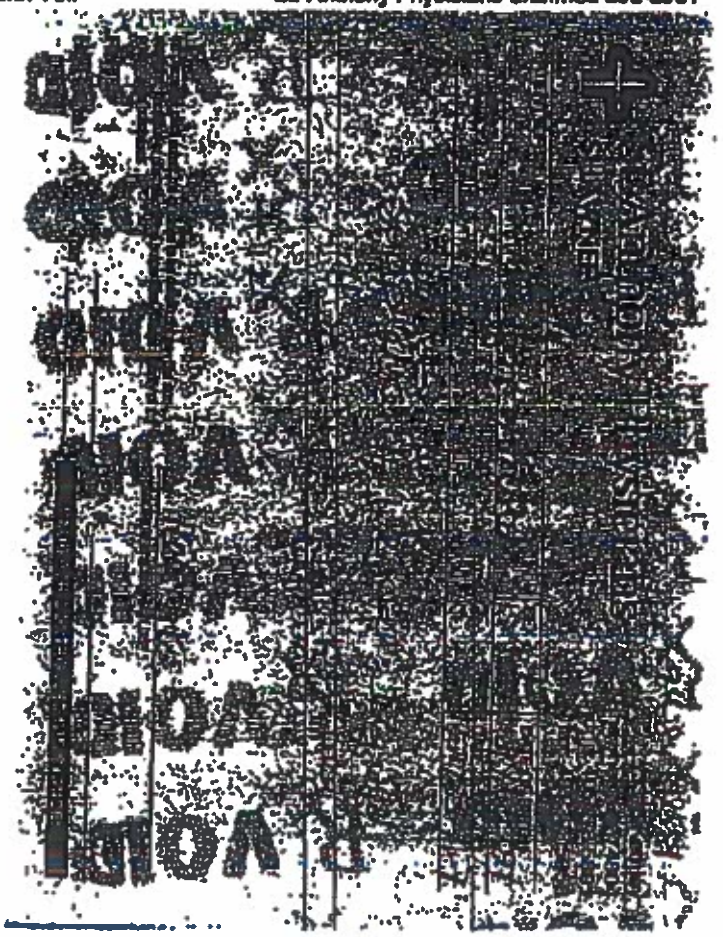
TC/CM Name (Print or Type):

TC/CM Signature:

TC/CM Supervisor Signature:

TC/CM Agency:

Program – Administrative Use Only



COMMUNITY SERVICE PLAN

C. SERVICES AND GOALS - #1

SERVICE/ SUPPORT	Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Put Appropriate Amount for the Payer Source: Informal	Private Pay	Other	Medicare	State Plan	Self Care	Program
	T1016	Case Mgt	Case Management Agency	250	Y	250	$ 14.25							$ 3,562.50

GOAL #1	Expected Outcome	Action Steps	Monitoring of Expected Outcome
	Sooner is managing her health, environment and safety needs and is directing all assistance to maintain a safe and supportive environment	Transition Coordination/Case Management will visit monthly, at a minimum, to monitor Sooner's community plan and goals and determine the need for change in services, level of assistance, supplies or education. TCCM will amend the community plan as needed. TCCM will collaborate with Beth and all team members, through the use of IDT, meeting, to address changes in Sooner's health and social status	HOW will outcome be monitored? Home Visits HOW OFTEN will monitoring occur? Monthly and PRN HOW LONG will monitoring continue? ■ Plan Year ☐ Until Expected Outcome is met

SERVICES AND GOALS - #2

SERVICE/ SUPPORT	Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Put Appropriate Amount for the Payer Source: Informal	Private Pay	Other	Medicare	State Plan	Self Care	Program
	T1019	Personal Care	Home Health Agency	56	W	2912	$ 3.92							$ 11,415.04

GOAL #2	Expected Outcome	Action Steps	Monitoring of Expected Outcome
	See Supplemental Goal and Outcome	See Supplemental Goal and Outcome	HOW will outcome be monitored? Home Visits HOW OFTEN will monitoring occur? Monthly HOW LONG will monitoring continue? ■ Plan Year ☐ Until Expected Outcome is met

LONG TERM SERVICES AND SUPPORTS

☐Living Choice ☐Medically Fragile

Supplemental Community Service Plan Goals & Outcomes

Participant Name	Boomer	Sooner	O	123456789
	Last	*First*	*M.I.*	*SoonerCare ID*

Challenges	Strengths
Risk for infection due to ventilator dependence	Able to direct own care
Immobility	Able to express needs
History of Falls	Strong informal support system in place
	Alert

ANTICIPATED OUTCOMES	ACTION STEPS
Goal # 2 Boomer is managing his personal care and homemaking needs with assistance. He is directing all aspects of his ADLs and IADLS. He is clean, groomed and free of odors and is apartment is clean. Odis has transportation needed to keep his appointments and for socialization.	A) Boomer will have assistance with homemaking and chores under self-directed services. B) Odis will recruit, hire and train his PSA under self-direction and will monitor hours to remain within authorized # of hours per plan year. C) PCA will assist Boomer 14 hours a week with the following as directed by Boomer: 1. Personal Care - 3 hours/week: Boomer will perform as much of his own personal care as he is able and PCA will provide transfer assistance, safety supervision and assist Boomer with reaching areas that he unable to safely reach. PCA to clean and sanitize bathroom following personal care. 2. General homemaking - 2 hours/week: PCA to dust, sweep, mop and vacuum living area and bedroom. Take out trash. 3. Meal Prep - 3 hours/week: PCA to prepare meals for member, clean and sanitize kitchen and wash dishes following meal prep. Clean out refrigerator weekly. Wipe out and sanitize microwave and clean coffee pot.

ANTICIPATED OUTCOMES	ACTION STEPS
Goal # 2	4. Laundry - 2 hours/week: PCA to sort, wash, dry, fold and put away linens and clothing. Change bed linens weekly. 5. Shopping and Errands - 2 hours/week: PCA to assist Boomer with preparing a list, shop for items, bring back and put away. Pick up prescription upon request. 6. Transportation - 2 hours/week: PCA to provide transportation to appointments, errands and socialization activities.

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☐ Medically Fragile

COMMUNITY SERVICE BACK-UP PLAN

Participant Name	Boomer	Sooner	O	SoonerCare ID #	123456789
	Last	*First*	*M.I.*		

REQUIRED DOMAINS

NOTE: Disaster-preparedness is not addressed in this document – See Disaster Preparedness Plan for actions related to disaster planning.

List Specific Risks	Tier I Formal Support	Tier II Informal Support	Tier III Back-Up Support	Tier IV Extreme Emergency
Direct Care Assistance Potential for risk of injury and illness if Personal Care needs not met and apartment kept clean & free of clutter	Home Health Agency Staffing Coordinator Case Management Agency/Case Manager	Family or Friends	PCP After Hours:	■ 911 ☐ Other
Critical Health - Supportive Services Potential for deterioration of health & function if skilled nurse not available for health monitoring & medication management	PCP Information goes here Case Management Agency	Family or Friends	PCP After Hours:	■ 911 ☐ Other

LONG TERM CARE WAIVER OPERATIONS
COMMUNITY SERVICE BACK-UP PLAN

REQUIRED DOMAINS

NOTE: Disaster-preparedness is not addressed in this document – See Disaster Preparedness Plan for actions related to disaster planning.

List Specific Risks	Tier I Formal Support	Tier II Informal Support	Tier III Back-Up Support	Tier IV Extreme Emergency
Equipment – Maintenance Options Potential risk for injury if equipment malfunctions or breaks	All DME Providers goes here	Family or Friends		☒ 911 ☐ Other
Transportation Potential risk for isolation and deterioration of health if transportation is not available to physician appointments or socialization activities.	SoonerRide or any other transit system in that area	Family or Friends		☒ 911 ☐ Other

LONG TERM CARE ADMINISTRATION

☐ **Living Choice** ☐ **Medically Fragile**

CRITICAL INCIDENT REPORT: EVALUATION

Participant Name				**SoonerCare ID**	
	Last	*First*	*MI*		
Name of Person Reporting					

A. CRITICAL INCIDENT LEVELS AND EVENTS

Critical Incident Level	INCIDENT Please check box that describes incident.	Reporting Time Lines	Follow-Up Requirements
Level I – Urgent	☐ Sexual abuse ☐ Lost or missing person ☐ Questionable, unexpected or preventable death ☐ Suicide attempt ☐ Neglect* ☐ Physical abuse* ☐ Exploitation*	Within 1 working day	***Investigation Required.*** Report on investigation required.
Level II – Serious	☐ Involvement with the criminal justice system ☐ Restraint use ☐ Medication error with adverse effects ☐ Falls with injury	Within 2 working days	Evaluation required. ***May require investigation.*** If investigated, report on investigation required.
Level III – Significant	☐ Verbal abuse* ☐ Hospitalizations ☐ Emergency room visits ☐ Other	Within 2 working days	Evaluation required. ***May require investigation.*** If investigated, report on investigation required.

*** OKDHS/APS is the lead investigative authority in the event of critical events regarding abuse, neglect or exploitation.**

B. DETAILS OF INCIDENT

Date and Time of Incident:		Date Agency Aware of Incident:	
Witnesses to Incident:		Location of Incident:	
Description of Incident:			
Action Taken and Outcome:			
Did the Incident result in a change in the agency's Continuous Quality Improvement Plan? ☐ Yes ☐ No If 'Yes' – has the change been implemented? Please comment:			
Agency Investigation Required? ☐ No ☐ Yes ****If Yes: <u>Submit Critical Incident Investigation Report</u>**			
Who was notified about this incident? ☐ OKHCA or Designee	☐ Supervisor/TC/CM ☐ Law Enforcement	☐ APS ☐ Legal Guardian	☐ Other (list)

C. SUPERVISORY REVIEW

Agency Supervisor has reviewed Critical Incident Report Evaluation: ☐ Yes ☐ No		
Date Critical Incident Report Evaluation was reviewed?	TC/CM Supervisor Signature:	
Was Critical Incident a result of Back Up Plan failure? ☐ Yes ☐ No		

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☐ My Life; My Choice ☐ Sooner Seniors ☐ Medically Fragile

CRITICAL INCIDENT REPORT: INVESTIGATION

Participant Name	Sooner	Boomer	O	SoonerCare ID	123456789
	Last	First	MI		
Name of Person Reporting	Case Manager/Home Health Provider/Support System				

A. CRITICAL INCIDENT

(Describe Critical Incident)

Detailed Information as best as you can

B. EVIDENCE COLLECTED

(Describe evidence collected – Types of evidence include: testimonial; documentary; demonstrative, and physical)

Statements and/or Tangible evidence

C. ASSESSMENT OF EVIDENCE

(What is the root cause of the Critical Incident?)

Was this preventable?

D. CONCLUSIONS AND RECOMMENDATIONS

(What are your conclusions? What are your recommendations to resolve this issue and assure the Participant's future health and welfare?)

What did you conclude and what did you implement to avoid future risks

E. QUALITY IMPROVEMENT IMPLICATIONS

(How will the conclusions and recommendations from Section D enhance your organization's continuous quality improvement system?)

How will you strengthen your current strategy to further prevent this incident from happening again

F. SUPERVISORY REVIEW

TC/CM Supervisor has reviewed Critical Incident Report Investigation: ■ Yes ☐ No

Date Critical Incident Report Investigation was reviewed? 03/23/2014 TC/CM Supervisor Signature:

Comments: For the Case Manager's Supervisor use

Monthly Monitoring

Member: _____ **Date:** _____

CM Agency: _____ **RID:** _____

OUTCOMES	**Service plan:_____ to _____**
CHRONIC HEALTH MANAGEMENT: Member is managing chronic health problems. Member has all needed medications and supplies. Taking all meds and keeping appointments. Member is informed of plan and understands pros and cons of not following. CM is providing oversight to service plan goals and is monitoring monthly. SN as authorized. **G0299/G0300: Correct code, frequency: *as authorized***	Met □ Unmet □ Partially met □ Changes/comments:
New Medication Orders:	Met □ Unmet □ Partially met □ Changes/comments:
Nutrition-Enteral Feedings:	Met □ Unmet □ Partially met □ Changes/comments:
DISEASE MANAGEMENT: **CM to add Disease Management outcomes from current goals to include wound care if members is receiving	Met □ Unmet □ Partially met □ Changes/comments:

CM Initials:

PERSONAL CARE MANAGEMENT: Has assistance as needed. PCA is completing all tasks per service plan goals (if applicable). Bathroom safety equipment in place and used appropriately. Skin is intact. Neat, clean and well groomed. Has assistance when PCA is not in place. **PDN Nursing**_____ **PCA units for personal care**_____***as authorized*** **ASR units**_____ ***as authorized*** **Incontinence supplies**: *Type and Frequency (Monthly)*_____	Met □ Unmet □ Partially met □ Changes/comments:
HOUSEHOLD MANAGEMENT: Has assistance as needed. Member is managing household tasks. Home is as clean as member desires, pathways are clear, has clean clothes/linens, groceries and supplies. PCA is completing all tasks per service plan goals (if applicable). Bills are paid and utilities are on. Transportation needs are met. **PCA units**_____ ***as authorized*** **ASR units**_____ ***as authorized*** **HDM: List Provider and number of meals per week** _____	Met □ Unmet □ Partially met □ Changes/comments:
SAFETY/FALL MANAGEMENT: Member is safe at home. Able to verbalize emergency plans for weather, evacuation, location of telephone numbers for emergency contact and services. Verbalizes understanding of fall prevention plan. Uses assistive devices/equipment as instructed. Member verbalizes understanding of all prevention tips and is following recommendations to avoid falls. Able to exit home in an emergency and can call for help if needed. Verbalizes understanding of monthly education on abuse, neglect and exploitation. ****If member unable to call for help or evacuate the home without assistance, include how this need will be met.** **PERS: □ SYSTEM TESTED THIS MONTH: □**	Met □ Unmet □ Partially met □ Changes/comments:

CM Initials:

PERSONAL GOAL: Meeting goal as evidenced by: ****Document personal goal.**	Met □ Unmet □ Partially met □ Changes/comments:
HIGH RISK MANAGEMENT: Member has supervision in place as needed. Following plan goals. Has medical oversight. No ER visits or hospitalization in last 30 days. Is able to call for help in case of emergency. ****If ER/Hospital include information below.** **ER Visit Location and date: _____** **Hospital Admission Location and date: _____** **Outpatient Visit: Location and date: _____**	Met □ Unmet □ Partially met □ Changes/comments:
MENTAL HEALTH: Member has counseling services available, if desired. Mood has improved. Appetite is adequate. Member is getting enough sleep. No thoughts of suicide. Less irritable. Less restless. Member knows when to seek emergency care for depression or other mental health issues. Taking mental health medications as prescribed.	Met □ Unmet □ Partially met □ Changes/comments:
SOCIALIZATION: Member reports feeling less alone. Member participates in _____ Member is making contact with _____ Involved in Activity:	Met □ Unmet □ Partially met □ Changes/comments:

CM Initials:

CAREGIVER BURDEN: More time to do things for self. Positive attitude and more energy. Less stress and a good appetite. Caregiver is seeing friends/family. Adequate supports in place. Continued desire and ability to continue in role.	Met □ Unmet □ Partially met □ Changes/comments:
SMOKING CESSATION: Member is giving accurate info about smoking history. Understands the health and safety risks of smoking, including disease and possible fire from displaced cigarettes. Will notify CM when ready to quit. Willing to accept responsibility for consequences of smoking. A cessation plan is available and encouraged.	Met □ Unmet □ Partially met □ Changes/comments:

***Include additional comments or updated goals in the section below.**

COMMENTS:

CASE MANAGER SIGNATURE: _____ Date: _____

MEMBER/GUARDIAN SIGNATURE: _____ Date: _____

Time In: _____ Time Out: _____

SELF DIRECTION

☐**Living Choice** ☐**Medically Fragile**

SELF-DIRECTED SERVICES-LETTER OF INTENT

Oklahoma Health Care Authority

Long Term Services and Supports

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

The member listed above has selected the Self-Directed Services option and will submit an application for consideration.

In addition, **please remind the member that in order to prevent a delay or loss of payment to the PCA or Direct Service Worker, the following information has to be completed.**

- All **employer** paperwork must be correctly completed before it is sent to Acumen FMS.
- All **employee** paperwork must be correctly completed before it is sent to Acumen FMS.
- The background check for the employee must be completed by Acumen FMS and is approved and clear.
- Self-Directed services have been authorized on the Service Plan.

If the Care Management Unit of the Oklahoma Health Care Authority requests additional information regarding a member's service plan, there may be a delay in authorization. The delay in authorization could affect the payroll for the employee.

If you have any questions, please feel free to contact the Living Choice or Waiver Program Coordinator at **888-287-2443.**

Self-Directed Services Self-Assessment
Oklahoma Health Care Authority
Long Term Services and Supports

Planning Your Services

Experience/Knowledge/Skill

I know when, where, and how I want all of my services delivered. ◯ **Yes** ◯ **No**

If no, please describe_____

I am able to train each employee who works with me on what assistance I need and how I want my services delivered. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to monitor and communicate when I am satisfied or dissatisfied with my services. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my abilities to coordinate support from family, friends, and others including my employee to meet all of my assistance needs. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to work with my Case Manager in planning for my self-directed services. ◯ **Yes** ◯ **No**

If no, please describe_____

Managing Your PCA

Experience/Knowledge/Skill

I have or can create a private and secure area in my home to maintain confidential employee records. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to interview potential employees. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to train employees. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident I can organize records, paperwork, and legal documents. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to evaluate my employee's work performance. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to fire an employee. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to provide feedback to my employee to improve service performance. ◯ **Yes** ◯ **No**

If no, please describe_____

I am able to adjust my schedule with my employee as needed to meet my service needs. ◯ **Yes** ◯ **No**

If no, please describe_____

I am able to provide my employee with the necessary supplies and materials to complete all PSA/APSA tasks. ◯ **Yes** ◯ **No**

If no, please describe_____

I know what would cause me to fire an employee. ◯ **Yes** ◯ **No**

If no, please describe_____

Managing Your Budget

Experience/Knowledge/Skill

I am able to negotiate wages and benefits with my employee and stay within the limits of my yearly budget. ◯ **Yes** ◯ **No**

If no, please describe_ _____

I feel confident I can manage my personal care hours as authorized on my service plan. ◯ **Yes** ◯ **No**

If no, please describe_ _____

Managing Your Health & Safety

Experience/Knowledge/Skill

I am confident in my ability to create an emergency back-up plan, including identification and recruitment of another person to fill in for the times when my regular employee does not show up for work. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to handle my own health and safety issues. ◯ **Yes** ◯ **No**

If no, please describe_____

I am confident in my ability to access medical attention if needed.

If no, please describe_____ ◯ **Yes** ◯ **No**

MEMBER/EMPLOYER ROLES and RESPONSIBILITIES
SELF-DIRECTED SERVICES
Oklahoma Health Care Authority
Long Term Services and Supports

When a member chooses to Self-Direct in one of the following QA & Community Living Services programs; Living Choice Demonstration or Medically Fragile Waiver, they become the **employer** of the Personal Care Assistant, (PCA), and/or the Advanced Supportive Restorative Assistant (ASRA) and is responsible for the following:

- Recruits and interviews PCA/ASRA applicants
- Performs reference checks
- Selects and hires PCA/ASRA and determines their wages
- Maximum wage for PCA is _____
- Maximum wage for ASRA is _____
- Schedules, trains, and supervises the PCA/ASRA on delivery of services
- Monitors, communicates and evaluates the PCA/ASRA's work performance
- Discharges the PCA/ASRA as necessary
- Follows employment laws (applicable federal and state laws)
- Completes paperwork submitted to Acumen FMS
- Meets all deadlines
- Tracks how many PCA hours are authorized and used according to budget worksheet. (Reports will be sent to members monthly by Acumen FMS)
- Verifies employee "time worked" and signs timesheet
- Arranges all backup support and handles emergencies when PCA/ASRA is late or fails to show up for work.

Member Name: _____

Member Signature: _____ Date: _____

SELF-DIRECTED SERVICES
AUTHORIZED REPRESENTATIVE CONSENT
Oklahoma Health Care Authority
Long Term Services and Supports

☐ **Living Choice** ☐ **Medically Fragile**

RE: Print Member Name: _____

Authorized Representative Name (Print) _____

Address_____

Telephone_____

Thank you for agreeing to assist the member referenced above with their employer responsibilities for Self-Directed Services.

As an authorized representative (AR) your role is to counsel and advise the member regarding any and all self-direction activities and decisions for which the member is responsible and take action on their behalf as directed by the member. **You may not be the PCA (personal care assistant) if you are the AR.**

By selecting the Self-Direction service option, the member is the employer of record and is responsible for the following:

- Recruit, hire and as necessary, discharge the personal care attendant
- Provide instruction and training to the personal care attendant on the tasks to be completed
- Develop the weekly work schedule based on the authorized service plan
- Determine the hourly wages
- Supervise the personal care attendant, document their time worked, and send timesheets to the fiscal reporting agent for payroll processing
- Provide tools and materials for work to be accomplished

As an authorized representative, you cannot make any decisions for or on behalf of the member or sign for the member unless you have a legal standing to do so.

If you should have any questions, you may contact the Long Term Services and Supports (LTSS) at 888-287-2443 and request to speak with a program coordinator.

If you have questions about employer or employee paperwork, payroll activity or time sheets, you may contact the reporting fiscal agent, Acumen at 1-866-537-8379. The customer service agent will verify the following information before they answer any of your questions.

- Member Medicaid ID#
- Member's address & phone #
- Last 4 digits of member's Social Security #
- Member's date of birth

AR Signature: _____ Date: _____

Member Signature: _____ Date: _____

Acknowledgment of Informed Choice
Self-Directed Services
Oklahoma Health Care Authority
Long Term Services and Supports

Living Choice ◯ **Medically Fragile** ◯

Participant Name				
Last		*First*	*M.I.*	*SoonerCare ID*

Self-Directed Services are offered in the Long Term Services and Supports (LTSS) Living Choice Demonstration and the Medically Fragile Waiver that gives you authority and control over who provides your Personal Care and Advanced Supportive/Restorative services and how these services are provided. This opportunity for self-direction and determination also requires you to assume additional responsibilities and perhaps additional risks that you do not have under the existing provider agency service that provides personal care services to you.

Acknowledgment of Responsibilities for Self-Directed Services

Please check **Yes or No** indicating your agreement with and acknowledgment of the following:

1.	**I have received and read the Self-Directed Information Handbook and understand what will be expected of me.**	☐ **YES** ☐ **NO**
2.	**I have completed the Self-Assessment Tool.**	☐ **YES** ☐ **NO**
3.	**I understand my Roles and Responsibilities in receiving Self-Directed Services.**	☐ **YES** ☐ **NO**
4.	**I am making a Voluntary and Informed Choice to receive Self-Directed Services.**	☐ **YES** ☐ **NO**
5.	**I understand that I may designate a family member or friend as an Authorized Representative to assist me in my employer responsibilities to the extent that I prefer.** ☐ **I understand that by choosing to designate an Authorized Representative that I do not give up any of my decision-making authority.** ☐ **I understand that an individual hired to provide Personal Care Services to me may not be my designated Authorized Representative.** ☐ **I understand that I may change my mind and revoke my designation of an Authorized Representative at any time by notifying my Case Manager and the FMS.**	☐ **YES** ☐ **NO**

6.	**Do you want to designate an Authorized Representative to assist you in receiving Self-Directed services? By circling yes, you confirm that:** ☐ **You have discussed with your designated Authorized Representative the specific assistance you would like from him/her regarding your Self-Directed services.** ☐ **You give permission to your Case Manager to contact your designated Authorized Representative listed below:** **Last Name_____ First Name_____ M.I.__** **Address_____** **Relationship to You:_____** **Please have your designated Authorized Representative sign below if he or she agrees with the following:** ☐ **I agree to serve as the Member's designated Authorized Representative and I have read the Self-Guided Orientation.** **Authorized Representative Signature_____ Date_____**	☐ **YES** ☐ **NO**
7.	**I am making a Voluntary and Informed Choice to withdraw from** **receiving Self-Directed Services effective: _____** **Last Name_____ First Name_____ M.I.__** **Address_____** **Phone_____**	☐ **YES** ☐ **NO**

Signature of Member **Date**

Signature of Guardian (if applicable) **Date**

Signature of TC/CM **Date**

TRANSITION TO SELF-DIRECTED SERVICES

Oklahoma Health Care Authority

Long Term Services and Supports

☐ **Living Choice** ☐ **Medically Fragile**

RE: Member Name: _____Member ID: _____Phone# _____

The Member listed above is ready to transition to the Self-Directed Services Option.
Please proceed by following your agencies normal policies to request an amendment to add self-directed services to the member's service plan.

Authorization requirements include the following:

- The self-directed service line cannot precede the **date of this memo**. ***Please start the service plan approximately 2 weeks prior to the transition date to allow for corrections or changes***.
- The Case Manager and Supervisor reflected on Community Service Plan or Community Service Plan Addendum must have completed self-directed agent training.
- The Community Service Plan (6gSP) or Community Service Plan Addendum must reflect the correct number of units.
  The Self-Directed Budget Worksheet is located on the Morning Sun Financial Services of Oklahoma Website: www.acumenfiscalagent.com
- The number of units requested on the Service Plan or Addendum must correspond to the number of hours/units listed in the goals.
- The Service Plan Goals must define activities to be completed by the PCA or Direct Care Service worker including the approximate number of hours needed per week to complete each task.
- The PCA or Direct Care Service worker's Scheduling and Back-up Plan must be submitted with the Community Service Plan or Community Service Plan Addendum.

- The current provider agency **must** be notified of the closure date for the PCA.

If you have any questions, please feel free to call Long Term Services and Supports at 888-287-2443.

Thank You

Long Term Services and Supports

Self-Directed Services - Goods and Services Expense Form

Oklahoma Health Care Authority

Long Term Services and Supports

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

***Please check one**:

- ◯ I have paid for this approved good or service and requesting reimbursement.
  (Must attach receipt or proof of payment with $ amount.)
- ◯ I have not paid for this good or service and requesting Morning Sun to pay directly.
  (Must attach estimate or bill with $ amount.)

***Make check payable to**: _____

***Mail Check to**: _____

Address**:** _____ Phone #: _____

Social Security or Federal ID number (if applicable): _____
(For use on 1099 if necessary)

***Description of Goods/Services**	**Date**	**Amount ($)**
Total Amount Due:		$ 0.00

***Specific Instructions/Comments:**

_____

_____

_____

*** Member/Employer's Signature:** _____

For OHCA Approval mailor faxto:
Attn: Long Term Service and Supports
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Fax: 405-530-7265
Phone: 888-287-2443

Member/Employer Related Operational Expenses

Self-Directed Services Oklahoma
Health Care Authority
Long Term Services and Supports

Employer related expenses include costs incurred for services related to the provision of personal care as listed below. To request reimbursement for expenses use the **SDS Goods and Services Expense** form. Expense requests must be submitted within 60 days of the date the expense is incurred. Any request for reimbursement of expenses must include adequate receipts or documentation of the expense to include vendor name, address, phone number, date and itemized list of purchases. All expenses are subject to prior approval by OHCA.

- Classified Advertising - cost to place an ad for recruitment of new employee **(please include a copy of the newspaper classified advertisement that shows the name of the paper and the date the ad ran)**
- Hepatitis B vaccination/Tuberculosis test – cost of vaccination or test for employee
- Transportation – cost of public transportation for non-medical trips related to the provision of personal care
- Mileage – per mile cost for trips related to the provision of personal care in service plan: per mile cost will be calculated using the current state employee rate; current rate is **.50** per mile
- Postage – cost of postage to mail self-directed forms to payroll agent or OHCA
- Copying – cost to make copies of self-directed forms for payroll agent or OHCA
- Faxing – cost to fax self-directed forms or timesheets to payroll agent or OHCA
- Office supplies – paper, pens, file folders used to maintain self-directed records
- Other expenses related to the provision of personal care services upon prior authorized approval by OHCA.

Oklahoma Health Care Authority
Self-Directed Services

Mileage Reimbursement Request Form

Employee Name: _____ Member Name: _____

Date	Destination	Total Miles: To and From Destination	Total Amount (.50 per mile)
			$ 0.00

***Mileage Reimbursement can not be claimed for the following:**

1. To and from Day Services
2. To and from supportive and competitive employment
3. Transporting school aged children to and from school

****Employee must have current automobile insurance. Vehicles used to transport members must have seat belts and must be used by the member at all times. Each vehicle must have first aid supplies.**

****Inaccurate or incomplete documentation will be returned for correction, which may result in delay of payments.**

Employee Signature:_____ Date:_____

Employer/Member Signature:_____ Date:_____

For OHCA Approval mail or fax to:

Attn: Long Term Services and Supports

Oklahoma Health Care Authority

4345 N. Lincoln Blvd.

Oklahoma City, OK 73105

Phone: 888-287-2443

Fax: 405-530-7265

Long Term Services and Supports

Self-Directed Budget Summary Worksheet

Member Name: _____ _____
Last First

Medicaid ID: _____

Service Begin Date: _____
MM/DD/YYYY

Service End Date: _____
MM/DD/YYYY

Service Type Employee Name(s)	Units per week	Hours per week	Units per Year	Annual Program Cost	Desired Hourly Wage	Annual Wage	Annual FICA, FUTA/SUTA	FMS Admin Deduction	Annual Difference
PCAs					$0.00	$0.00	$0.00	$0.00	$0.00
1				[redacted]					
2									
3									
4									
ASRs					$0.00	$0.00	$0.00	$0.00	$0.00
1				[redacted]					
2									
3									
4									
Totals	0	0	0	$ 0.00					

Average Unit Cost (Enter these amounts on the members Service Plan)

	Units per Year	Unit Rate	Total Amount
PCA - S5125			$ 0.00
ASR - S5125 TF			$ 0.00
Goods and Services – T1999			$ 0.00

Goods and Services Estimated Expense	
Classified Advertising	$
Hepatitis B Vaccination/TB Test	$
Transportation	$
Mileage	$
Postage	$
Copying/Faxing	$
Office Supplies	$
Other	$
Total Goods and Services Estimated Expenses	$ $ 0.00

Oklahoma SDP
Employee Rate Form

To make sure employees are paid correctly, please give Acumen the following information so the employee is paid the correct rate for the service(s) provided. This is a request for Acumen to pay the following rate for the below employee.

Employee's Name (please print): _____

Employee's Social Security Number (last 4 digits): _____

Service Code	***Description***	***Rate of Pay***
PCA	Personal Care Assistant	$_____
ASR	Advanced Supportive Restorative	$_____
RSP	Respite	$_____

Member's Name (please print): _____

_____ _____

Member/Employer Signature Date

- Complete this form for each new employee
- Pay rate changes can only be made at the time of your annual service plan reassessment
- You must complete a new form for any employee that needs a rate of pay changed
- You must inform your employee of any rate changes

FAX: (877) 364-2837
Email: AcumenOK@acumen2.net
MAIL: 4823 South Sheridan, Suite 310
Tulsa, OK 74145

Acumen Fiscal Agent Account Statement

Dates show the activity for the dates of service.

Employer: **John Smith**

12345 E 25TH ST
CATOOSA **OK** **74015**

Activity Period 02/01/2020-02/29/2020
Participant ID: OK1234
Program: OK SDP

Client Name: Mary Smith

Service & Auth period

Account Information

Beginning balance, what has been paid and what is remaining as of the Statement Date.

	Authorization Type	Initial Balance	Utilization	Remaining Balance	Pending Entries	Available
PCA 12/16/2019 - 09/30/2020	Units	4697.00	1289.00	3408.00	0.00	3408.00
ASR 12/16/2019 - 09/30/2020	Units	1036.00	319.00	717.00	5.00	712.00

Pending Entries = entries approved but not paid as of the Statement Date.
Available = Remaining minus pending as of Statement Date.

Employee Information

Lists each employee and their current status. Employee # is an Acumen assigned number.

Employee Name	Status	Employee #
Duck, Donald	Active	OK5732
Mouse, Minnie	Terminated	OK5715

Code and Rate Information

Each employee's rate of pay by service and date range.

Employee Name	Description	Start Date	End Date	Rate
Duck, Donald	ASR	12/16/2019		14.75
Duck, Donald	PCA	12/16/2019		13.70
Mouse, Minnie	ASR	12/16/2019	12/31/2019	15.42
Mouse, Minnie	PCA	12/16/2019	12/31/2019	14.32

Training & Certification

Any required certifications and their expirations. Expiration will show actual expiration or for transitioning 6/30/20. These are updated as received.

Employee Name	Requirement Name	Expiration Date	Certification Status
Duck, Donald	CPR	06/30/2020	Active
Mouse, Minnie	CPR	06/30/2020	Active

3/8/2020 6:34:43 PM

Payroll Check Information

Shows each check that was paid during the period of the statement. Each tax and Work Comp listed show the employer burden. Billing is the total billing amount, Gross + Employer Taxes & Work Comp, of each check.

Remittance#: 43581
Date: 02/24/2020
Payee: DUCK, DONALD
Total Net: 796.87
Gross: 962.51
Medicare: 13.96
FICA: 59.68
SUTA: 3.08
FUTA: 5.78
Work Comp: 58.33
Billing: 1103.34

Disbursement Information

Check number, date and net amount.

CheckNumber: 0000049961 **CheckDate:** 02/24/2020 **CheckNet:** 796.87

Payroll Check Information

Remittance#: 53351
Date: 03/09/2020
Payee: DUCK, DONALD
Total Net: 907.91
Gross: 1108.72
Medicare: 16.07
FICA: 68.74
SUTA: 3.55
FUTA: 6.65
Work Comp: 67.19
Billing: 1270.92

Disbursement Information

CheckNumber: 0000060026 **CheckDate:** 03/09/2020 **CheckNet:** 907.91

Payroll Check - Punch Details

Specific shift details for each check in the period.

Check Number	Employee Name	Service Code	Work Date	Start Time	End Time	Wage	Hours
49961	DUCK,DONALD	ASR	2/1/2020	3:58PM	4:47PM	14.75	0.82
49961	DUCK DONALD	ASR	2/2/2020	5:04PM	6:07PM	14.75	1.05
49961	DUCK DONALD	PCA	2/2/2020	6:08PM	10:34PM	13.70	4.43
49961	DUCK DONALD	ASR	2/3/2020	4:57PM	5:58PM	14.75	1.02
49961	DUCK DONALD	PCA	2/3/2020	5:59PM	10:01PM	13.70	4.03
49961	DUCK DONALD	ASR	2/4/2020	3:57PM	5:05PM	14.75	1.13
49961	DUCK DONALD	PCA	2/4/2020	5:06PM	9:13PM	13.70	4.12
49961	DUCK DONALD	ASR	2/5/2020	3:59PM	5:00PM	14.75	1.02
49961	DUCK DONALD	PCA	2/5/2020	5:01PM	9:20PM	13.70	4.32
49961	DUCK DONALD	ASR	2/6/2020	4:58PM	6:02PM	14.75	1.07

QUALITY ASSURANCE

Medically Fragile Performance Review Process

Waiver Year: *July 1 through June 30*

Performance Reviews are conducted quarterly, please see the schedule below:

Waiver Enrollment Number:

Schedule (Calendar Yr.)	**Review Period** (Waiver Yr.)	**# of CM & HH** Mbrs. who rec'd Services	**# of SD Members** Mbrs. who rec'd Services
1st Quarter (*Jan., Feb., March*)	Jul. 1 – Sept. 30, 2020 (every new/renewed member)		
2nd Quarter (*April, May, June*)	Oct. 1 – Dec. 31, 2020 (every new/renewed member)		
3rd Quarter (*July, Aug., Sept.)*	Jan. 1 – March 31, 2021 (every new/renewed member)		
4th Quarter (*Oct., Nov., Dec.)*	Apr. 1 – June 30, 2021 (every new/renewed member)		

*Members receiving PDN services are not included in this review.

QA staff will request current enrollment for Medically Fragile waiver prior to the beginning of the quarter (**January, April, July and Oct**.), an email will be sent to program coordinator to request the enrollment for **Review Period**, (*See Schedule Above*). Allow 3-5 working days to complete and return the enrollment list to QA. Request a Business Objects query be ran to verify enrollment information. By the 10th of the first month of the quarter, program enrollment with detailed Case Management, Home Health Agency and Self-Direction member information should be verified and recorded in the annual Performance Review workbook, the information is sorted by Provider Agency. By the 15th of the first month of the quarter, Performance Review Initial Letters are sent to the identified Provider Agencies.

Typically, Provider Agencies will have a fifteen (15); days to return the requested documentation. *See Performance Review Desk Procedures for step by step process.*

This process is repeated for each of the following quarters. The objective is to review records for each member enrolled in the waiver annually.

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☒ Medically Fragile

CASE MANAGEMENT NOTES

Participant Name	Sooner	Boomer		SoonerCare ID	012345678
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES
01/01/2019	4:30 pm	4:40 pm		1	CM called and scheduled MHV for tomorrow.

TC/CM Name

TC/CM Signature

Units (this page) 1
Total Units 9

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☒ Medically Fragile

CASE MANAGEMENT NOTES

Participant Name	Sooner	Boomer		SoonerCare ID	012345678
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES
01/01/2019	4:40 pm	6:10 pm		6	Monthly Home Monitoring Visit-High Risk: Member was up in is power chair in the kitchen with his mother and SN, Betty. He was alert and laughing often. His color was good and he was very well groomed. Suzie, mother, stated that Boomer's current authorized services are adequate to meet his needs and are being delivered as authorized. Member's authorized services through Medically Fragile: RN assessment/evaluation 10 units with Healthy Homecare, Case Management 300 units per year. Private duty nursing 36 hours per week. Personal care-20 hours per week, Pulse ox probes, wipes, large tabbed briefs-200 per month, disposable bed pads-210 per month. Non Med Fragile services in place: No sting barrier spray, Neb kits, Prescriptions, suction catheters, nebulizer, dressing su1mlies through the state. Private insurance is currently payor source for Prostat and Peptamen formulas, feeding pump, pump sets, syringes.

TC/CM Name

TC/CM Signature

Units (this page) 6
Total Units 9

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☒ Medically Fragile

CASE MANAGEMENT NOTES

Participant Name	Sooner	Boomer		SoonerCare ID	012345678
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES
01/01/2019	4:40 pm	6:10 pm			Outcome #1: Health-Goal met: Boomer's healthcare needs are met. Suzie, mother, states that she recently took him to see his PCP as he was running a temperature. Lab was drawn and respiratory infection was ruled out. Mom schedules and ensures that Boomer keeps all doctor appointments. He sees multiple physicians, specialists. Boomer now has a new neurologist, Dr. John who will do the routine Botox injections to his bilateral feet. His neurosurgeon who manages his Baclofen pump is no longer with St. Francis so mom is waiting for a referral to a new Dr. Mom provides transportation to his appointments. They now have a new accessible van with a lift. The wound on his coccyx remains unchanged at this time. It has slightly opened again but there are no signs infection. Intensive wound care is done by RN and mother. RN with Preferred Pediatrics works M, T, W for 12 hours per day. SN performs ongoing assessments, wound care, monitoring for seizure activity, chest percussion with his vest, nebulizer treatments, gives medications, tube feedings, ROM, transfers, bathing, frequent incontinent care and repositioning. SN also does bathing, dressing, grooming, oral care, does member's laundry, housekeeping, takes out his trash when she is present. PCA and family perform these tasks when SN not present. The tube feedings are providing adequate nutrition and promoting his wound healing and member continues to gain weight and his color has improved. Plans for debridement of the wound and possible wound vac placement are pending. They will follow up with their wound care doctor. Outcome #2-Medications-Goal met: Boomer has all his meds in the home. Family or SN administer his meds as prescribed through his peg tube. A log is kept of his neuro status and monitoring of seizure activity. He has had no seizures and is tolerating his meds well.

TC/CM Name

TC/CM Signature

Units (this page)
Total Units 9

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☒ Medically Fragile

CASE MANAGEMENT NOTES

Participant Name	Sooner	Boomer		SoonerCare ID	012345678
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES
01/01/2019	4:40 pm	6:10 pm			Outcome #3: Personal care-Goal met: Boomer has assistance with his personal care tasks for 20 hours week from mother/PCA. PCA assists with bathing, dressing, grooming. No ASR tasks performed by PCA. RN performs personal care tasks when present M, Tues, and Wed. Extensive incontinent care is done with every 2 hour brief changes and repositioning. Family and SN are very meticulous with his care. His hygiene needs are met. He has no new areas breakdown. These tasks are performed by family when SN not present. Boomer is receiving his incontinent supplies monthly and is utilizing them to manage his incontinence. Outcome #4: Housekeeping-Goal met: Family and RN assists Boomer with his housekeeping tasks daily. The home is very clean, neat and tidy with clear pathways. SN does his laundry, housekeeping when she is present. Family performs these tasks when SN not present. Mother does Boomer's errands and manages his appointments and finances. SN and family administer Boomer's tube feedings as prescribed. He continues to gain weight in response to his feedings. In addition, his wounds have mostly healed well in response to the feedings. He is receiving his Mickey button kits with tubing, syringes from DME, along with his formulas.

TC/CM Name

TC/CM Signature

Units (this page)
Total Units 9

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☒ Medically Fragile

CASE MANAGEMENT NOTES

Participant Name	Sooner	Boomer		SoonerCare ID	012345678
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES
01/01/2019	4:40 pm	6:10 pm			Outcome #5/6: Safety and Socialization- Goal met: Boomer is safe in his home. He has had no falls. He has 24 hr. close safety supervision provided. He has all needed equipment in the home for safety with mobility and transfers. There is a monitor at his bedside. He has a pulse ox monitor for monitoring 02 levels. Family is private paying for his 02 as it did not qualify through Medicaid. He has had no falls. Smoke alarms are in working order and there is an alarm system in place. Family are aware of and accept the possibility of delayed evacuation in an emergency. CM talked with Mom about abuse, neglect and exploitation. She verbalized understanding of identification, prevention and reporting of ANE. She has the emergency phone numbers in her home folder. Outcome #7: Case Management-Goal met: CM continues to visit monthly per high risk protocol. Mom is aware that CM available for assistance with any needs. Outcome #8: Life Planning-Goal met: Boomer has an Advanced Directive. No assistance with life planning needed at this time. Satisfaction: Mom states that she is satisfied with all Medically Fragile and Non-Medically Fragile services. CM Action Steps: CM will continue to visit monthly per high risk protocol.

TC/CM Name

TC/CM Signature

Units (this page)
Total Units 9

LONG TERM SERVICES AND SUPPORTS

☐ Living Choice ☒ Medically Fragile

CASE MANAGEMENT NOTES

Participant Name	Sooner	Boomer		SoonerCare ID	012345678
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES
01/01/2019	8:00 pm	8:30 pm		2	CM completed documentation of home visit. CM also completed monthly CM progress notes.

TC/CM Name

TC/CM Signature

Units (this page) 2
Total Units 9

Oklahoma HealthCare Authority

LONG TERM SERVICES AND SUPPORTS
Case Management Performance Review Worksheet

☐ **Living Choice** ☐ **Medically Fragile**

Member's Name: _____ **RID:** _____

Provider Agency: _____ **Case Manager:** _____

Review Timeframe: _____

☐ **Progress Notes Received** ☐ **MMR Received**

Records document that services were provided in accordance to the service type specified on the service plan. *PM (SP 4.1)*		
Met	**Not Met**	**Notes**
☐	☐	

Records document that services were provided in accordance with the scope of services specified on the service plan. *PM (SP 4.2)*		
Met	**Not Met**	**Notes**
☐	☐	

Records document that services were provided in accordance with the service amount as specified on the service plan. *PM (SP 4.3)*		
Met	**Not Met**	**Notes**
☐	☐	

Records document that services were provided in accordance with the duration of services specified on the service plan. *PM (SP 4.4)*		
Met	**Not Met**	**Notes**
☐	☐	

Records document that services were provided in accordance with the frequency of services specified on the service plan. *PM (SP 4.5)*		
Met	**Not Met**	**Notes**
☐	☐	

Oklahoma HealthCare Authority

LONG TERM SERVICES AND SUPPORTS
Case Management Performance Review Worksheet

COPP documents requirements related to training for the prevention of AN&E and Unexplained Death. *PM (H.W 1.1)*		
Met	**Not Met**	**Notes**
☐	☐	

Records document training for the prevention of abuse, neglect, exploitation and unexplained death. *PM (H.W 1.2)*		
Met	**Not Met**	**Notes**
☐	☐	

Additional Notes:

Oklahoma HealthCare Authority

LONG TERM SERVICES AND SUPPORTS
Home Health Performance Review Tool

☐ **Living Choice** ☐ **Medically Fragile**

Member Name: _____ **Provider Agency:** _____

PCA / ASR Name: _____ **Review Timeframe:** _____

Home Health Non-Certified Provider Checklist

Provider submitted a copy of current license? Yes ☐ **No** ☐ *PM (QP 12 verified annually)*

PCA Qualifications: These items are evaluated to verify provider compliance for each PCA / ASR who deliver services to waiver members.

OSBI	☐	*PM (QP 2.1)*
Competency Check (*Evaluator's Name & Date*)		
Member Rights	☐	
Code of Ethics	☐	
Confidentiality Statement *(PCA Signature & Date)*		
HIPAA Statement *(PCA Signature & Date)*		
ODH 805 Employment Application *(01012001)*	☐	
Community Service Worker's Check	☐	
Proof of Age/ Copy of D. L. or ID *(18 yrs. or older)*	☐	
References X 2/ Verified	☐	
Nurse Aide Registry Check *(Date)*		
Annual Evaluation	☐	

Oklahoma HealthCare Authority

LONG TERM SERVICES AND SUPPORTS
Home Health Performance Review Tool

ASR Competency (*Advance Supportive Restorative*) *(Evaluator & Date)*	
AST CPR Date *(Absolute Safety Training)*	
A, N, & E Training Verified *(Abuse, Neglect & Exploitation)*	☐

PM (HW 11)

Additional Notes:

Oklahoma HealthCare Authority

LONG TERM SERVICES AND SUPPORTS
CM and HH Post-Payment Review Worksheet

Member's Name: _____ **RID:** _____

Provider Agency: _____ **Case Manager:** _____

Review Timeframe: _____

Review of Case Management Claims

Percentage of service claims paid that were submitted for members who were enrolled in the waiver on the date that the service was delivered.

PM (FA1.2)

CM Units Documented	Claims Review	Discrepancies

Review of PCA / ASR Claims *PM (FA 12)*

Percentage of service claims paid that were submitted for members who were enrolled in the waiver on the date that the service was delivered.

PM (FA1.2)

PCA/ASR Units Documented	Claims Review	Discrepancies

Additional Notes:

MEMBER EXPERIENCE SURVEY

- One of the activities used to strengthen the program performance is the quarterly Member Satisfaction Survey

- Survey's are conducted by phone or mailed for the member to complete and return. Visits are conducted at the same time as the Quarterly Performance Review

- Member's perspective on program performance is vital to program improvement efforts

Member Experience Survey

MES will be administered throughout the waiver fiscal year to members on the Medically Fragile Waiver program.

1. I know my Case Manager's name and contact information.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

2. I feel comfortable talking with my Case Manager if I have a complaint or problem with my services or providers.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

3. My Case Manager provided me with a copy of my Service Plan and Goals and checks in monthly to ensure service delivery and ask about any unmet needs.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

4. Every year, I am involved in the PLANNING and the DECISION MAKING process regarding my care. I'm happy with the QUALITY of services provided on the program.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

5. I know my Personal Care Assistant, (PCA) and/or Advanced Supportive Restorative (ASR) by name and how to contact the Home Health Agency.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

6. The Home Health agency offers to send a substitute if my PCA/ASR is unable to come on the day scheduled.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	N/A
☐	☐	☐	☐	☐	☐

7. My PCA/ASR aide is knowledgeable and properly trained to complete assigned tasks on my service plan.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

8. I have received a copy of the complaint and grievance process with the telephone number for the Member Inquiry Department.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

9. The time(s) my PCA/ASR comes is convenient for me.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

10. I received information on how to report incidents of abuse, neglect and exploitation.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

DME TO HOME HEALTH RULE

REASON FOR CHANGE

- CMS Home Health Final Rule of 2016.
  - Currently, DME is an optional stand-alone benefit for Oklahoma SoonerCare members. This CMS rule requires states to move DME under home health as a mandatory benefit.

NOTABLE COVERAGE CHANGES

- Some of the notable changes will be to adult coverage of the following:
  - Nebulizers.
  - C-paps.
  - Sleep studies.
  - Bath chairs.
  - Enteral (tube fed) formulas and supplies.
  - Incontinence supplies.
    - Please note, incontinence supplies for members ages 0-20 **must** be provided by People First Industries.

FACE-TO-FACE REQUIREMENT

- Face-to-face encounter.
  - A patient visit in which a practitioner, as defined by 42 C.F.R. 440.70(f), completes a face-to-face assessment related to the primary reason the beneficiary requires durable medical equipment. The face-to-face encounter must occur no more than six months prior to the start of services. The ordering physician must document the face-to-face encounter, including the practitioner who conducted the encounter, and the date of the encounter. Clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record. The face-to-face encounter may occur through telehealth.

EXISTING AUTHORIZATIONS

- For members who have an existing prior authorization through one of the waiver programs, the prior authorization will be valid through the current end date.
- For continuation of services that will be considered under TXIX, requests will need to be submitted to OHCA.

PRIOR AUTHORIZATION SUBMISSIONS

- Must be submitted through the secure SoonerCare provider portal by the DME provider.
- Supporting documents must be uploaded at the time of PA submission.
    - Order or script.
    - Certificate of medical necessity (if applicable).
    - Documentation from member's medical records to support the need for requested service.
- Manually priced items will not be priced at the PA level. They will be priced at the claims level.

PHYSICIAN ORDER FOR INCONTINENCE SUPPLIES

Ages 21 and above (Diapers, Pull-Ons, Liners, Under pads, Wipes and Non-Sterile Gloves)

Initial Request X Amendment _____ Recertification _____

OKLAHOMA
Health Care Authority

TO BE COMPLETED BY PHYSICIAN

SECTION I – PHYSICIAN INFORMATION

Ordering Physician MUST be SoonerCare Contracted

Printed name: _____

Provider ID or NPI: _____

Contact name: _____

Phone number: _____

SECTION II – MEMBER INFORMATION

Name: _____

Member ID: _____

Date of birth: _____

Address: _____

Phone number: _____

SECTION III

Weight: _____ (lbs)

Sex : M _____ F _____

Type of incontinence: Urinary _____ Bowel _____ Both _____

Expected length of need: Months _____ OR Lifetime _____

SECTION IV

INCONTINENCE DIAGNOSIS CODES: _____ _____ _____ _____ _____

MEDICAL DIAGNOSIS CODES (which relates to incontinence): _____ _____ _____

SECTION V – MOBILITY

Ambulatory w/o assistance _____

Ambulatory w/assistance _____

Non Ambulatory _____

SECTION VI - COGNITIVE FUNCTION

(Related to toileting needs, see www.okhca.org/mau, Incontinence Supplies, for info.)

Able to communicate needs (verbal or non-verbal) _____

Unable to communicate needs _____

SECTION VII - ABSORBENT PRODUCTS ORDERED (MUST BE A NUMBER)

Diapers: _____ #/month

Pull-ons: _____ #/month

Liners/Shields: _____ #/month

Under pads (Reusable): Chair _____ #/month

Bed _____ #/month

Under pads (Disposable): _____ #/month

Wipes: _____ #/month

Non-Sterile Gloves (100 per box) _____ #boxes/month

SECTION VIII

PHYSICIAN SIGNATURE: _____ **DATE:** _____

DME SUPPLIER PRIOR AUTHORIZATION REQUEST SECTION

TO BE COMPLETED BY CONTRACTED DME PROVIDER

PA # _____

DME Supplier:	Phone #:	Date Span Of Service From: To:
DME Provider ID:	Assignment Code: 12 – DME	

Line Item	HCPCS Code	Description (Must Be On One Line Item)	Total Units for Date Span
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			
K			
L			

Documentation must include:

1. A signed provider prescription specifying the requested item, which must include the following information: (1) date of the order; (2) name of the ordering/referring practitioner; (3) name of the member; and (4) all items, options or additional features that are separately billed, including a narrative description, a HCPCS code, a HCPCS narrative, or a brand name/model number; OR a completed ***HCA-52 form***; **AND**

2. A documented diagnosis of an underlying chronic medical condition that involves loss of bladder or bowel control for incontinence supplies to be approved; a diagnosis of only urinary incontinence, fecal incontinence or enuresis is not sufficient. Examples include (but are not all inclusive) a diagnosis of neurogenic bladder, spinal cord injuries, spina bifida, cerebral palsy, quadriplegia, paraplegia, neoplasm of the bladder or rectum, etc.; **AND**

3. Documentation must include the height and weight of the member, the type of incontinence (bowel/bladder/combined) and expected length of need in order to support the size and amount of products requested; **AND**

4. The member must be ambulatory or in toilet training for requests submitted for underwear or pull-on(s), When a request for underwear or pull-on(s) is submitted and the member is noted to be both non-ambulatory AND unable to communicate needs, the request will be denied. For members receiving diapers/briefs, incontinence pads or liners, documentation must support the member is not amenable to a bowel/bladder training program or has failed a bowel/bladder training program.

5. The member may qualify for incontinence supplies for a short period of time when the member has documented full skin thickness injuries, such as Stage III/IV pressure ulcer(s) in the perineal/perianal area that would be exposed to urine and/or feces. Documentation should include the frequency and duration supplies are expected to be utilized when full skin thickness injuries are present. Supplies will be authorized for time periods no greater than 90 days in this instance. Additional 90 day increments will require a new authorization with documentation to support the request, including information regarding the wound. Requests for members with excoriation or dermatitis in the perineal area would not be allowed.

6. When requesting A4335 Incontinence supplies, documentation must be submitted specific to the supply being requested. Disposable wipes are used to clean the skin; other items such as the diaper, toilet paper, paper towels and washcloths can be used to initially clean the member, then disposable wipes can be used to clean the skin. **Disposable wipes are only allowed when diapers have been approved.**

Reason
011-Documents sent insufficient for comprehensive review
Remarks
1 9/4/2020 Incontinence supplies cancelled. Documentation requirements for incontinence supplies will consist of HCA52 form for ages 4-20,HCA-52A form for ages 21 and above along with an office note from the members medical records that notates the need for incontinence supplies and why. Please resubmit PA with HCA52A. All cancelled PA's must be submitted as new PA request.

CLAIM SUBMISSIONS

- Will require an ordering physician to be on the claim.
- Manually priced items will require the following with claim submission.
  - HCA-50.
  - Cost invoice.
  - MSRP – if no MSRP available, need explanation as to why.
  - Delivery ticket.

CHANGES TO THE WAIVER

- Face-to-face encounter must be performed by a medical provider (six months).

- ALL DME and incontinence must be ordered or referred by a medical provider (Physician, P.A. and N.P.).
  - Excludes PERS.
  - Grab bars (installed).

CASE MANAGER

- Services listed on the care plan:
  - OHCA (Medically Fragile and Living Choice).
- Liaison between DME provider and member's medical provider.
  - State plan approval or denial.
  - Oral supplements (not covered under state plan).
- Nutritional Supplements.
  - B codes.

MEDICALLY FRAGILE WAIVER AND LIVING CHOICE

- Items still covered under MFW and Living Choice:
  - B4100 food thickener.
  - Oral nutritional supplement using the appropriate B codes.

- Service plan:
  - DME items would now be under state plan (approved).
  - Current PA's will remain valid through end date.
  - Plan changes or reauthorizations for DME services will need to go through state plan.

MEDICALLY FRAGILE WAIVER AND LIVING CHOICE

- Items denied or not covered under state plan:
  - DME may reach out to the member's case manager for assistance obtaining additional documentation.
  - DME item may be requested to add to the planned service for consideration of payment by the MFW and Living Choice.

- Request for approval under MFW and Living Choice.
  - The DME or the member should provide a copy of the denial letter to the CM.
  - The CM will submit the OHCA denial letter with an addendum.

RESOURCES

- www.okhca.org
  - DME webpage.
  - Forms webpage.
- DMEAdmin@okhca.org
- SoonerCareEducation@okhca.org
- www.okhca.org/ltc provider's post.

EVV

MEDICALLY FRAGILE WAIVER AND LIVING CHOICE

- Jan. 1, 2021
  - Oklahoma is compliant with 21st Century Cures Act
  - All Personal Care Services should be billed in the AuthentiCare system

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73145

okhca.org
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767