
SCOPES OF SERVICES

Alabama Community Transition (ACT) Waiver

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ALABAMA MEDICAID AGENCY

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2 CASE MANAGEMENT SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Case Management is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case Management Service may be used to locate, coordinate, and monitor necessary and appropriate services.

Case Management Service may also serve to provide necessary coordination with providers of non-medical, non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible.

Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. Case Management is a waiver service available to all ACT Waiver clients.

B. Objective

The objective of Case Management is to assist clients to make decisions regarding long term care. It also ensures continued access to waiver and non-waiver services that are appropriate, available, and desired by the client.

C. Description of Service to be Provided

The unit of service will be 15 minutes beginning on the date that the client is determined to be eligible for ACT Waiver Services and is entered into the Medicaid Long Term Care System. Case Management Service provided prior to waiver approval should be considered administrative. At least one face to face visit is required monthly in addition to any other Case Management activities.

1. Within the context of home and community-based services, Case Management Service may include, but is not limited to, the following functions:
 - a. Conducting assessments of need and necessity for waiver services;
 - b. Completing and processing level of care applications for admission, readmission, or redetermination of eligibility;
 - c. Developing, monitoring, and revising the client's Care Plan in coordination with the client/caregiver;
 - d. Arranging and authorizing waiver services according to the client's Care Plan;
 - e. Making referrals and assisting clients to gain access to needed Medicaid State Plan and other non-waiver services;

- f. Coordinating the delivery of waiver and non-waiver services included in the client's Plan of Care;
 - g. Monitoring the quality and effectiveness of waiver and non-waiver services provided to the client;
 - h. Making at a minimum, a monthly face-to-face visit with every active waiver client to monitor the Plan of Care;
 - i. Monitoring the cost effectiveness of waiver services for an individual;
 - j. Processing transfers from county-to-county or from Operating Agency to Operating Agency;
 - k. Facilitating transfers to or from other home and community-based waiver programs or other types of long term care;
 - l. Reinstating ACT Waiver Services following a client's short-term nursing home stay;
 - m. Processing terminations of waiver eligibility and services;
 - n. Establishing and maintaining case records.
2. Prior to waiver approval, all potential clients are screened by the Case Manager to access their possible eligibility and to determine their desire for waiver participation. The intake screening activities and eligibility determination are distinct from Direct Case Management but are included in this scope of service since they are preliminary activities necessary for waiver enrollment. Case Management provided to a client prior to waiver approval is considered administrative.

Medicaid will not reimburse for activities performed which are not within the scope of service.

Community Case Management (CCM)

Community Case Management (CCM) Services assist individuals who receive waiver services in gaining access to needed and desired waiver and other State Plan services, as well as needed medical, social, educational and other appropriate services, regardless of the funding source for the services to which access is gained. CCM services may be used to locate, coordinate, and monitor necessary and appropriate services. CCM activities will be used to assist in the transition of an individual from institutional settings into community settings. The CCM will assist in the coordination of services that help maintain an individual in the community. CCM activities may also serve to provide necessary coordination with providers of non-medical and non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which the person may be eligible. CCM are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the participant's Plan of Care. CCM is a waiver service available to all ACT Waiver clients. CCM assist clients to make decisions regarding long term care services and supports. CCM ensures continued access to waiver and non-waiver services that are appropriate, available and desired by the participant.

Description of Service to be Provided:

The unit of service will be per 15 minute increments commencing on the date that the participant is determined eligible for ACT Waiver services and entered into the Medicaid Long Term Care (LTC) file. Case Management service provided prior to waiver approval should be considered administrative. At least one face-to-face visit is

required each month in addition to any other case management activities. A unit of service for CCM that assists in the transitioning of individuals from institutional settings into the community will be per 15 minute increments beginning on the first date the case manager goes to the institution to complete an initial assessment.

There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During this period it is required that the case manager make at least three face-to-face visits and have monthly contact with the individual or sponsor. For CCM a unit of service that assists individuals transitioning from institutional settings into the community will be 15 minutes beginning on the first date the case manager goes to the institution to complete an initial assessment. If CCM is provided it should not be billed until the first day the participant is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

In instances in which services are offered by a relative, the State will ensure that there is no conflict of interest by prohibiting the relative who is the direct service provider from participating in the plan of care development and signing the Service Authorization Form if the participant is unable to do so. The CCM will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the plan of care.

D. Staffing

1. Routine, ongoing, Case Management Service will be conducted by Case Managers who meet minimum qualifications below:
 - a. Professionals having earned a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field, from an accredited college or university, or having earned a degree from an accredited School of Social Work; or,
 - b. A Registered Nurse with current licensure;
 - c. Have references which will be verified and documented in the personnel file. References must include statewide criminal background checks, previous employers, and the Nurse Aide Registry, and,
 - d. Training in Case Management curriculum approved by the Alabama Medicaid Agency and the Case Management service provider.
2. All Case Managers will be required to attend a Case Managers' Orientation Program provided by the Operating Agency and approved by the Alabama Medicaid Agency and attend on-going training and in-service programs deemed appropriate.
 - a. Initial orientation and training must be completed within the first three (3) months of employment as a Case Manager. Any exception to this requirement must be approved by the Alabama Medicaid Agency. Proof of the training must be recorded in the Case Manager's personnel file.
 - b. The Operating Agency will be responsible for providing a minimum of six (6) hours relevant in-service training per calendar year for Case Managers. This annual in-service training requirement may be provided during one training session or may be distributed

(prorated) throughout the year based on the date of employment. Proof of training must be recorded in the personnel file. Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, location and outcome of training.

In-service training for case managers should include worker safety, and infection control training and updates as necessary.

3. The Operating Agency shall maintain records on each Case Manager, which shall include the following:
 - a. Application for employment and verification of educational and licensing requirements;
 - b. Statewide criminal background checks;
 - c. References which are verified thoroughly by the DSP and documented in the personnel file;
 - d. Job description;
 - e. Record of health (annual tuberculin tests);
 - f. Record of pre-employment and annual in-service training;
 - g. Orientation;
 - h. Evaluations;
 - i. Supervision or peer review;
 - j. Copy of photo identification;
 - k. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
 - l. Reference contacts;
 - m. Documentation of quality assurance reviews.
4. The Operating Agency must have a Quality Assurance Program for Case Management Service in place and approved by the Alabama Medicaid Agency. The Quality Assurance Program shall include Case Manager record reviews at a minimum of every other month. Documentation of quality assurance reviews and corrective action must be maintained by the Operating Agency and will be subject to review by the Alabama Medicaid Agency.

E. Procedure for Service

1. Administrative Case Management
 - a. Intake and Screening
 - (1) Procedures for processing referrals to the ACT Waiver program and case assignment will be determined by the Operating Agency. Client freedom of choice options regarding Case Management Service shall be honored. All

enrolled waiver clients are allowed to choose case management providers and available Case Managers.

b. Level of Care Determination

- (1) Following referral, intake and temporary case assignment, the Case Manager makes a face-to-face visit with the client for evaluation and completion of the HCBS application. To clarify the assessment information, the Case Manager may consult with the client and/or family, and physician, with regard to medical, behavioral, functional and social information.
- (2) Once the Case Manager feels that he or she has adequate information for a level of care determination, an initial Plan of Care is completed. The HCBS application is reviewed by a Registered Nurse at the Operating Agency's state office for appropriateness of waiver admission. Justification for level of care determination must be properly documented in the client's file.

c. Eligibility Determination

- (1) Establishing and verifying a client's financial eligibility is an important function of the Case Manager. If a client is seeking waiver services, but is not currently SSI eligible and it appears that he or she may qualify for SSI, he or she should be referred to the local social security office. If a client is not SSI eligible due to income from parent(s) or spouse, a financial application (Form 204/205) must be processed to establish financial eligibility. The Case Manager should always inform the client/family of the application process. Medicaid (financial and Long Term Care) eligibility must be verified monthly.

d. **Choice of Institution or Community Care**

- (1) **Under the provision of the ACT Waiver, applicants for waiver services or a designated responsible party will, when the applicant is found eligible for waiver services, be offered the alternative of home and community-based services or institutional services.**

2. Direct Case Management

a. Plan of Care Development

- (1) The Plan of Care encompasses a comprehensive review of the client's problems and strengths. Based on identified needs, mutually agreed upon goals are set. The Plan of Care development should include participation by the client and/or family/primary caregiver, and Case Manager. **The Plan of Care development process provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized.**

All waiver and non-waiver services provided to meet a client's needs should be included in the Plan of Care.

b. Initial Authorization of Waiver Services

The Case Manager will submit a written Service Authorization Form to the DSP Agency authorizing waiver service(s) and designating the units, frequency, beginning and ending

dates of service, and types of duties in accordance with the individual client's needs as set forth in the Plan of Care.

c. Service Coordination

- (1) To coordinate the provision of a direct ACT Waiver service to be delivered at the client's place of residence, an initial visit should be held at the client's place of residence and should include at a minimum the Case Manager, the DSP Supervisor, the client and caregiver as applicable. It is advisable to also include the DSP Worker in the initial visit.
- (2) An initial visit is required when a DSP begins to provide services to a client in the client's place of residence.
- (3) If a client receives more than one direct service from a DSP, only one initial visit is required. If a client has more than one DSP, an initial visit should be conducted with each DSP.

d. Monitoring

- (1) Each case will be monitored monthly through contacts and at least one face-to-face visit with the client. Special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed.
- (2) The amount, frequency and beginning date of service depend on the client's needs.
- (3) Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled by prioritizing clients according to medical conditions that are unstable, clients who require extensive care, and/or clients who have limited support systems.
- (4) Clients and/or responsible relatives shall be instructed to notify the Case Manager if services are not provided as planned, or if the client's condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the Plan of Care. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Plan of Care and service authorizations will be updated to reflect any changes in service needs.

e. Changes In Services Within Authorization Period

- (1) **Services may be initiated or changed at any time within an authorization period to accommodate a client's changing needs.** Any change in Waiver Services necessitates a revision of the Plan of Care. The revised Plan of Care must coincide with the narrative explaining the change and a new Service Authorization Form should be submitted by the Case Manager to DSP.

- (2) If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP will contact the Case Manager to discuss having these duties added.
- (a) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
 - (b) The Case Manager will approve any modification of duties to be performed by the Waiver Service Worker and re-issue the Service Authorization Form accordingly.
 - (c) Documentation of any change in a Plan of Care will be maintained in the client's file.
 - (i) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.
 - (ii) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.
 - (iii) If an individual declines waiver services or has become ineligible for services, a Service Authorization Form indicating termination is required from the Case Manager.
 - (iv) A new Service Authorization is required following each redetermination of eligibility, even if there are no changes to the authorized services.

f. Missed Visits and Attempted Visits

The Direct Service Provider will report missed and attempted visits to the Case Manager on Monday of each week. The DSP will notify the Case Manager promptly whenever two (2) attempted visits occur in the same week. Missed or attempted visits with clients who are at-risk will be reported to the Case Manager immediately. The Case Manager should use this information to evaluate the effectiveness of the Plan of Care and to monitor client satisfaction.

g. **Re-determination**

- (1) A complete review of every case will be done at least annually. The review shall include completion of the same HCBS application used in the initial assessment. The client's choice of location to receive long term care and Medicaid eligibility will be verified.

h. Termination of Waiver Services

- (1) Any time a client no longer requires a service, the service must be officially terminated. Advance notice and appeal rights regarding the reduction, suspension or termination of a waiver service must be granted to the client. Waiver Services may be terminated at any time during an authorization period. Termination of a service will necessitate a revision of the Plan of Care. A

Service Authorization Form indicating the service is terminated must be forwarded to each DSP.

- i. Case Termination and Transfer
 - (1) When an applicant or a current waiver client relocates to another county or Operating Agency, the case is transferred to the receiving Case Manager. The sending Case Manager prepares all necessary materials and makes initial contact with the receiving Case Manager. The receiving Case Manager is responsible for coordinating the continuation of the client's waiver services.
 - (2) Termination involves all activities associated with closing a waiver case when a client exits the program for specified reasons. When a client is to be terminated from the waiver, all service providers should be notified of the client's discharge immediately. At the point of termination, the Case Manager should assist as much as possible in making alternative arrangements in meeting the client's needs.
- j. Documentation and Record-Keeping
 - (1) Adequate documentation is one of the most important tools in determining the success of the waiver program. It is vital to maintain documentation on all aspects of the waiver: from the initial data gathering process, delivery of services, complaints and grievances from recipients and providers, billing and payment records, levels of care, plans of care, Case Management narrative and cost effectiveness data. This information is used to assure that the State is operating the waiver in accordance with the approved waiver document and that waiver services are appropriate for the individuals being served.
 - (2) **The Operating Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.**
 - (3) All records regarding the provision and supervision of Case Management must be maintained in a secure, accessible location for five (5) years after services are terminated.

F. Rights, Responsibilities, and Service Complaints

- 1. The Operating Agency has the responsibility of informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
- 2. The Operating Agency will ensure that the client/responsible party is informed of their right to lodge a complaint about the quality of waiver services provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.
 - a. Complaints which are made against a Case Manager will be investigated by the Operating Agency and documented in the client's file.
 - b. The Case Manager Supervisor will contact the Case Manager by letter or telephone about any complaint against the Case Manager and any recommended corrective action.

- c. The Case Manager Supervisor will take the necessary action and document the action taken in the client's and employee's files.
 - d. All other complaints to be investigated will be referred to the Case Manager who will take appropriate action.
3. The Operating Agency must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Service as well as in the contract, the Operating Agency shall be required to adhere to the following stipulations:

- 1. The Operating Agency will designate an individual to serve as the waiver coordinator who will employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated waiver coordinator must have the authority and responsibility for the direction of the Operating Agency. The Operating Agency shall notify in writing the Alabama Medicaid Agency within three (3) working days of a change in the waiver coordinator, address, phone number or an extended absence of the waiver coordinator.
- 2. The Operating Agency will maintain an organizational chart indicating the lines of authority and responsibility and make it available to the Alabama Medicaid Agency upon request.
- 3. Administrative and supervisory functions shall not be delegated to another agency or organization.
- 4. The Operating Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery. All policies and procedures must be approved by the Alabama Medicaid Agency.

3 TRANSITIONAL ASSISTANCE SERVICES

SCOPE OF SERVICE

ACT WAIVER

A. Service Definition (Scope):

1. Transitional assistance services and expenses consists of the following items, when appropriate and necessary for the participant's discharge from a nursing facility and safe transition to the community:
2. Security deposits that are required to obtain a lease on an apartment or home;
3. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
4. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
5. Household services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy;
6. Moving expenses

B. Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Conditions of Payment: To qualify for payment as transitional assistance under the ACT Waiver, expenses must be:

1. Authorized and included in the participant's service plan;
2. Incurred within 60 days before a participant's discharge form a nursing facility or hospital or another provider-operated living arrangement; and
3. Necessary for the participant's safe transition to the community.
4. Transitional Assistance Services cannot exceed \$1,500.

C. Non-payable Services and Expenses:

Transitional assistance does not include expenses:

1. For monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes;
2. For residential facilities that are owned or leased by and ACT waiver provider; or
3. That are not necessary for the participant's safe transition to the community.

Service Delivery Method

Provider Managed

Provider Category: Agency

Provider Type: Business Vendor

Provider Qualifications

License (specify): Business License

Other Standard (specify):

Verification of Provider Qualifications/Entity Responsible for Verification: Operating Agency

Frequency of Verification: As Required

Provider Category: Individual

Provider Type: Business Vendor

Provider Qualifications

License (*specify*): Business License

Verification of Provider Qualifications/Entity Responsible for Verification: Operating Agency Case Manager

Frequency of Verification: At initial enrollment and annually

4 HOME MODIFICATIONS

SCOPE OF SERVICE

ACT WAIVER

A. Service Definition (Scope)

Those physical adaptations to the home, required by the participant's plan of care, which are necessary to ensure the health, welfare and safety of the participants, or which enables the participants to function with greater independence in the home and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies which are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver participant, such as floor covering, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home, or permanent adaptations to rental property are also excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

B. Objective:

The objective of Environmental Accessibility Adaptations Services (EAA) is to ensure the health, welfare and safety of waiver participants which enables them to function with greater independence in their current living arrangements.

C. Provider Qualifications:

EAA will be provided by entities capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor.

D. Description of Services to Be Provided:

1. The ACT Waiver program will pay for this service when items requested are not covered under the regular State Plan program and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA medical record on each participant must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.
2. The adaptations shall not include any improvements to the home which are not of direct medical or remedial benefit to the client, such as floor covering, roof repair, central air conditioning, etc.
3. All services shall be provided in accordance with applicable state or local building codes, and ADAAG regulations. This service will be provided by a licensed contractor.

E. Conduct of Service

1. This service will be authorized by the ACT Waiver case manager. The case manager should consult with a Rehabilitation Technology Specialist (RTS) to assist when there is questionable doubt as to the construction of EAA. RTS may also be utilized in developing specifications and in obtaining final approval of completed modification adaptations. The case manager must make sure that all the requirements are met.
2. Environmental Accessibility Adaptations must be prior authorized and approved by Alabama Medicaid, or its designee, and must be listed on the participant's Plan of Care. The maximum amount for this service is \$5,000 per waiver recipient for the entire stay on the waiver. Any expenditure in excess of \$5,000 must be approved by the state coordinator and the Medicaid designated personnel.
3. A PRESCRIPTION IS NOT REQUIRED FOR THIS SERVICE.
4. If the participant is not pleased with the service, the contractor is required to make adjustments as long as the complaints are within reason.

This service is necessary to assist an individual to transition from an institutional level of care to the home and community based waiver. Limits on EAA are \$5,000 per waiver participant for the entire stay on the waiver. Any expenditure in excess of \$5,000 must be approved by the ACT Waiver Coordinator and the Medicaid Agency designated personnel. The service should not be billed until the first day the participant is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

Service Delivery Method: Provider managed

Provider Type: Licensed Contractor

Provider Qualifications

License (*specify*): Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor.

Verification of Provider Qualifications

Entity Responsible for Verification: Operating Agency and Rehabilitation Technology Specialist

Frequency of Verification: Prior to contract approval, annually or bi-annually for approved providers based on meeting previous requirements, or more often if needed based on service monitoring concerns.

5 ASSISTIVE TECHNOLOGY

SCOPE OF SERVICE

ACT WAIVER

Service Definition (Scope):

Assistive Technology includes devices, pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisitions, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. This service is necessary to prevent institutionalization or to assist an individual to transition from an institution to the ACT Waiver. All items shall meet applicable standards of manufacture, design and installation.

A. Objective:

The objective of Assistive Technology service is to increase, maintain or improve functional capabilities for individuals with disabilities. It will also help ensure the health and safety for the recipient which enables them to function with greater independence in their current residence.

B. Provider Qualifications:

Businesses providing Assistive Technology services will possess a business license. Vendors are responsible for client orientation to the equipment.

C. Description of Services to be Provided:

1. The ACT Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each recipient must substantiate the need of services, must include all findings and information supporting medical necessity, and must detail all treatment provided. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted.
2. Assistive Technology includes pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities individuals with disabilities.
3. The amount for this service is \$15,000.00 per waiver recipient. Any expenditure in excess of \$15,000.00 must be approved by the ACT State Coordinator and the Medicaid designated personnel.
4. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric). The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

D. Conduct of Service

1. Assistive Technology must be ordered by the physician. It must be documented in the Plan of Care and case narrative. The case manager must have the prescription for Assistive Technology before requesting prior approval.
2. To obtain prior authorization numbers for this service, the case manager must submit a copy of the following documents:
 - a. Medicaid Prior Authorization Form (#342).
 - b. Price quotation list from the company supplying the recipient with equipment and specifying the description.
 - c. A copy of the physician's prescription. Copies must be legible.
3. Assistive Technology must be prior authorized and approved by the Alabama Medicaid Agency or its designee and must be listed on the client's Plan of Care. The prior authorization packet is submitted to ADSS by the case manager and ADSS submits prior authorization requests using the Medicaid Prior Authorization Form (342). Prior authorization is also required for Transitional Assistive Technology. ADSS will submit the prior authorization request packet to the Alabama Medicaid Agency Long Term Care for review and coordination.
4. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.
5. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.
6. The case manager should secure an EOMB (Explanation of Medicare Benefits) from the vendor if Medicare can be applied towards purchase before the final payment will be processed for Assistive Technology. Explanation of benefits should also be secured if the recipient has other insurance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount for this service is \$15,000.00 per waiver recipient. Any expenditure in excess of \$15,000.00 must be approved by the state coordinator and the Medicaid designated personnel.

Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric).

Service Delivery Method: Provider managed

Provider Type: Vendor with a business license

Provider Qualifications: Business License

Other Standard: Vendor is responsible for orientation to the equipment.

Verification of Provider Qualifications Entity Responsible for Verification: Operating Agency

Frequency of Verification: As needed

6 SKILLED NURSING SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Skilled Nursing is a service provided to individuals in need of skilled medical observation and nursing services performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who will perform the duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing. Skilled nursing under the waiver will not duplicate skilled nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefit, home health should be utilized first and exhausted before Skilled Nursing under the waiver is utilized.

Skilled Nursing Services are not an entitlement. It is based on the needs of the individual client as reflected in the Care Plan.

B. Objective

The objective of Skilled Nursing Service is to provide skilled medical monitoring, direct care and intervention for clients with HIV/AIDS to maintain him/her through home support. This is necessary to avoid institutionalization.

C. Description of Service to be Provided

1. The unit of service is 15 minutes of direct Skilled Nursing provided in the client's residence. The number of units authorized per visit must be indicated on the Care Plan and the service authorization. The amount of time does not include the Skilled Nurse's transportation time to or from the client's residence or the Skilled Nurse's break or mealtime.
2. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's Care Plan established by the Case Manager.
 - a. Medicaid will not reimburse for activities performed which are not within the scope of services defined.
3. Skilled Nursing Service duties include:
 - a. Administering medications and treatments prescribed by a licensed or otherwise legally authorized physician or dentist.
 - b. Additional acts requiring appropriate education and training designed to maintain access to a level of health care for the consumer may be performed under emergency or other conditions, which are recognized by the nursing and medical professions as proper to be performed by a RN or LPN.
 - c. Administering skilled services as ordered by the physician
 - d. Evaluating effectiveness of nursing services and reporting changes in client's condition as warranted.

- e. Skilled medical observation and monitoring of the client's physical, mental or emotional condition and the reporting of any changes
- f. Orienting the client to daily events
- g. Observing and reporting home safety, including a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Case Manager for follow-up.
- h. Accompanying the client to medical appointments, if necessary
- i. In emergencies, accompanying a client to the hospital emergency department via ambulance

NOTE: Under no circumstances should any type of skilled medical or nursing service be performed by an unskilled worker.

- 4. No payment will be made for services not documented on the Care Plan and the service authorization.
- 5. The level of in-home skilled nursing (RN or LPN) provided to each client will be dependent upon the individual client's needs as established by the Case Manager and set forth in the client's Care Plan, physician's orders, and DSP treatment plan/goals.
 - a. Skilled Nursing Service will provide skilled medical or nursing observation and services as ordered by the physician and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.
 - b. Orders from the client's physician(s) are required initially, when any changes occur, and annually.
 - c. It is the responsibility of the Skilled Nursing Provider to obtain such physician orders for the skilled nursing services needed by the client.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub contractual arrangements.

- 1. Skilled Nursing Supervisors must meet the following qualifications and requirements:
 - a. Be a Registered Nurse (RN) who is currently licensed by the Alabama State Board of Nursing to practice nursing
 - b. Have references, which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks (including sex offender registry) and previous employers

- c. Have at least two (2) years experience as a Registered Nurse in public health, hospital, home health, or long-term care nursing
 - d. Have the ability to evaluate the Skilled Nursing Worker in terms of his or her ability to carry out assigned duties and his or her ability to relate to the client
 - e. Have the ability to assume responsibility to provide orientation and in-service training for Skilled Nursing Workers by individual instruction, group meetings or workshops
 - f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Skilled Nursing Service
 - g. Submit to a program for the testing, prevention, and control of tuberculosis annually
 - h. Possess a valid, picture identification
2. Skilled Nursing Worker must be a Licensed Practical Nurse (LPN) or Registered Nurse (RN) who meets the following qualifications and requirements:
- a. Be currently licensed by the Alabama State Board of Nursing to practice nursing
 - b. Have at least two (2) years experience as an RN or LPN
 - c. Submit to a program for testing, prevention, and control of tuberculosis, annually
 - d. Be able to follow the Care Plan with minimal supervision unless there is a change in the client's condition
 - e. Possess a valid, picture identification
 - f. Have references, which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable)
- NOTE: Skilled Nursing Services provided by an LPN require supervision by a licensed RN.**
3. Minimum Training Requirements for Skilled Nursing Workers (RN or LPN)
- a. The Direct Service Provider (DSP) must assure Medicaid and the Operating Agency (OA) that the nurse has adequate experience and expertise to perform the skilled services and the care required by the client.
 - b. Skilled Nursing Supervisors and Skilled Nursing Workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.
4. The DSP Agency shall maintain records on each employee which shall include the following:

- a. Application for employment;
- b. Statewide criminal background checks, including national sex offender registry check, and references which are verified thoroughly by the DSP
- c. Job description;
- d. Record of health with annual tuberculin tests for any staff member, including administrative, that has direct client contact;
- e. Record of pre-employment and annual in-service training; • For Skilled Nursing Supervisors and Skilled Nursing Workers validation of required CEUs for licensure will be accepted for in-service
- f. Orientation;
- g. Evaluations;
- h. Supervisory visits;
- i. Copy of photo identification;
- j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
- k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. Initially, one Skilled Nursing Assessment visit will be authorized by the Case Manager to be conducted by the DSP. The purpose of the Skilled Nursing Assessment visit is to determine the extent and level (RN or LPN) of Skilled Nursing Service needed so that physician's orders for Skilled Nursing can be obtained and the treatment plan/goals may be developed by the DSP. The Skilled Nursing Assessment visit is conducted in addition to the initial visit to begin the service, but may be conducted at the same time as the initial visit (*Refer to #6 and #9a below*).
2. The DSP Agency for the Skilled Nursing Service will obtain a verbal order from the client's physician to evaluate/assess the client and initiate the service.
3. The DSP will go to the client's home for the Skilled Nursing Assessment. The DSP will obtain the initial physician's orders for Skilled Nursing. After receiving the physician's orders, the DSP Agency must send a copy of the physician's orders and the DSP's treatment plan/goals to the Case Manager to be placed in the client's file. The DSP must specify whether the Skilled Nursing Service will be provided at the RN or LPN level.
 - a. Written orders are preferred, however, in some situations the nurse may accept a verbal order provided the nurse obtains the physician's signature within two (2)

working days from receipt of the verbal order. Physician orders must be signed by the physician and dated. A stamped signature is not acceptable. 4. The information from the DSP will be used by the Case Manager to complete the client's Care Plan and Service Authorization form. The Case Manager will authorize and submit a Service Authorization Form to the DSP Agency authorizing the Skilled Nursing service at the LPN or RN level with an agreed upon starting date. The Service Authorization must designate the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs and physician's orders. This documentation will be maintained in the client's file.

4. The DSP Agency will initiate Skilled Nursing within 3 working days or earlier if indicated by the physician's orders after receiving the Service Authorization Form in accordance with the following:
 - a. Services must not be provided prior to the authorized starting date as stated on the Service Authorization Form
 - b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form.
 - c. No payment will be made for services unless authorized on the Service Authorization Form and listed on the POC. 6. An initial visit is required when a DSP begins to provide services to a client in the client's place of residence.
 - d. If the client receives more than one direct service from the DSP, only one initial visit is required. If a client has more than one DSP, an initial visit should be conducted with each DSP.
 - e. The initial visit should be held at the client's place of residence and the Case Manager, the Skilled Nursing Supervisor, the client, and the caregiver, if feasible should be included. It is advisable to include the Skilled Nursing Worker in the initial visit, also.
 - f. The initial visit and the Skilled Nursing Assessment Visit may be conducted at the same time. 7. The Skilled Nursing DSP must determine when changes are needed to the level of Skilled Nursing provided (RN or LPN), physician's orders, or treatment plan/goals. Copies of any changes must be forwarded to the Case Manager to maintain in the client's file. The Case Manager will update the Care Plan and issue another Service Authorization when the need to do so is indicated by this information from the DSP.
5. The DSP will retain a client's file for at least five (5) years after services are terminated.
6. Provision of Service Authorized
 - a. Skilled Nursing Services may be provided at the same time other authorized waiver services are being provided.

- b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for respite care services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.
- c. The Skilled Nursing Worker is not allowed to provide transportation when he/she is accompanying a client.
- d. Skilled Nursing Worker will maintain a separate service log for each client to document his or her delivery of services.
 - (1) The Skilled Nursing Worker shall complete a service log that will reflect the types of services that were provided, the number of hours of service, and the date and time of the service.
 - (a) The service log must be signed upon each visit by the client, or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Skilled Nursing Worker must document the reason the log was not signed by the client or family member/responsible party.
 - (b) The Skilled Nursing Worker must fully document the skilled nursing services that were authorized by the client's physician and performed for the client during each visit in which Skilled Nursing was provided. The nurse's notes must reflect the provision of services and observed condition of the client.
 - (c) The documentation forms for Skilled Nursing will be reviewed and signed by the Skilled Nursing Supervisor at least once every two (2) weeks. Daily service logs and documentation forms will be retained in the client's file.
 - (d) Client visits may be recorded electronically via telephony. Electronic documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone,

client staying with relatives. These electronic records may be utilized in place of client signatures.

- (e) The DSP Supervisor should notify the Case Manager in writing regarding any report or indication from the DSP Worker regarding a significant change in the client's physical, mental or emotional health. The DSP Supervisor should document such action in the DSP client file.

7. Monitoring of Service:

- a. Skilled Nursing Services must be provided under the supervision of the Registered Nurse who meets the requirements of a Skilled Nursing Supervisor and will:
 - (1) Make an initial visit prior to the start of the Skilled Nursing service for the purpose of reviewing the Care Plan, providing written information to the client regarding rights and responsibilities, how to register complaints, and discussing the provisions and supervision of the service(s).
 - (2) Be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the Operating Agency. If this position becomes vacant, the Operating Agency must be notified within 24 hours.
 - (3) The Skilled Nursing Supervisor will provide on-site (client's residence) supervision at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Skilled Nursing Worker. The client must be present for the supervisory visit.
- b. The DSP must complete the 60 day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the case manager within 10 calendar days after the 60-day supervisory review. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Skilled Nursing Service. Documentation regarding this action should be in the DSP client record.
- c. The Skilled Nursing Supervisor must provide direct supervision of each Skilled Nursing Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Worker's personnel record.
 - (1) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

- (2) Client and Skilled Nursing Worker have to be present.
 - d. The Skilled Nursing Supervisor will provide and document the supervision, training, and evaluation of Skilled Nursing Workers according to the requirements in the approved Waiver Document.
 - e. Each supervisory visit conducted will be documented in the client's file. The Skilled Nursing Supervisor's report of the on-site visits will include, at a minimum:
 - (1) Documentation that services are being delivered consistent with the plan of care
 - (2) Documentation that the client's needs are being met;
 - (3) Reference to any complaints which the client or family member/responsible party has lodged and action taken
 - (4) A brief statement regarding any changes in the client's skilled nursing service needs.
 - f. The Skilled Nursing Supervisor will provide skilled nursing assistance to the LPN as necessary based on the Care Plan. Any supervision/assistance given must be documented in the individual client record.
8. Missed Visits and Attempted Visits
- a. Missed Visits
 - (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
 - (2) The DSP shall have a written policy assuring that when a Skilled Nursing Service Worker is unavailable, the Skilled Nursing Supervisor assesses the need for services and arranges for a substitute Skilled Nursing Worker to provide services as necessary.
 - (a) If the Skilled Nursing Supervisor sends a substitute Skilled Nursing Worker, the substitute will complete and sign the service log and obtain the signature or telephone authorization from the client or family member/responsible party after finishing duties.
 - (b) If the Skilled Nursing Supervisor does not send a substitute Skilled Nursing Worker, the Supervisor will contact the client and inform them of the unavailability of the Skilled Nurse. The Nurse Supervisor must assure that the client's health and safety is not at risk because of the missed visit.
 - (3) The DSP will document missed visits in the client's file.

(4) Whenever the DSP determines that services cannot be provided as authorized, the Case Manager must be notified by telephone immediately. All missed visits must be reported in writing on the "Weekly Missed/Attempted Visit Report" form sent to the Case Manager on Monday of each week.

(5) The DSP may not bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Skilled Nursing Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may not bill for the attempted visits.

(b) The Skilled Nursing Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the Case Manager within one (1) day after the second attempted visit whenever two attempted visits occur within the SAME week.

(d) The DSP will notify the Case Manager immediately when an attempted visit occurs for a client who is at-risk for missed visits

9. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Care Plan no longer meets the client's needs;

(2) Client does not appear to need Skilled Nursing;

(3) Client dies or moves out of the service area;

(4) Client indicates Skilled Nursing Service is not wanted;

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided

b. The Case Manager will notify the DSP immediately if a client becomes medically and financially ineligible for waiver services.

- (1) The Case Manager must verify Medicaid eligibility on a monthly basis.
- c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Care Plan, the DSP shall contact the Case Manager to discuss having these duties added.
- (1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
 - (2) The Case Manager will approve any modification of duties to be performed by the Skilled Nursing Service worker and re-issue the Service Authorization Form accordingly, if he/she concurs with the request after receipt of the physician's orders to that effect.
 - (3) Documentation of any changes in a Care Plan will be maintained in the client's file.
 - (a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.
 - (b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.
 - (c) If an individual declines Skilled Nursing Services or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

10. Documentation and Record-Keeping

- a. The DSP shall maintain a record keeping system which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the Operating Agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

- (1) A current HCBS application;
- (2) All physician's orders and treatment plans
- (3) Both current and historical Service Authorization Forms specifying units, services, and schedule of Skilled Nursing visits for the client;
- (4) All nurses notes including the initial assessment for skilled nursing. The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.
- (5) Records of all missed or attempted visits;

- (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;
 - (7) Evaluations from all 60 day on-site supervisory visits to the client;
 - (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
 - (9) The name of the primary caregiver
 - (10) Any other notification to Case Manager;
 - (11) Permission statements to release confidential information, as applicable
- b. The DSP will retain a client's file for at least five (5) years after services are terminated.
 - c. The DSP Agency shall comply with federal and state confidentiality laws and regulations about client and employee files. Rights, Responsibilities, and Service Complaints
11. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
12. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Skilled Nursing Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.
- a. Complaints which are made against Skilled Nursing Workers will be investigated by the DSP and documented in the client's file.
 - b. All complaints to be investigated will be referred to the Skilled Nursing Service Supervisor who will take appropriate action.
 - c. The Skilled Nursing Supervisor will take any action necessary and document the action taken in the client's and employee's files.
 - d. The Skilled Nursing Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken. 3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

F. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency within (3) working days of a change in the agency administrator, address, phone number, or of an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Operating Agency.
3. Administrative and supervisory functions shall not be delegated to another agency or organization.
4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.
5. The DSP Agency must maintain an annual operating budget, which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.
6. During the life of the contract, the DSP Agency shall acquire and maintain contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.
8. The DSP Agency shall maintain an office, which is open during normal business hours and staffed with qualified personnel.
9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.
11. The DSP shall conform to applicable federal, state and local health and safety rules and regulations and have an ongoing program to prevent the spread of infectious diseases among its employees.

G. Provider Experience

1. Providers of Skilled Nursing Service Care must meet all provider qualifications prior to rendering the Skilled Nursing Care Service.
2. All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

7 RESPITE CARE SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Respite Care is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary, short term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. Respite Care is intended to supplement, not replace care provided to waiver clients.

Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely in the absence or availability of the primary caregiver.

C. Description of Service to be Provided

1. The unit of service is 15 minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.
2. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year (October 1-September 30) in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. As implied in the definition, Respite Care is for the relief of the family member or primary caregiver; therefore, there must be a primary caregiver identified for each client that uses the Respite Care Service. The primary caregiver does not have to reside in the residence; however, there must be sufficient documentation to establish that the primary caregiver to be relieved furnishes substantial care of the client.
4. This service must not be used to provide continuous care while the primary caregiver is working or attending school.

5. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form.
6. The type of in-home respite (skilled or unskilled) provided to each client will be dependent upon the individual client's needs as established by the Case Manager and set forth in the client's Plan of Care.
 - a. Skilled Respite:
 - (1) Skilled Respite Service will provide skilled medical or nursing observation and services and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.
 - (a) Orders from the client's physician(s) are required annually and when any changes occur.
 - (b) It is the responsibility of the Skilled Respite Provider to obtain such physician orders for the skilled nursing services needed by the client.
 - (2) In addition to providing supervision to the client, Skilled Respite may include, but is not limited to, the following activities:
 - (a) Assistance with activities of daily living (ADLs), such as,
 - Bathing, personal hygiene and grooming
 - Dressing
 - Toileting or activities to maintain continence
 - Preparing and serving meals or snacks and providing assistance with eating
 - Transferring
 - Ambulation
 - (b) Home support that is essential to the health and welfare of the recipient, such as,
 - Cleaning
 - Laundry
 - Assistance with communication
 - Home safety

Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Case Manager for follow-up.

- (c) Skilled nursing services as ordered by the client's physician, including administering medications.
 - (d) Skilled medical observation and monitoring of the client's physical, mental or emotional condition and the reporting of any changes.
 - (e) Orienting the client to daily events.
- b. Unskilled Respite:
- (1) Unskilled Respite Services will provide and/or assist with activities of daily living and observations. Unskilled Respite will be performed by a Personal Care worker.
 - (2) In addition to providing supervision to the client, Unskilled Respite may include, but is not limited to, the following activities:
 - a. Meal or snack preparation, meal serving, cleaning up afterwards;
 - b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;
 - c. Assistance with communication which includes placing phone within client's reach and physically assisting client with use of the phone and orientation to daily events;
 - d. Support for activities of daily living, such as,
 - bathing
 - personal grooming
 - personal hygiene
 - assisting clients in and out of bed
 - assisting with ambulation
 - toileting and/or activities to maintain continence
 - e. The Respite Care worker will ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the RCW Supervisor as well as the Case Manager for follow-up;
 - f. Reporting observed changes in the client's physical, mental or emotional condition;
 - g. Reminding clients to take medication.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by an Unskilled Respite worker.

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

1. Skilled Respite Supervisors must meet the following qualifications and requirements:
 - a. Be a Registered Nurse (RN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.
 - b. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks, previous employers, and the Nurse Aide Registry.
 - c. Have at least two (2) years experience as a Registered Nurse in public health, hospital, home health, or long term care nursing.
 - d. Have the ability to evaluate the Skilled Respite Worker (SR Worker) in terms of his or her ability to carry out assigned duties and his or her ability to relate to the client.
 - e. Have the ability to assume responsibility for in-service training for RCWs by individual instruction, group meetings or workshops.
 - f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Respite Care Service.
 - g. Submit to a program for the testing, prevention, and control of tuberculosis annually.
 - h. Possess a valid, picture identification.
2. Skilled Respite Worker - A Licensed Practical Nurse (LPN) or Registered Nurse (RN) who meets the following requirements:
 - a. Be currently licensed by the State of Alabama to practice nursing.
 - b. Have at least two years experience in public health, hospital, or long term care nursing.
 - c. Submit to a program for testing, prevention, and control of tuberculosis, annually.
 - d. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.
 - e. Possess a valid, picture identification.
 - f. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks, previous employers, and the Nurse Aide Registry.

Minimum Training Requirements for Skilled Respite Care Workers (LPN or RN): The Direct Service Provider (DSP) must assure Medicaid and the Operating Agency (OA) that the nurse has

adequate experience and expertise to perform the skilled services and the care required by the client. Provide validation of CEUs for licensure.

3. Unskilled Respite Supervisors and workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.

Unskilled Respite Supervisors must have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks, previous employers, and the Nurse Aide Registry.

Unskilled Respite Worker – USR workers must meet the following qualifications and requirements:

- a. Have references which will be verified and documented in the Direct Service Provider personnel file. References must include statewide criminal background checks, previous employers, and/or Nurse Aide Registry.
 - b. Be able to read and write.
 - c. Possess a valid, picture identification.
 - d. Be able to follow the Plan of Care with minimal supervision.
 - e. Assist client appropriately with activities of daily living.
 - f. Complete a probationary period determined by the employer with continued employment contingent on completion of an unskilled respite care in-service training program.
 - g. Must submit to a program for the testing, prevention, and control of tuberculosis annually.
4. Minimum Training Requirements for Unskilled Respite Care Worker: The Unskilled Respite Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Unskilled Respite Care training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each USR worker to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:

- a. Activities of daily living, such as,
 - bathing (sponge, tub)
 - personal grooming
 - personal hygiene

- proper transfer technique (assisting clients in and out of bed)
 - assistance with ambulation
 - toileting
 - feeding the client
- b. Home support, such as,
- maintaining a safe and clean environment,
 - providing care which includes; individual safety, laundry, serve and prepare meals and
 - household management
- c. Recognizing and reporting observations of the client, such as,
- physical condition
 - mental condition
 - emotional condition
 - prompting the client of medication regimen
- d. Record keeping, such as,
- A service log signed by the client or family member/responsible person and USR Care worker to document what services were provided for the client in relation to the Plan of Care.
 - Submitting a written summary to the USR Care Worker Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.
- e. Communication skills
- f. Basic infection control/Universal Standards
- g. First aid emergency situations
- h. Fire and safety measures
- i. Client rights and responsibilities
- j. Other areas of training as appropriate or as mandated by the Operating Agency
5. The DSP will be responsible for providing a minimum of 12 hours of relevant in-service training per calendar year for each USR worker. In-service training is in addition to USR Worker orientation training. For USR workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a USR Worker.

6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
7. Topics for specific in-service training may be mandated by the Operating Agency.
8. In-service training may entail demonstration of maintaining a safe and clean environment and providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency least 45 days prior to the planned implementation.
9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the 12 hours required in-service for all USR workers each calendar year.
10. The DSP Agency shall maintain records on each employee which shall include the following:
 - a. Application for employment;
 - b. Statewide criminal background checks and references
 - c. Job description;
 - d. Record of health (annual tuberculin tests);
 - e. Record of pre-employment and annual in-service training;
 - (1) For Skilled Respite Supervisors and Skilled Respite Workers validation of required CEUs for licensure will be accepted for in-service.
 - (2) For USR Supervisor validation of required CEUs for licensure will be accepted.
 - f. Orientation;
 - g. Evaluations;
 - h. Supervisory visits;
 - i. Copy of photo identification;
 - j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
 - k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Respite Care designating the units, frequency, beginning date of service, and

- types of duties in accordance with the individual client's needs. This documentation will be maintained in the client's file.
2. The DSP Agency will initiate Respite Care within three (3) working days of the designated START DATE receiving the Service Authorization Form in accordance with the following:
 - a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.
 - b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form.
 - c. No payment will be made for services unless authorized and listed on the Plan of Care.
 - d. The DSP will retain a client's file for at least five (5) years after services are terminated.
 3. Provision of Service authorized:
 - a. Respite Care cannot be provided at the same time other authorized waiver services are being provided with the exception of Case Management.
 - b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for respite care services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.
 4. Respite Care Worker will maintain a separate service log for each client to document their delivery of services.
 - a. The Respite Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.
 - b. The service log must be signed upon each visit by the client, or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Respite Care Worker must document the reason the log was not signed by the client or family member/responsible party.
 - c. The Skilled Respite Worker must fully document the skilled nursing services that were authorized by the client's physician and performed for the client during each visit in which Skilled Respite was provided.

- d. The service logs for Unskilled Respite and the documentation forms for Skilled Respite will be reviewed and signed by the Unskilled or Skilled Respite Supervisor respectively at least once every two (2) weeks. Daily service logs and documentation forms will be retained in the client's file.
 - e. Client visits may be recorded electronically via telephony. Electronic documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.
 - f. The DSP Supervisor should notify the Case Manager in writing regarding any report or indication from the DSP Worker regarding a significant change in the client's physical, mental or emotional health. The DSP Supervisor should document such action in the DSP client file.
5. Monitoring of Service:
- Unskilled Respite Care must be provided under the supervision of the Registered Nurse or Licensed Practical Nurse who meets the requirements of D.1.b.-h. and will:
- a. Make an initial visit to the client's residence prior to the start of Respite Care for the purpose of reviewing the Plan of Care, providing written information to the client regarding rights and responsibilities, how to register complaints, and discussing the provisions and supervision of the service(s)."
 - b. Be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours if the position becomes vacant.
 - c. Provide and document supervision of, training for, and evaluation of Unskilled Respite Care Workers according to the requirements in the approved waiver document.
 - d. Provide on-site (client's residence) supervision of the Unskilled Respite Care Worker at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Unskilled Respite Care Worker.
 - e. Assist Unskilled Respite Care Workers as necessary as they provide individual Respite Service as outlined by the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.
 - f. The Skilled Respite Supervisor will provide on-site (client's residence) supervision of the Skilled Respite Care Worker at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Skilled Respite Care Worker.

- g. The SR and USR Supervisor must provide direct supervision of each SR and USR Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Worker's personnel record.

Direct supervision may be carried out in conjunction with an on-site supervisory visit.

The SR and USR Supervisor will provide and document the supervision, training, and evaluation of SR and USR Workers according to the requirements in the approved Waiver Document.

6. Missed Visits and Attempted Visits

a. Missed Visits

- (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
- (2) The DSP shall have a written policy assuring that when a Respite Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.
 - (a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.
 - (b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Respite Care Worker.
- (3) The DSP will document missed visits in the client's files.
- (4) Whenever the DSP determines that services cannot be provided as authorized, the Case Manager must be notified by telephone immediately. All missed visits must be reported in writing on the "Weekly Missed/Attempted Visit Report" form to the Case Manager on Monday of each week.
- (5) The DSP may not bill for missed visits.

b. Attempted Visits

- (1) An attempted visit occurs when the Respite Care Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.
- (2) If an attempted visit occurs:
 - (a) The DSP may not bill for the attempted visits.
 - (b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.
 - (c) The DSP will notify the Case Manager within one (1) day after second attempted visit whenever two attempted visits occur within the SAME week.

7. Changes in Services

- a. The DSP will notify the Case Manager within one (1) working day of the following changes:
- (1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;
 - (2) Client does not appear to need Respite Care;
 - (3) Client dies or moves out of the service area;
 - (4) Client indicates Respite Care Service is not wanted;
 - (5) Client loses Medicaid financial eligibility;
 - (6) When services can no longer be provided.

- b. The Case Manager will notify the DSP immediately if a client becomes medically and financially ineligible for waiver services.

The Case Manager must verify Medicaid eligibility on a monthly basis.

- c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

- (1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
- (2) The Case Manager will approve any modification of duties to be performed by the Respite Care and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.
- (3) Documentation of any changes in a Plan of Care will be maintained in the client's file.
 - (a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.
 - (b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.
 - (c) If an individual declines Respite Care or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

8. Documentation and Record-Keeping

- a. The DSP shall maintain a record keeping system which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the Operating Agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

- (1) A current HCBS application;
 - (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Respite Care visits for the client;
 - (3) All service logs;
 - The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.
 - (4) Records of all missed or attempted visits;
 - (5) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;
 - (6) Evaluations from all 60 day on-site supervisory visits to the client;
 - (7) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
 - (8) The name of the primary caregiver.
- b. The DSP will retain a client's file for at least five (5) years after services are terminated.
- c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Case Manager has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Respite Care Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.
 - a. Complaints which are made against Respite Care Workers will be investigated by the DSP and documented in the client's file.

- b. All complaints to be investigated will be referred to the Respite Care Worker Supervisor who will take appropriate action.
 - c. The Respite Care Worker Supervisor will take any action necessary and document the action taken in the client's and employee's files.
 - d. The Respite Care Worker Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency within (3) working days of a change in the agency administrator, address, or phone number.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Operating Agency.
3. Administrative and supervisory functions shall not be delegated to another agency or organization.
4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.
5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.
6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.
8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Respite Care must meet all provider qualifications prior to rendering the Respite Care Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

8 PERSONAL CARE SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Personal Care Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

Personal Care Service is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

Personal Care Service is to help waiver clients perform everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently.

C. Description of Service to be Provided

1. The unit of service will be 15 minutes of direct PC Service provided in the client's residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or the Personal Care Worker's break or mealtime. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care established by the case manager.

Medicaid will not reimburse for activities performed which are not within the scope of service.

2. PC Service duties include:
 - a. Support for activities of daily living, such as,
 - bathing
 - personal grooming
 - personal hygiene
 - meal preparation
 - assisting clients in and out of bed

- assisting with ambulation
 - toileting and/or activities to maintain continence
- b. Home support that is essential to the health and welfare of the recipient, such as,
- cleaning
 - laundry
 - home safety

Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PCW Supervisor as well as the case manager for follow-up.

- c. Reporting observed changes in the client's physical, mental or emotional condition.
- d. Reminding clients to take medication.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by the PCW.

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

PC Supervisors and PC Workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.

1. Personal Care (P/C) Supervisors must be a licensed nurse(s) who meet the following requirements:
 - a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include statewide criminal background checks, previous employers and the Nurse Aide Registry.
 - b. Be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.
 - c. Have at least two (2) years experience as an RN or LPN in public health, hospital, or long term care nursing.
 - d. Have the ability to evaluate the Personal Care Worker (PC Worker) in terms of his/her ability to carry out assigned duties and to relate to the client.
 - e. Have the ability to coordinate or provide orientation and in-service training to PC Workers on either an individual basis or in a group setting.

- f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or case manager's dissatisfaction, complaints or grievances regarding the provision of PC Service.
 - g. Submit to a program for the testing, prevention, and control of Tuberculosis annually.
 - h. Possess a valid, picture identification.
2. PCWs must meet the following qualifications:
- a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include statewide background checks, previous employers, and the Nurse Aide Registry.
 - b. Be able to read and write.
 - c. Possess a valid, picture identification.
 - d. Be able to follow the Plan of Care with minimal supervision.
 - e. Assist client appropriately with activities of daily living as related to personal care.
 - f. Complete a probationary period determined by the employer with continued employment contingent on completion of a Personal Care in-service training program.
 - g. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

3. Minimum Training Requirements for Personal Care Workers:

The Personal Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property.

The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Personal Care training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each PCW to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:

- a. Activities of daily living, such as,
 - bathing (sponge, tub)
 - personal grooming

- personal hygiene
 - meal preparation
 - proper transfer technique (assisting clients in and out of bed)
 - assistance with ambulation
 - toileting
 - feeding the client
- b. Home support, such as,
- cleaning
 - laundry
 - home safety
- c. Recognizing and reporting observations of the client, such as,
- physical condition
 - mental condition
 - emotional condition
 - prompting the client of medication regimen
- d. Record keeping, such as,
- A service log signed by the client or family member/responsible person and PCW to document what services were provided for the client in relation to the Plan of Care.
 - Submitting a written summary to the PCW Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the case manager.
- e. Communication skills
- f. Basic infection control/Universal Standards
- g. First aid emergency situations
- h. Fire and safety measures
- i. Client rights and responsibilities
- j. Other areas of training as appropriate or as mandated by the Operating Agency.
4. The DSP will be responsible for providing a minimum of twelve (12) hours of relevant in-service training per calendar year for each PC Worker. In-service training is in addition to PC Worker

orientation training. For PC Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a PC Worker.

5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
6. Topics for specific in-service training may be mandated by the Operating Agency.
7. In-service training may entail demonstration of providing care to the client.

Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency at least forty-five (45) days prior to the planned implementation.

8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the 12 hours required in-service for all PC Workers each calendar year.
9. The DSP Agency shall maintain records on each employee, which shall include the following:
 - a. Application for employment;
 - b. Job description;
 - c. Statewide criminal background checks and references;
 - d. Record of health (annual tuberculin tests);
 - e. Record of pre-employment and in-service training;

(For PC Supervisor validation of required CEUs for licensure will be accepted.)
 - f. Orientation;
 - g. Evaluations;
 - h. Supervisory visits;
 - i. Copy of photo identification;
 - j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
 - k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The case manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Personal Care Service and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs.

2. The DSP Agency will initiate PC Service within three (3) working days of the designated START DATE on the Service authorization form in accordance with the following:
 - a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.
 - b. The DSP Agency will adhere to the services and schedule as authorized by the case manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Provision of Service Authorized:
 - a. Personal Care Service cannot be provided at the same time other authorized waiver services are being provided except Case Management.
 - b. Personal Care Workers will maintain a separate service log for each client to document their delivery of services.
 - (1) The Personal Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.
 - (2) The service log must be signed upon each visit by the client, or family member/responsible party and the PC Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Personal Care Worker must document the reason the log was not signed by the client or family member/responsible party.
 - (3) The service log will be reviewed and signed by the Personal Care Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.
 - (4) Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

Services provided by relatives or friends may be covered only if relatives or friends meet qualifications for providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for personal care services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be

informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

4. Monitoring of Service:

PC Service must be provided under the supervision of the registered nurse or licensed practical nurse who meets the requirements of D.1. and will:

- a. Make an initial visit prior to the start of PC Service for the purpose of reviewing the plan of care, providing the client written information regarding rights and responsibilities and how to register complaints, and discussing the provisions and supervision of the service(s)."

The initial visit should be held at the client's place of residence and should include the case manager, the PC Supervisor, the client, and the caregiver, if feasible. It is advisable to also include the PC Worker in the initial visit.

- b. Be immediately accessible by phone during the time PC Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.
- c. Provide and document supervision of, training for, and evaluation of PCWs according to the requirements in the approved waiver document.
- d. Provide on-site (client's residence) supervision of the PCW at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PCW. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Personal Care Service. Documentation regarding this action should be in the DSP client record.
- e. The DSP must complete the 60 day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the case manager within 10 calendar days after the 60 day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC Service.
- f. Assist PCWs as necessary as they provide individual Personal Care Service as outlined in the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.

- g. The PC Supervisor must provide direct supervision of each PC Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the PC Worker's personnel record.

- Direct supervision may be carried out in conjunction with an on-site supervisory visit.

The PC Supervisor will provide and document the supervision, training, and evaluation of PC Workers according to the requirements in the approved Waiver Document.

5. Missed Visits and Attempted Visits

a. Missed Visits

- (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
- (2) The DSP shall have a written policy assuring that when a Personal Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary/or reduced by the DSP.

Clients who are designated by the case manager as being at-risk should be given first priority when Personal Care Service visits must be temporarily prioritized and

- (a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.
- (b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Personal Care Worker.
- (3) The DSP will document missed visits in the client's files.
- (4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the case manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "**Weekly Missed/Attempted Visit Report**" form to the case manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.
- (5) The DSP may not bill for missed visits.

b. Attempted Visits

- (1) An attempted visit occurs when the PCW arrives at the home and is unable to provide services because the client is not at home or refuses services.
- (2) If an attempted visit occurs:
 - (a) The DSP may not bill for the attempted visits.

(b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the case manager promptly whenever an attempted visit occurs and will notify the case manager within one (1) working day after the second attempted visit whenever two attempted visits occur within the SAME week.

6. Changes in Services

a. The DSP will notify the case manager within one (1) working day of the following changes:

- (1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;
- (2) Client does not appear to need Personal Care Service;
- (3) Client dies or moves out of the service area;
- (4) Client indicates Personal Care Service is not wanted;
- (5) Client loses Medicaid financial eligibility;
- (6) When services can no longer be provided.

b. The case manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the case manager to discuss having these duties added.

- (1) The case manager will review the DSP's request to modify services and respond within one (1) working day of the request.
- (2) The case manager will approve any modification of duties to be performed by the PCW and re-issue the Service Authorization Form
- (3) Documentation of any change in a Plan of Care will be maintained in the client's file.
 - (a) If the total number of hours of service is changed, a new Service Authorization Form is required from the case manager.
 - (b) If the types or times of services are changed, a new Service Authorization Form is required from the case manager.
 - (c) If an individual declines PC Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

7. Documentation and Record-Keeping

- a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the operating agencies, or other agencies contractually required to review information.

The DSP shall maintain a file on each client, which shall include the following:

- (1) A current HCBS application;
 - (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Personal Care visits for the client;
 - (3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Personal Care Worker;
 - (4) All service logs;
 - The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.
 - (5) Records of all missed or attempted visits;
 - (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;
 - (7) Evaluations from all 60 day on-site supervisory visits to the client;
 - (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
 - (9) Initial visit for in-home services;
 - (10) Any other notification to case manager;
 - (11) Permission statements to release confidential information, as applicable.
- b. The DSP will retain a client's file for at least five (5) years after services are terminated.
- c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of PC Service provided and will provide information about how to register a complaint with the case manager as well as the Alabama Medicaid Agency.
 - a. Complaints which are made against PCW will be investigated by the DSP Agency and documented in the client's file.

- b. All complaints which are to be investigated will be referred to the PCW Supervisor who will take appropriate action.
 - c. The PCW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.
 - d. The PCW Supervisor will contact the case manager by letter or telephone about any complaint and any corrective action taken.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Operating Agency.
3. Administrative and supervisory functions shall not be delegated to another agency or organization.
4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.
5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.
6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.
9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Personal Care Service must meet all provider qualifications prior to rendering the Personal Care Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

9 PERSONAL ASSISTANCE SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Service Definition (Scope):

PAS are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on the job. These activities would be performed by the individual if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on the job. This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those in competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community which employs individuals with disabilities and there is interaction with non-disabled individuals who are in the same employment setting. This service will be sufficient to support the competitive employment of people with disabilities of at least 40 hours per month. The service will also be sufficient in amount, duration, and scope so that an individual with a moderate to severe level of disability would be able to obtain the support needed maintain employment.

B. Objective:

The objective of PAS is to provide a range of services designed to assist an individual with physical disabilities to perform activities on the job.

C. Provider Experience

Agencies desiring to be a provider must have demonstrated to the operating agency (OA) experience in providing PAS or a similar service.

D. Description of Services to Be Provided

1. This service will be provided to individuals with disabilities inside and outside of their home. It may enable them to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work.
2. The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistant's transportation time to or from the recipient's home or place of employment.
3. The PAS received by an individual will be based on the individual's needs. The number of hours must be stipulated on the Plan of Care and Service Provider Contract.
4. IF THIS SERVICE IS USED FOR EMPLOYMENT, THE OA IS REQUIRED TO HAVE A SIGNED AGREEMENT WITH THE EMPLOYER STATING THAT IT IS ACCEPTABLE TO HAVE A PAS WORKER ON THE JOB-SITE.
5. PAS is required, but are not limited to assisting with:

Outside Home/Job Site: Essential shopping, transportation to and from work, eating, toileting, medication monitoring, entering or exiting doors. PAS services must be provided under the supervision of the registered nurse who meets the PAS staffing requirements and will:

- a. Make visits to client's residence after the initial visit by the registered nurse.
 - b. Be immediately accessible by phone during the hours services are being provided. Any deviation from this requirement must be prior approved in writing by the OA and the Alabama Medicaid Agency. If this position becomes vacant the OA must be notified within 24 hours.
 - c. Provide and document supervision of, training for, and evaluation of PAS workers according to requirements in the approved waiver document.
 - d. Provide on-site (clients' place of residence) supervision of the PAS worker at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record and reported to the OA. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances of the PAS worker.
 - e. Observe each PAS worker with at least one assigned client at a minimum of every 6 months or more frequently if warranted by substandard performance. This function may be carried out in conjunction with the 60 day supervisory visits, or at another time. Documentation of direct supervisory visits must be maintained in the employee personnel file.
 - f. Assist PAS workers as necessary to provide individual PAS as outlined by the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.
6. Minimum training requirements must be completed prior to working with a client. The DSP is responsible for providing/or conducting the training. Proof of training must be recorded in the personnel file.

The PAS training program should stress physical, emotional and developmental needs and ways to work with the population served, including the need for respect of the client, his/her privacy, workplace and property.

NOTE: The PAS training program must be approved by the OA.

Minimum training requirements must include the following areas:

- a. Monitor the client, e.g., observe for signs of change in condition, prompt client to take medications as directed, basic recognition of medical problems and medical emergency, basic first aid for emergencies.
- b. Recordkeeping, e.g., a daily log signed by the client or family member/ responsible person and PAS Worker to document what services were provided for the client in relation to the Plan of Care and signed at least once every two weeks by the supervising nurse.
- c. Basic Infection Control
- d. Communication skills
- e. The DSP is responsible for providing a minimum of 12 hours relevant in-service training per calendar year. (The annual in-service training requirements can be done on a prorated basis.) Documentation shall include topic, name and title of trainer, training objectives, outline of

content, length of training, list of trainees, location, and outcome of training. Topics for specific in-service training may be mandated by Medicaid or the OA. In-service training may entail furnishing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid, and/or the OA, prior to being offered and may not exceed 4 of the 12 in-service annual training hours. The DSP shall submit proposed program(s) to the OA at least 45 days prior to the planned implementation. Note: In-service training is in addition to the required training prior to delivery of personal care.

7. Personnel files:

Individual records will be maintained to document that each member of the staff has met the above requirements.

E. Conduct of Service

An individual client record must be maintained by the DSP. Requirements under this section (E) must be documented in each individual client record.

1. The DSP will initiate PAS within three working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date stated on the Provider Contract.
2. The DSP will notify the case manager within three working days of the following client changes:
 - a. Client's condition has changed and the Plan of Care no longer meets client needs or client no longer appears to need PAS.
 - b. Client dies or moves out of service area.
 - c. Client no longer wishes to participate in PAS.
 - d. Knowledge of client's Medicaid ineligibility or potential ineligibility.
 - e. Client becomes unemployed.
3. The DSP will maintain a recordkeeping system which establishes a client profile in support of units of PAS delivered, based on the Service Provider Contract. The DSP will arrange a daily log reflecting the personal assistance services provided by the PAS worker for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or employer/family member/responsible person if the client is unable to sign.
4. The DSP must complete the 60 day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the Plan of Care and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the case manager within ten (10) calendar days after the 60 day supervisory review.
5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives PAS as authorized.
6. Whenever two consecutive attempted visits occur, the case manager must be notified immediately.

7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the operating agency which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan.
8. The DSP will inform clients of their right to complain about the quality of PAS provided and will provide clients with information about how to register a complaint.
9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PAS to review the Plan of Care and in order to give the client written information. The Plan of Care must be developed and the service contract form submitted prior to the provision of PAS. The DSP must maintain documentation.
10. The case manager will authorize PAS by designating the amount, frequency and duration of service for clients in accordance with the client's Plan of Care which is developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the Plan of Care and the Service Provider Contract. If the DSP identified PAS duties that would be beneficial to the client's care but are not specified in the Plan of Care and the Service Provider Contract, the DSP must contact the case manager.
11. The case manager will review a client's Plan of Care within three working days of the receipt of the DSP's request to modify the Plan of Care.
12. The case manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating services. The case manager must verify Medicaid eligibility monthly.
13. Under no circumstance should any type of skilled medical service be performed by a PAS worker.
14. No payment will be made for services not listed on the Plan of Care and Service Provider Contract.
15. The DSP will retain a client's file for at least five years after services are terminated.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work. The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistant's transportation time to or from the recipient's home or place of employment.

Provider Type:

Home Care Agency or Home Health Agency

Provider Qualifications

License (specify):

Business

Certificate (specify):

Certificate of Need (CON) if the provider type is a Home Health Agency

Other Standard (specify):

Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications /Entity Responsible for Verification:

Alabama Department of Senior Services Certification Surveyor

Frequency of Verification:

Annually upon initial approval and biannually thereafter if no compliance concerns exist.

10 HOMEMAKER SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Homemaker Service provides assistance with general household activities such as meal preparation and routine housecleaning and tasks, such as, changing bed linens, doing laundry, dusting, vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. This service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing.

Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the Plan of Care.

B. Objective

The objective of Homemaker Services (HM) are to preserve a safe and sanitary home environment, assist clients with home care management duties, to supplement and not replace care provided to clients, and to provide needed observation of clients participating in the ACT waiver.

C. Description of Service to be Provided

1. The unit of service is 15 minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.
2. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the Plan of Care.

Medicaid will not reimburse for activities performed which are not within the scope of services.
3. No payment will be made for services that are not listed on the Plan of Care and the Service Authorization Form.
4. Homemaker Services duties include, but are not limited to, the following:
 - a. Meal or snack preparation, meal serving, cleaning up afterwards;
 - b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;
 - c. Essential shopping for food and other essential household or personal supplies which may be purchased during the same trip, and picking up prescribed medication;

- d. Assistance with paying bills (which includes opening bills, writing checks but not signing them) and delivering payments to designated recipients on behalf of the client;
- e. Assistance with communication which includes placing phone within client's reach and physically assisting client with use of the phone, orientation to daily events, paying bills, and writing letters;
- f. Observing and reporting on client's condition;
- g. The homemaker is not allowed to transport the client by vehicle in the performance of their task;
- h. Reminding clients to take medications;
- i. Observing and reporting on home safety. The Homemaker service worker will insure that the client is residing in a safe environment. Insuring home safety means that the worker will have a general awareness of the home's surroundings and any concerns with safety issues will be reported to the Homemaker Supervisor as well as the case manager for follow up.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by a Homemaker.

- 5. The Direct Service Provider (DSP) is not responsible for providing funds, supplies, or groceries to perform Homemaker Services.

D. Staffing

The DSP must provide all of the following staff positions through employment and/or subcontractual arrangements.

- 1. All Homemaker Supervisors will have the following qualifications:
 - a. High school diploma or equivalent;
 - b. Be able to evaluate homemakers in terms of their ability to perform assigned duties and relate to the client;
 - c. Have the ability to coordinate or provide orientation and in-service training to Homemaker Workers on either an individual basis or in a group setting;
 - d. Submit to a program for the testing, prevention, and control of tuberculosis annually;
 - e. Must have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide criminal background checks, previous employers, and the Nurse Aide Registry;
 - f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Manager's dissatisfaction, complaints or grievances regarding the provision of Homemaker service;

- g. Have the ability to evaluate the Homemaker Worker (HM Worker) in terms of his/her ability to carry out assigned duties and relate to the client;
 - h. Possess a valid, picture identification.
2. All individuals providing Homemaker Service must meet the following qualifications:
- a. Be able to read and write;
 - b. Submit to a program for the testing, prevention, and control of tuberculosis annually;
 - c. Have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide background checks, previous employers, and the Nurse Aide Registry;
 - d. Be able to work independently on an established schedule;
 - e. Possess a valid, picture identification;
 - f. Be able to follow the Plan of Care with minimal supervision;
 - g. Complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker in-service training program.

3. Minimum Training Requirements for Homemakers:

The Homemaker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing and/or conducting the training. The Homemaker training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

The annual in-service training is in addition to the training required prior to the provision of care.

All Homemakers must have at least six (6) hours, in-service training annually from the following areas:

- a. Maintaining a safe and clean environment;
- b. Providing care including individual safety, laundry, serve and prepare meals, and household management;
- c. First aid in emergency situations;
- d. Fire and safety measures;
- e. Client rights;
- f. Record keeping; such as,

- A service log signed by the client or family member/ responsible person and Homemaker Worker to document what services were provided for the client in relation to the Plan of Care.
 - Submitting a written summary to the Homemaker Worker Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.
- g. Communication skills;
 - h. Basic infection control/Universal Standards;
 - i. Other areas of training as appropriate or as mandated by the Operating Agency.
4. The DSP will be responsible for providing a minimum of six (6) hours of relevant in service training per calendar year for each Homemaker Worker. In-service training is in addition to Homemaker Worker orientation training. For Homemaker Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a Homemaker Worker.
 5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
 6. Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.
 7. In-service training may entail demonstration of maintaining a safe and clean environment for the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency at least 45 days prior to the planned implementation.
 8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Homemaker Workers each calendar year.
 9. The DSP Agency shall maintain records on each employee, which shall include the following:
 - a. Application for employment;
 - b. Job description;
 - c. Statewide criminal background checks and references;
 - d. Record of health (annual tuberculin tests);
 - e. Record of pre-employment and in-service training;
 - f. Orientation;

- g. Evaluations;
- h. Supervisory visits;
- i. Copy of photo identification;
- j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
- k. Reference contacts;
- l. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Homemaker Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs.
2. The DSP Agency will initiate Homemaker Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:
 - a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.
 - b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized.
3. The DSP Agency may recommend to the Case Manager any changes in the hours, times, or specified duties requested. The Case Manager will review a client's Plan of Care within one (1) working day of the DSP's request to modify the Plan of Care. A change in the Service Authorization Form will be submitted to the DSP Agency if the Case Manager concurs with the request.
4. Homemakers will maintain a separate service log to document their delivery of services.
 - a. The Homemaker shall complete a service log daily. The service log will reflect the types of services provided, the number of hours of service, and the times of service.
 - b. The service log must be signed upon each visit by the client, or family member/responsible party and the Homemaker Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Homemaker must document the reason the log was not signed by the client or family member/responsible party.
 - c. The service log will be reviewed and signed by the Homemaker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.
 - d. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A

monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone. These electronic records may be utilized in place of client signatures.

5. Provision of Service Authorized:

- a. Homemaker Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.
- b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for homemaker services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.

6. Monitoring of Service

Homemaker Service must be provided under the supervision of the individual who meets the qualifications in D.1. and will:

- a. Make the initial visit prior to the start of Homemaker Service for the purpose of reviewing the plan of care, providing the client written information regarding rights and responsibilities and how to register complaints, and discussing the provision and supervision of the service(s)."

The initial visit should be held at the client's place of residence and should include the Case Manager, the Homemaker Supervisor, the client and caregiver if feasible. It is advisable to also include the Homemaker Worker in the initial visit.

- b. Be immediately accessible by phone during the time Homemaker Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.
- c. Provide and document supervision of, training for, and evaluation of Homemaker Workers according to the requirements in the approved waiver document.
- d. Provide on-site (client's residence) supervision of the Homemaker Worker at a minimum of every 60 days for each client. Supervisory visits must be documented in the

individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Homemaker Worker. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Homemaker Service. Documentation regarding this action should be in the DSP client record.

- e. The DSP must complete the 60 day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the Case Manager within 10 calendar days after the 60 day supervisory review.
- f. Assist Homemaker Workers as necessary as they provide individual Homemaker Service as outlined in the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.
- g. The Homemaker Supervisor must provide direct supervision of each Homemaker Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Homemaker Worker's personnel record.
 - (1) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

The Homemaker Supervisor will provide and document the supervision, training, and evaluation of Homemaker Workers according to the requirements in the approved Waiver Document.

7. Missed Visits and Attempted Visits

- a. Missed Visits
 - (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
 - (2) The DSP shall have a written policy assuring that when a Homemaker Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.
- b. Clients who are designated by the Case Manager as being at-risk should be given first priority when Homemaker Service visits must be temporarily prioritized and/or reduced by the DSP.
 - (1) If the Supervisor sends a substitute, the substitute will complete and sign the daily log after finishing duties. If a substitute Homemaker Worker was offered to the client/caregiver, but refused, this should be documented in the DSP client record on the "Weekly Missed/Attempted Visit Report."
 - (2) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Homemaker Worker.

- (3) The DSP will document missed visits in the client's files.
- (4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "Weekly Missed/ Attempted Visit Report" form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.
- (5) The DSP may not bill for missed visits.

c. Attempted Visits

- (1) An attempted visit occurs when the Homemaker Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.
- (2) If an attempted visit occurs:
 - (a) The DSP may not bill for the attempted visits.
 - (b) The Supervisor will contact the client or family member to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.
 - (c) The DSP will notify the case manager within one (1) working day after the second attempted visit whenever two (2) attempted visits occur within the SAME week.

8. Changes in Services

- a. The DSP will notify the Case Manager within one (1) working day of the following changes:
 - (1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;
 - (2) Client does not appear to need Homemaker Service;
 - (3) Client dies or moves out of the service area;
 - (4) Client indicates Homemaker Service is not wanted;
 - (5) Client loses Medicaid financial eligibility;
 - (6) When services can no longer be provided.
- b. The Case Manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.
- c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

- (1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
- (2) The Case Manager will approve any modification of duties to be performed by the HMW and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.
- (3) Documentation of any change in the Plan of Care or Service Authorization Form will be maintained in the client's file.
 - (a) If the total number of hours or types of services are changed, a new Service Authorization Form is required from the Case Manager.
 - (b) If an individual declines Homemaker Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

9. Documentation and Record-Keeping

- a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the operating agencies, or other agencies contractually required to review information upon request.
- b. The DSP shall maintain a file on each client, which shall include the following:
 - (1) A current HCBS application;
 - (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Homemaker visits for the client;
 - (3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Homemaker Worker;
 - (4) All service logs;
 - (a) The service log must be reviewed and initialed by the Homemaker Supervisor at least once every two (2) weeks.
 - (5) Records of all missed or attempted visits;
 - (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,
 - (7) Evaluations from all 60 day on-site supervisory visits to the client;
 - (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
 - (9) Initial visit for in-home services;
 - (10) Any other notification to Case Manager;
 - (11) Permission statements to release confidential information, as applicable.

- c. The DSP will retain a client's file for at least five (5) years after services are terminated.
- d. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Homemaker Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.
 - a. Complaints which are made against HMW will be investigated by the DSP Agency and documented in the client's file.
 - b. All complaints which are to be investigated will be referred to the HMW Supervisor who will take appropriate action.
 - c. The HMW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.
 - d. The HMW Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and the Operating Agency.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.
4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.
5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.
6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.
8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.
9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Homemaker Service must meet all provider qualifications prior to rendering the Homemaker Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

11 ADULT DAY HEALTH SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Adult Day Health (ADH) is a service that provides ACT Waiver clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service.

Adult Day Health is not an entitlement. It is based on the needs of the adult client.

B. Objective

The objective of Adult Day Health is to provide a continuing organized program of rehabilitative, therapeutic and supportive health and social services and activities to the ACT Waiver clients who are functionally impaired and who, due to the severity of their functional impairment, are not capable of living in the community independently.

C. Description of Adult Day Health Service to be Provided

The unit of service will be a client day of Adult Day Health Service consisting of four (4) or more hours at the center. The four (4) hour minimum for a client day does not include transportation time. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form.

Medicaid will not reimburse for services rendered by a provider that has not been approved by Medicaid's Waiver QA Program as an ADH Provider.

Medicaid will not reimburse for activities performed which are not within the scope of service.

Adult Day Health Service is provided within a maintenance model of care, which provides services that include the following health and social activities, needed to ensure optimal functioning of the client.

1. Observe the status of the individual health that includes support in carrying out physician orders as needed; monitoring of vital signs as needed; observing the functional level of the client and noting any changes in the physical condition of each individual; supervising medication and observing for possible reaction; teaching positive health measures and encouraging self-care; appropriately reporting to the caregiver and case manager any changes in the client's condition.
2. According to the Alabama Board of Nursing medications can be administered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing. The medication must be filled by a pharmacy with physician instructions written on the label. The written instructions on the container are

considered a physician order. However, the nurse has an additional obligation to keep a record of all medications given to a client in the client's file. This policy is applicable, if a nurse is on staff at the facility. Medications cannot be administered by any other staff member at the ADH center. However, the other staff member can remind a client to take medication when necessary.

3. Observe and assist the client to maintain good personal hygiene on a daily basis.
4. Provide planned therapeutic activities on a daily basis to stimulate the client's mental and physical activity, communication and self-expression. These include reality orientation exercises, crafts, music, educational and cultural program, and games, etc.
5. Provides a variety of opportunities for group socialization.
6. Observe and assist the client with meal and eating.
7. Develop a plan to address medical emergencies, fire, and natural disaster.
8. Assist in the development of self-care, personal hygiene, and social support services.
9. Provide nourishment appropriate to the number of hours he or she attends the Adult Day Health center, but not equal to a full nutritional regime (3 meals per day). Specific diet requirements should be encouraged.
10. No other waiver service, except Case Management, may be provided during the time the client is receiving Adult Day Health Service.

Note: Under no circumstances should the unlicensed Adult Day Health Workers perform any type of skilled medical or nursing service.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub-contractual arrangements.

1. Director of Adult Day Health Centers

All Adult Day Health Center Directors must meet the following requirements:

- a. Have a statewide criminal background check;
- b. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;
- c. Have sufficient education (high school diploma or equivalent) and language ability to communicate effectively, understand written instructions and write basic reports;
- d. Have the ability to evaluate Adult Day Health employees in terms of their ability to perform assigned duties and communicate with the clients;
- e. Have the ability to assume responsibility for orientation and in-service training for Adult Day Health Workers by individual instructions, group meetings, or workshops;

- f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Adult Day Health Service;
 - g. Submit to a program for the testing, prevention, and control of tuberculosis annually;
 - h. Possess a valid, picture identification.
2. Adult Day Health Workers

Staff, volunteer and paid employees must meet the following requirements:

- a. Be able to follow the Plan of Care with minimal supervision;
 - b. Be able to read and write;
 - c. Submit to a program for the testing, prevention, and control of tuberculosis annually;
 - d. Have statewide criminal background check;
 - e. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;
 - f. Have a valid Alabama driver's license if transporting Adult Day Health clients;
 - g. Possess a valid, picture identification.
3. Training

The Adult Day Health training program should stress the physical, emotional and developmental needs of the population services, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing and/or conducting the training. The Adult Day Health training program must be approved by the Operating Agency. Proof of the training must be recorded in the Adult Day Health Worker personnel file.

Individual records will be maintained on each Adult Day Health Worker to document that each member of the staff has met the requirements below.

All Adult Day Health Workers must have at least six (6) hours in-service training annually. Training requirements must include the following areas:

- a. Behavioral interventions, acceptance, and accommodation;
- b. Providing care and supervision including individual safety and non-medical care;
- c. First aid in emergency situations;
- d. Documenting client's participation;
- e. Fire and safety measures;
- f. Confidentiality;

- g. Client rights;
- h. Needs of the elderly and disabled population;
- i. Basic infection control/Universal Standards;
- j. Communication skills;
- k. Other areas of training as appropriate or as mandated by the Operating Agencies

Documentation of the training provided shall include topic, name and title of trainer, objective of the training, date of the training, outline of content, length of training, list of trainees and location.

Topics for specific in-service training may be mandated by the Operating Agency.

In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency at least 45 days prior to the planned implementation. The in-service training is in addition to the required training prior to delivery of Adult Day Health Service.

The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service training for all Adult Day Health Workers each calendar year.

The Adult Day Health center must maintain records on each employee, which must include the following:

- (1) Application for employment;
- (2) Job description;
- (3) Statewide criminal background check;
- (4) Have references which have been verified thoroughly by the DSP and documented in the personnel file;
- (5) Record of health (annual tuberculin tests);
- (6) Record of pre-employment and in-service training;
- (7) Orientation;
- (8) Evaluations;
- (9) Reference contacts;
- (10) Records of all complaints/incidents lodged by the client/family and action taken;
- (11) Other forms as required by state and federal law, including agreements regarding confidentiality.

4. Nursing Staff

A Registered Nurse(s) or Licensed Practical Nurse(s) who meets the following requirements:

- a. Currently licensed by the Alabama State Board of Nursing.
- b. At least two (2) years experience as a Registered Nurse or Licensed Practical Nurse in public health, hospital or long-term care nursing.
- c. Must submit to a program for the testing, prevention, and control of tuberculosis annually.
- d. Statewide criminal background check;
- e. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;
- f. Possess a valid, picture identification.

E. Procedure of Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the Adult Day Health center authorizing Adult Day Health Service designating the units, frequency, beginning date of service, and types of activities in accordance with the clients needs.
2. The Adult Day Health Provider will initiate Adult Day Health Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:
 - a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.
 - b. The Adult Day Health Provider will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.
 - c. On the first day of service the provider will review the plan of care, provide the client written information regarding rights and responsibilities and how to register complaints, and discuss the provisions and supervision of the service(s).
3. Missed Visits
 - a. A missed visit occurs when the client is scheduled but does not attend.
 - b. All client absences for the week must be reported in writing to the Case Manager on Monday of the new week.
4. Changes in Services
 - a. The Adult Day Health Provider will notify the Case Manager within one (1) working day of a change in the client's condition, or if Plan of Care no longer meets the client's needs or the client no longer appears to need Adult Day Health Service.
 - (1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;

- (2) Client does not appear to need Adult Day Health Service;
 - (3) Client dies or moves out of the service area;
 - (4) Client indicates Adult Day Health Service is not wanted; and,
 - (5) Client loses Medicaid financial eligibility;
 - (6) When services can no longer be provided.
- b. The Case Manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.
 - c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.
 - (1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
 - (2) The Case Manager will approve any modification of duties to be performed by the Adult Day Health Worker and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.
 - (3) Documentation of any change in a Plan of Care will be maintained in the client's file.
 - (a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.
 - (b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.
 - (c) If an individual declines Adult Day Health Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

5. Documentation Record-Keeping

The Adult Day Health Provider will maintain a record-keeping system, which establishes a client profile based on the Service Authorization Form.

The DSP shall maintain a file on each client, which shall include the following:

- (1) A current HCBS application;
- (2) Both current and historical Service Authorization Forms;
- (3) Documentation of all care and services provided;
- (4) Records of all complaints lodged by clients or family members/responsible parties and any action taken;
- (5) All service logs;

- (6) Any notification to Case Manager;
- (7) Daily attendance records must be kept in each individual client file. The attendance record should be initialed daily and signed weekly by the client. In the event the client is not able to sign and family member or responsible party is not present to sign, the Adult Day Health center must document on the attendance record the reason the attendance record was not signed in the client file. The attendance record must be reviewed and initialed by the Adult Day Health Center Director at least every two (2) weeks.

The Adult Day Health Provider should notify the Case Manager in writing regarding any report or indication from the Adult Day Health Worker regarding a significant change in the client's physical, mental or emotional health. The Adult Day Health Supervisor should document such action in the DSP client file.

- 6. The Adult Day Health Provider must submit to the Case Manager, every 60 days a brief summary of the client's condition, an evaluation of the effectiveness of the service as it relates to the Plan of Care, and suggestions relative to the client's needs. The activities the client participates in should be included in the brief summary.
- 7. The Adult Day Health Provider shall comply with federal and state confidentiality laws and regulations in regard to client and personnel file.
- 8. The Case Manager will request Adult Day Health Service by authorizing the amount, beginning dates of service, and frequency of service for clients in accordance with the client's Plan of Care which will be developed in consultation with the client.
- 9. The Case Manager will notify the Adult Day Health Provider immediately if a client becomes medically or financially ineligible for Adult Day Health Service.
- 10. The number of days a client attends each week is dependent upon the individual client's needs as set forth in the Plan of Care established by the case manager.
- 11. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form.
- 12. Medicaid will not reimburse for activities performed which are not within the scope of services.

F. Conditions of Participation

- 1. The Adult Day Health Provider must maintain a current Adult Day Health approval issued from the Alabama Medicaid Agency. (The Alabama Medicaid Agency issues approval for only those Adult Day Health centers that participate in the ACT Waiver program.) Approval depends upon compliance with the Adult Day Care Standards in Appendix B.2.a and the Adult Day Health Service requirements in the approved ACT Waiver document. The approval will be issued by the Alabama Medicaid Agency after an on-site visit by the Quality Assurance Unit. The Adult Day Health center will be issued an approval for the facility to participate in the ACT Waiver program for a period of no more than two (2) years if all requirements are met. Requirements for approval are as follows:

- a. The Adult Day Health center must meet the standards in waiver document Appendix C-3:9;
- b. The Adult Day Health center must meet the requirements in the approved waiver document;
- c. Services must be delivered consistent with the Plan of Care;
- d. The clients needs must be met.

There should be no deviation from these requirements.

2. The Adult Day Health Provider will incorporate in the procedures for operation of the center adequate safeguards to protect the health and safety of the clients in the event of a medical or other emergency.
3. The Adult Day Health Provider must maintain a current (within past 12 months) fire inspection.
4. The ADH provider must conduct and document (monthly) fire and or weather drills. Documentation of drills shall include date, time, duration, number of clients' participation, number of staff participating and name of staff conducting the drill.
5. The Adult Day Health Provider must maintain a current (within past 12 months) health inspection if food is prepared and an approval from the Health Department (within 12 months) if receiving catered food.
6. The Adult Day Health Provider must maintain adequate staff for the number of clients served in the center.
 - a. One Adult Day Health Worker plus the director for 1-10 clients.
 - b. Two Adult Day Health Workers plus the director for 11-25 clients.
 - c. Three Adult Day Health Workers plus the director for 26-35 clients.
 - d. Four Adult Day Health Workers plus the director for 36-43 clients.

Add one Adult Day Health Worker for each additional 8 clients.

7. The Adult Day Health Provider must have at least two staff members certified in CPR and First Aid.
8. The Adult Day Health Provider must have one person trained to act on behalf of the Adult Day Health Director in his or her absence.
9. The Adult Day Health Provider must have a registered nurse (RN) or license practical nurse (LPN) available monthly for consultation. Monthly health screens include, but are not limited to: checking vital signs, weighing clients if applicable, and monthly health and nutritional teaching.

G. Rights, Responsibilities, and Service Complaints

The Operating Agency has the responsibility of ensuring that the Adult Day Health Provider has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Adult Day Health Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

1. Complaints that are made against Adult Day Health Workers will be investigated by the Adult Day Health Provider and documented in the client's file.
2. All complaints that are to be investigated will be referred to the Adult Day Health Director who will take appropriate action.
3. The Adult Day Health Director will take any action necessary and document the action taken in the client and employee's files.
4. The Adult Day Health Director will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.
5. The Adult Day Health Provider must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

H. Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this Scope of Services as well as in the Adult Day Care standards and the contract, the Adult Day Health Provider shall be required to adhere to the following stipulations:

1. The Adult Day Health Provider shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the Adult Day Health Center. The Adult Day Health Provider shall notify the Operating Agency within three (3) working days in the event of a change in the agency administrator, address, or phone number.
2. The agency will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands-on" client care level staff shall be set forth in writing. This information shall be readily accessible to all staff and shall include an organizational chart. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the Adult Day Health Provider and to the Operating Agency.
3. The Adult Day Health Provider shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.
4. Administrative and supervisory functions shall not be delegated to another agency or organization.
5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the Adult Day Health center. A list of the members of the governing body will be made available to the Operating Agency and the Alabama Medicaid Agency upon request.
6. The Adult Day Health Provider must maintain an annual operating budget, which will be made available to the Operating Agency or the Alabama Medicaid Agency upon request.

7. The Adult Day Health Provider will acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff including board members, from liability incurred while acting on behalf of the Adult Day Health Center. Upon request, the Adult Day Health Provider will furnish a copy of the insurance policy to the Operating Agency and the Alabama Medicaid Agency.

12 COMPANION SERVICE

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Companion Service is to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the ACT Waiver.

C. Description of Service to be Provided

1. The unit of service will be 15 minutes of direct Companion Service provided to the client. The maximum number of units that can be authorized may not exceed four (4) hours daily. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form.

The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime.

2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care which is established by the Case Manager and subject to approval by the Medicaid Agency.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. Companion Service includes:

- a. Supervision/observation of daily living activities, such as,

- (1) Reminding client to bathe and take care of personal grooming and hygiene;
- (2) Reminding client to take medication;
- (3) Observation/supervision of snack, meal planning and preparation, and/or eating;
- (4) Toileting or maintaining continence.

- b. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The Companion Worker is not allowed to transport clients, only to accompany them.
- c. Supervision/assistance with laundry.
- d. Performance of housekeeping duties that are essential to the care of the client.
- e. Assist with communication.
- f. Reporting observed changes in the client's physical, mental or emotional condition.
- g. Observing/reporting home safety. The Companion Worker will ensure that the client is residing in a safe environment. Ensuring home safety means the Companion Worker will have a general awareness of the home's surroundings and any concerns with safety issues will be reported to the Companion Worker Supervisor as well as to the Case Manager for follow up.

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

1. Companion Worker Supervisors' Qualifications

All Companion Worker Supervisors will have the following qualifications:

- a. High school diploma or equivalent;
- b. Be able to evaluate Companion Worker in terms of their ability to perform assigned duties and communicate with the individuals;
- c. Be able to assume responsibility for in-service training for Companion Workers by individual instructions, group meetings, or workshops;
- d. Submit to programs for the testing, prevention, and control of tuberculosis annually;
- e. Criminal background check;
- f. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;
- g. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Companion Service;
- h. Possess a valid, picture identification.

2. All Companions Workers must meet the following qualifications:

- a. Be able to read and write;

- b. Submit to programs for the testing, prevention, and control of tuberculosis annually;
 - c. Statewide criminal background check;
 - d. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;
 - e. Possess a valid, picture identification;
 - f. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition;
 - g. Complete a probationary period determined by the employer with continued employment contingent on completion of the in-service training program.
3. Minimum Training Requirements for Companion Worker

The Companion Worker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Companion Worker training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

The Companion Worker must successfully complete orientation training in areas specified below prior to providing Companion Services or have documentation of personal, volunteer, or paid experience in the care of adults, families, and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing.

- a. Meal planning and preparation;
- b. Laundry/shopping;
- c. Provision of care and supervision including individual safety;
- d. First aid in emergency situations;
- e. Documentation of services provided per written instructions;
- f. Basic infection Control/Universal Standards;
- g. Fire and safety measures;
- h. Assist clients with medications;
- i. Communication skills;
- j. Client rights;

- k. Other areas of training as appropriate or as mandated by the Operating Agency.
4. The annual in-service training will be provided by the DSP and is in addition to the training required prior to job placement.
5. All Companion Workers must have at least six (6) hours in-service training annually. For Companion Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a Companion Worker.
6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
7. Topics for specific in-service training may be mandated by the Operating Agency.
8. In-service training may entail demonstration of providing care to the client.

Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the Operating Agency prior to the planned training. The DSP shall submit the proposed program(s) to the Operating Agency at least 45 days prior to the planned implementation.

9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Companion Workers each calendar year.
10. The DSP Agency shall maintain records on each employee which shall include the following:
 - a. Application for employment;
 - b. Job description;
 - c. Statewide criminal background check;
 - d. References which are verified thoroughly by the DSP and documented in the personnel file;
 - e. Record of health (annual tuberculin tests);
 - f. Record of pre-employment and in-service training;
 - g. Orientation;
 - h. Evaluations;
 - i. Supervisory visits;
 - j. Copy of photo identification;
 - k. Reference contacts;

1. Other forms as required by State and Federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager will submit a Service Authorization Form and a copy of the Plan of Care to the DSP Agency, authorizing Companion Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs as set forth in the Plan of Care.
2. The DSP Agency will initiate Companion Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:
 - a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form:
 - b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.
3. Provision of Service Authorized:
 - a. Companion Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.
 - b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for companion services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.
 - c. The Companion Worker is not allowed to provide transportation when he/she is accompanying a client.
4. Companion Workers will maintain a separate service log for each client to document their delivery of services.
 - a. The Companion Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.
 - b. The service log must be signed upon each visit by the client, or family member/responsible party and the Companion Worker. In the event the client is not

physically able to sign and the family member/responsible party is not present to sign, then the Companion Worker must document the reason the log was not signed by the client or family member/responsible party.

- c. The service log will be reviewed and signed by the Companion Worker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.
- d. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

5. Monitoring of Service

- a. The Companion Worker Supervisor will visit the home of clients to monitor services.

- (1) The Companion Worker Supervisor will make the initial visit to the client's residence prior to the start of Companion Service for the purpose of reviewing the plan of care, providing the client written information regarding rights and responsibilities, how to register complaints, and discussing the provisions and supervision of the service(s).

The initial visit should be held at the client's place of residence and should include the Case Manager, the Companion Supervisor, the client and caregiver if feasible. It is advisable to also include the Companion Worker in the initial visit.

- (2) The Companion Worker Supervisor will provide on-site supervision at the client's place of residence at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the Companion Worker. Supervisory visits must be documented in the individual client record.

The DSP must complete the 60 day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the Case Manager within 10 calendar days after the 60 day supervisory review.

In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Companion Service. Documentation regarding this action should be in the DSP client file.

- (3) Each Companion Worker supervisory visit will be documented in the client's file. The Companion Worker Supervisor's report of the on-site visits will include, at a minimum:

- (a) Documentation that services is being delivered consistent with the Plan of Care;
- (b) Documentation that the client's needs are being met;
- (c) Reference to any complaints which the client or family member/responsible party have lodged and action taken;
- (d) A brief statement regarding any changes in the client's Companion Service needs;
- (e) The Companion Service Supervisor will provide assistance to Companion Worker as necessary.
- (f) Companion Worker Supervisor must be immediately accessible by phone during the time Companion Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified in writing within 24 hours if the position becomes vacant.
- (g) The Companion Worker Supervisor must provide direct supervision of each Companion Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Companion Worker's personnel record.
 - Direct supervision may be carried out in conjunction with an on-site supervisory visit.
- (h) The Companion Worker Supervisor will provide and document the supervision, training, and evaluation of Companion Workers according to the requirements in the approved Waiver Document.

6. Missed Visits, and Attempted Visits

a. Missed Visits

- (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
- (2) The DSP shall have a written policy assuring that when a Companion Worker is unavailable, the Companion Worker Supervisor will assess the need for services and makes arrangements for a substitute to provide services as necessary.

Clients who are designated by the Case Manager as being at-risk should be given first priority when Companion Service visits must be temporarily prioritized and/or reduced by the DSP.

- (a) If the Companion Worker Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

- (b) If the Companion Worker Supervisor does not send a substitute, the Companion Worker Supervisor will contact the client and inform them of the unavailability of the Companion Worker.
 - (3) The DSP will document missed visits in the client's files.
 - (4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "Weekly Missed/ Attempted Visit Report" form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.
 - (5) The DSP may not bill for missed visits.
- b. Attempted Visits
- (1) An attempted visit occurs when the Companion Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.
 - (2) If an attempted visit occurs:
 - (a) The DSP may not bill for the attempted visits.
 - (b) The Companion Worker Supervisor will contact the client to determine the reason why the client was not present or why services were refused, and document in the client's file.
 - (c) The DSP will notify the Case Manager promptly whenever an attempted visit occurs and will notify the CM within one (1) working day after the second attempted visit whenever two attempted visits occur within the SAME week.

7. Changes in Services

- a. The DSP will notify the Case Manager within one (1) working day of the following changes:
 - (1) Client's condition and/or circumstances have changed and that the Plan of Care no longer meets the client's needs;
 - (2) Client does not appear to need Companion Service;
 - (3) Client dies or moves out of the service area;
 - (4) Client indicates Companion Service is not wanted;

- (5) Client loses Medicaid financial eligibility;
 - (6) When services can no longer be provided.
- b. The Case Manager will notify the DSP within one (1) working day if a client becomes ineligible for waiver services.
- c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.
- (1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
 - (2) The Case Manager will approve any modification of duties to be performed by the Companion and re-issue the Service Authorization Form accordingly.
 - (3) Documentation of any changes in a Plan of Care will be maintained in the client's file.
 - (a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.
 - (b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.
 - (c) If an individual declines Companion Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.
8. Documentation and Record-Keeping
- a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the operating agencies, or other agencies contractually required to review information.

The DSP shall maintain a file on each client, which shall include the following:

- (1) A current HCBS application;
- (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Companion visits for the client;
- (3) Documentation of client-specific assistance and/or training rendered by the supervisor to a Companion Worker;
- (4) All service logs;

- (5) Records of all missed or attempted visits;
 - (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;
 - (7) Evaluations from all 60 day on-site supervisory visits to the client;
 - (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
 - (9) Initial visit for in-home services;
 - (10) Any other notification to Case Manager;
 - (11) Permission statements to release confidential information, as applicable.
- b. The DSP will retain a client's file for at least five (5) years after services are terminated.
 - c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

- 1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
- 2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Companion Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.
 - a. Complaints which are made against Companion Workers will be investigated by the DSP and documented in the client's file.
 - b. All complaints to be investigated will be referred to the Companion Worker Supervisor who will take appropriate action.
 - c. The Companion Worker Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.
 - d. The Companion Worker Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.
- 3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Service as well as in the contract with the Operating Agency, the DSP shall be required to adhere to the following stipulations:

1. The DSP shall designate an individual to serve as the administrator who shall employ qualified personnel and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated administrator will have the authority and responsibility for the direction of Companion Service for the DSP Agency. The DSP Agency shall notify the operating agency within three (3) working days in the event of a change in the administrator, address, telephone number, or of an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This shall be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.
3. Administrative and supervisory functions shall not be delegated to another organization.
4. A list of the members of the DSP's governing body shall be available to the Operating Agency and the Alabama Medicaid Agency upon request.
5. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the waiver document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.
6. The DSP shall acquire and maintain liability insurance during the life of this contract to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the DSP. Upon request, the DSP shall furnish a copy of the insurance policy to the Operating Agencies and/or the Alabama Medicaid Agency.
7. The DSP shall conform to applicable federal, state and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employee (such as making substitutions for ill Companion Workers and training Companion Workers in personal hygiene and proper food handling and storage).
8. The DSP shall maintain an office which will be open during normal business hours and staffed with qualified personnel.
9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will assure that the service is rendered.

10. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

H. Provider Experience

Providers of Companion Service must meet all provider qualifications prior to rendering the Companion Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or client access.

13 HOME DELIVERED MEALS

SCOPE OF SERVICE

ACT WAIVER

A. Definition

Home Delivered Meals are provided to an eligible individual age 21 or older who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

When specified in the Plan of Care, this service may include seven (7) or 14 frozen meals per week. A client may be authorized to receive seven (7) frozen meals plus seven (7) breakfast meals in lieu of 14 frozen meals. In addition, the service may include the provision of two (2) or more shelf-stable meals (not to exceed 6 meals per 6-month period) to meet emergency nutritional needs when authorized on the client's Plan of Care. Services during a disaster will be handled as outlined in "F" below.

Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual client.

B. Objective

The objective of Home Delivered Meal Service is to provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability or dependency, who require nutritional assistance to remain in the community, and who do not have a care giver available to prepare a meal for them.

C. Description of Service to be Provided

1. A Unit of Service is either one (1) package of frozen or one package of breakfast meals delivered once a week to a client's residence. Each package of meals contains seven (7) frozen meals or seven (7) breakfast meals. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the client's residence. The types of meals available are:

Frozen Meal--A frozen meal consists of an entree plus two (2) side dishes; fruit juice; bread; margarine; dessert; and milk. Meals are packed seven (7) meals/box and will contain the entree plus two (2) side dishes, fruit juice, bread, dessert, and margarine. Milk is delivered separately in the refrigerated form.

Breakfast Meal--A breakfast meal consists of fortified cereal in an individual serving bowl; fruit or vegetable juice; bread; a fruit or yogurt; milk; and condiments (margarine, jelly, jam, cream cheese, peanut butter, syrup, etc.) All items are delivered in room temperature or refrigerated form. A meal pack will contain seven (7) meals. This meal option may not be served alone. It must be served in conjunction with a unit of frozen meals.

Shelf-Stable Meal--A shelf-stable meal consists of an entree; fruit or vegetable juice; crackers or breadsticks; vegetable, soup, canned fruit, or dried fruit; cookie, snack cake, snack cracker, cereal, pudding, canned fruit, or dried fruit; and nonfat dry milk. Meals will be packaged as individual meals. The delivery meal pack will contain two (2) shelf-stable meals. Shelf-stable meals may only be provided when frozen meals have also been authorized.

2. The number of units of service provided to each client is dependent upon the individual client's needs and is set forth in the client's plan of care, established by the Case Manager in consultation with the client. The client must be identified as having difficulty in shopping and/or preparing appropriate, nutritious meals. The client must have adequate and appropriate means for storing and heating frozen meals, be capable of performing the simple tasks associated with storing and heating a frozen meal, or have other appropriate arrangements approved by the Case Manager.
 - a. Clients authorized to receive one (1) unit of service per week will receive one 7-pack of frozen meals.
 - b. Clients authorized to receive two (2) units of service per week will receive two 7-packs of frozen meals or a combination of one 7-pack of frozen meals and one 7-pack of breakfast meals.
 - c. The maximum number of meals authorized per week will be 14 meals.
 - d. Breakfast meals must be ordered in combination with frozen meals and may not be ordered alone.

If the client attends an Adult Day Health (ADH) center five (5) days a week and receives two meals at the ADH center, the client will not be eligible for this service. If the client attends the center five (5) days a week and receive one meal daily at the ADH center, the client may receive one (1) pack of frozen meals per week, which equals to seven (7) meals. If the client attends the center less than five (5) days a week, the Case Manager should make sound judgement as to whether the client is eligible for the service.

Based on established need, some clients may get home delivered hot meals (provided outside the waiver program) and waiver meals. This is to be an exception and not the norm and as such, approved on a case by case basis depending upon the level of care need. There must be a clear audit trail, which clearly defines how many meals the client receives.

3. Standard Diets
 - a. Menus must comply with the most recent Dietary Guidelines for Americans, published by the Secretary of Health and Human Services and the Secretary of Agriculture.
 - b. Each meal in a pack of frozen meals must provide a minimum of 700 kilocalories. The mean level of the indicator nutrients per frozen meal in a pack of frozen meals must be equal to or higher than one-third (1/3) of the Dietary Reference Intake (DRI) for adults as determined by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Home Delivered Meals service will not constitute a full daily nutritional regimen.
 - c. Menus for breakfast meals must be matched to menus for frozen meals. The mean level of the indicator nutrients provided in a pack of frozen meals and a pack of breakfast meals must equal or exceed 2/3 of the DRI for adults.
 - d. While the individual has freedom of choice regarding this service, it is the responsibility of the Case Manager to ensure the appropriateness of the service and to ensure the client qualifies for the service. All clients eligible for this service must be given free choice of all qualified providers.

If, after careful review of the assessment information and discussion of the client's situation, the Case Manager does not think the Home Delivered Meals are appropriate for the individual, (or there are risks to the client associated with the meals), other options that will assist in meeting the nutritional needs of the client should be discussed with the client and documented in the case record. Should the client insist on the meals, providing they meet the other qualifying criteria, additional information should be secured from the physician. In the event the client continues to insist on meals against the Case Manager's and Physician's advice, the client has a right to make this choice. Documentation of the risk being taken by the client must be documented in the case record and discussed in detail with the client, responsible relative or friend, if available, and the physician.

4. Menu Requirements for Emergency Meals
 - a. Shelf-stable meals will be delivered at least every six (6) months to at-risk clients. Shelf-stable meals are to be used in the event of an emergency when the DSP cannot deliver meals as scheduled. The number of units will be determined by the client's plan of care, not to exceed six (6) meals per 6-month period.
 - b. All foods in the meal must be individually packaged food products that can be stored without refrigeration and that can be eaten with little or no preparation. The meal must provide a minimum of 700 kilocalories and one-third (1/3) of the DRI for the indicator nutrients for adults. Sodium content of the meals may be somewhat high because of the necessary reliance on commercially formulated food products.
 - c. Shelf-stable meals are intended for use solely in emergency situations.
 - d. During times of the year when the state is at an increased risk of disaster from hurricanes, tornados or ice/snow conditions, the meals vendor will be required to maintain at a minimum, a sufficient inventory to operate all frozen meal delivery routes for two (2) days. In the event of an expected storm or disaster, the Meals Coordinator will authorize implementation of a Medicaid-approved Disaster Meal Services Plan. This plan (outlined in "F") will provide frozen meal alternatives in anticipation of possible power outages.
5. All menus must be reviewed and approved by the Meals Services Coordinator, who is a Registered Dietitian licensed to practice in the State of Alabama and employed by the OA.
6. The DSP will provide a list of its regularly scheduled holidays to the OA, and the DSP will not be required to deliver meals on those days. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP will also provide the regular hours of business operation. Arrangements should be made by the DSP to see that clients do not go without a meal as a result of the holiday schedule.
7. The DSP must provide meals 52 weeks a year. During holiday periods, meal delivery schedules may be adjusted per agreement between the OA and the DSP. When the delivery schedule must be altered due to a holiday, the DSP must bill the services for the date of the regularly scheduled delivery, as long as there is documentation that the delivery occurred prior to the bill date.
8. Service Standards

- a. Each DSP must provide one (1) frozen meal per day, seven (7) days per week for 52 weeks per year, and any additional authorized meals.
- b. The facility at which the meals are prepared and/or packaged, as well as the manner of handling, transporting, serving and delivery of these meals, must meet all applicable health, fire, safety and sanitation regulations.
- c. No home canned or prepared food shall be used in preparation and service of the meals.
- d. Primary meal components of frozen meals (entree plus two side dishes) must be produced at a food processing plant with United States Department of Agriculture (USDA) approval or its equivalent in the state of Alabama. The DSP will furnish the OA with copy of said USDA approval or its equivalent in the state of Alabama to produce meals for the frozen meal program. Products must be quick frozen in a blast freezer or the equivalent.
- e. Primary meal components shall be packaged in individual trays, properly sealed, and labeled with the contents and instruction for storage and preparation. Each meal is stamped with the “best by” date and the “produced” date .
- f. Primary meal components of frozen meals (entree plus two side dishes) must be packaged as single meal units in a container that is suitable for re-thermalization in a microwave or conventional oven at temperatures up to 400° F.
- g. The DSP will be responsible for meal delivery to the client.
 - (1) Delivery routes must be clearly established. Meal packs must be delivered once weekly on days mutually agreed upon by the DSP and the OA. Clients will be informed of the delivery date and projected delivery time. The DSP must deliver meals within plus or minus two hours of projected delivery time and deliver all meal components to a client in a single stop.
 - (2) Cold food will be individually portioned. The only exception is that milk will be delivered in one half-gallon container for every service unit of frozen meals and breakfast meals. Cold food will be transported in approved insulated carriers which will maintain the required cold (41 degrees Fahrenheit or below) temperatures until the time of delivery to the client. Frozen meals must be transported in approved insulated carriers that will maintain the meals in a solid frozen state until the time of delivery to the client. Alternatively, a frozen meal delivery truck may be used to transport and deliver meals.
 - (3) Meal delivery must be documented with a signed delivery ticket. The client, family, friend, or neighbor must sign verifying that the meals were received or other mutually agreed upon electronic means of verification. Meals may not under any circumstance be left at a home if the intended client or the designated representative (family member, friend, or neighbor) is not available to receive them. In the situation where the client is blind and unable to sign for the delivery, it is the case manager’s responsibility to document that fact in a manner agreed upon by the OA and the DSP. In the event of extenuating circumstances where the client can not sign, the DSP personnel must make a note in the

signature area and initial that information.

- (4) The DSP will be responsible for notifying the client and the case manager in the event of a change in the delivery day or projected delivery time. Because of the logistics involved in notifying all clients of a change in the delivery day, modification of the delivery day must be a last resort.
- (5) Home Delivered Meals are provided for the benefit of the client and to meet client needs rather than others in the client's household.

D. Provider Certification Requirements

1. The DSP shall give initial and on-going training in the proper service, handling, and delivery of food to all staff. Proof of the training must be recorded in the personnel file.
2. The DSP must comply with all applicable statutes, regulations, guidelines and policies at the local, State, and Federal levels including, but not limited to:
 - a. Food purchasing; food preparation and processing; food packaging and labeling; food storage, transport, and service; food safety; and food sanitation.
 - b. Equal Opportunity, Civil Rights, Affirmative Action, and Age Discrimination.
 - c. Fire and safety codes for both equipment and employees.
 - d. Use of Federal and State funds.
 - e. Client rights and confidentiality.
3. The DSP will procure and keep current any license, certification, permit, or accreditation required by local, State, or Federal statutes or regulations and shall, upon request of the OA, submit proof of any such license, certification, permit or accreditation.
4. The DSP will have verified references on each employee in direct contact with recipients and recipient information maintained in the employee personnel file. References must include statewide criminal background checks, previous employers, and the Nurse Aide Registry.

E. Procedure of Services

1. The DSP will initiate Home Delivered Meals on the date negotiated with the Case Manager and indicated on the Service Authorization Form. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.
 - a. The Case Manager will provide the DSP with the name, telephone number, address, driving directions, and an alternate contact for each client. Information will be sent to the DSP electronically.
 - b. Requests for adding up to five (5) new clients to an established delivery route should normally be accommodated by the DSP on the next scheduled delivery or within fourteen (14) calendar days if service is established by cut off time each week.
 - c. Requests for major increases in clients, especially if it requires establishment of new delivery route(s), may require up to three (3) weeks advance written notice to the DSP.

2. Missed and Attempted Deliveries
 - a. A missed delivery occurs when the client or the person designated to receive the delivery is at the client's residence waiting for the meal delivery and the delivery is not made. In the event of a missed delivery, the DSP will advise the Case Manager by phone or electronically of the non-delivery of the meal pack. Notification must occur no later than the next business day of the non delivery. The DSP must have an effective back-up service provision plan in place to ensure that the client receives the meals as authorized.
 - b. An attempted delivery occurs when the meals could not be delivered to a client because the client or designated representative was not available to accept delivery. In the event of an attempted delivery, the DSP will advise the Case Manager by phone or electronically of the non-delivery of the meal pack. Notification must occur within 24 hours of the non-delivery. The Case Manager will be responsible for client follow-up and arranging emergency meals for at-risk clients.
 - c. The DSP may not bill for missed or attempted deliveries. If meals distributed to clients are later learned to be lacking components or to have contained components of unacceptable quality, payment to the DSP will be adjusted according to a schedule mutually agreed upon by the DSP and the OA.
 - d. The Case Manager will be responsible for instructing each client, both verbally and in writing concerning the storage and preparation of the frozen and breakfast meals. This will also include written re-thermalization instructions.
 - e. If a client goes to the hospital or nursing home for a temporary stay and meals for this time period have been delivered, the Case Manager would be responsible for determining the date meal delivery should resume based on the number of complete meals still available to the client for consumption. If the temporary absence is anticipated, the meals can be suspended in advance.
3. The DSP will notify the Case Manager electronically within three (3) working days if notified of any of the following client changes:
 - a. Client's condition has changed and the Plan of Care no longer meets the client's needs or client no longer appears to need home delivered meal services.
 - b. Client dies or moves out of service area.
 - c. Client no longer wishes to participate in Home Delivered Meal Service.
 - d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.
 - e. When services can no longer be provided.
4. The Case Manager will review a client's service plan within one (1) working day of receipt of a request from the DSP to modify service plan.
5. The DSP will maintain an electronic record keeping system that establishes an eligible client profile, in support of units of Home Delivered Meal Service provided, based on the Service Authorization Form.

6. The Case Manager will request Home Delivered Meal Services by designating the type meal, amount, frequency and duration of service for clients in accordance with the client's Plan of Care developed in consultation with the client. More than one meal for each day's consumption may be delivered if authorized by the client's Plan of Care. Requests for services will be transmitted electronically.
7. The OA will send notice electronically to the DSP immediately (within 24 hours of discovery) if a client becomes ineligible for services. The DSP will be responsible for terminating all further services upon receipt of notification.
8. The DSP must be able to provide meal delivery services in the designated service area within 60 days after a new service contract is signed. Service contracts may be canceled by either the DSP or the OA, with or without cause. Contracts may be canceled by the DSP by giving the OA not less than 90 days written notice of intent to terminate services as of a specified date. Contracts may be canceled by the OA by giving the DSP not less than 30 days written notice of intent to terminate services as of a specified date.
9. The OA will employ a licensed Registered Dietitian licensed to practice in the State of Alabama to serve as Meals Services Coordinator. This individual will review and approve all menus, all food product specifications, all packaging materials and procedures, and delivery operations; provide nutritional oversight and monitoring, consultation and training assistance to the OA; and perform quality assurance activities.
10. Written instructions for distribution to clients regarding the use of the meals will be developed by the Meals Services Coordinator. Written and verbal instructions will be provided by the Case Manager to the client/responsible person prior to the start of service. The Case Manager will monitor use of the meals.

F. Meal Services During a Disaster

- 1) During hurricane season (June-November), vendor production units serving the southern region of the state will maintain, at a minimum, sufficient inventory of the items listed below to operate all frozen meals delivery routes for two (2) days. During the ice/snow/tornado season (December-May), vendor production units serving the northern region of the state will maintain, at a minimum, sufficient inventory of the items listed below to operate all frozen meals delivery routes for two (2) days. In such emergency situations, production units will shift inventories to
 - a) Shelf stable meals packed 7 per box. Provided in lieu of frozen meals. Delivered 1 per client for all persons authorized to receive 1 service unit of frozen meals and 2 per client for all persons authorized to receive 2 service units of frozen meals.
 - b) Water packed in gallon size units. Provided in lieu of ½-gallon fresh milk. Delivered 1 per client for all persons authorized to receive 1 service unit of frozen meals and 2 per client for all persons authorized to receive 2 service units of frozen meals.
 - c) Breakfast meals packed 7 per box. Packed as designated for regular menu. Delivered 1 per client for all persons authorized to receive 1 service unit of breakfast meals.

- d) Non-fat dry milk individual packets. Provided in lieu of ½ gallon fresh milk. Delivered 7 per client for all persons authorized to receive 1 service unit of breakfast meals.
 - e) Cereal Grain Breakfast Bars. Provided in lieu of 2 pints orange juice. Delivered 7 per client for all persons authorized to receive 1 service unit of breakfast meals.
- 2) The combination of shelf-stable meals packed 7 per box/1 gallon of water will hereafter be referred to as frozen meal alternates. The combination of breakfast meals packed 7 per box/7 individual portions of non-fat dry milk/7 cereal grain breakfast bars will hereafter be referred to as breakfast meal alternates.
 - 3) Meals Coordinator may authorize delivery of frozen meal alternates and breakfast meal alternates for up to two (2) days prior to an expected storm/disaster.
 - 4) With authorization of the Meals Coordinator, modified disaster deliveries may be made after a storm/disaster until the ability to store and prepare frozen or breakfast meals is restored in the client's home. At times, it is likely that deliveries will be mixed on a route. Some clients will continue to need disaster meals, but others may resume regular meal deliveries.

The vendor will supply units of frozen and breakfast meal alternatives to the production units as required to sustain service. Menus for breakfast meals delivered to production units after a major storm/disaster may be modified to eliminate any cream cheese and margarine.

- 5) Prior to an expected storm, production units in the projected path will print out driver manifests for the next 3-day period. These manifests reflect the standing orders for the clients.
- 6) As required to reduce or rotate inventory of shelf-stable meals, Meals Coordinator may authorize the vendor to provide frozen meal alternates in lieu of frozen meals to clients affected by a holiday closing. All clients scheduled to receive a meal delivery on one of the official vendor holidays may receive a double delivery of frozen meals the preceding week. Shelf-stable meals packed 7 per box and 1 gallon of water may replace no more than one (1) service unit of frozen meals for a client in a double delivery. All clients affected by a holiday closing will be provided with a letter two weeks before the holiday alerting them to the double delivery and the mix of meals that will be delivered. The vendor will be responsible for delivery of Costs for a 7 pack of shelf stable meals plus 1 gallon of water (frozen meal alternate) will be the same as for a 7 pack of frozen meals plus ½ gallon of fresh milk. Costs for a 7 pack of breakfast meals, 7 packages of non-fat dry milk and 7 breakfast bars (breakfast meal alternate) will be the same as for a 7 pack of breakfast meals plus ½ gallon fresh milk and 2 pints orange juice.
- 7) When the Meals Coordinator authorizes implementation of this plan, notice will be sent to the appropriate staff at Medicaid and Department of Senior Services. No specific documentation will be required in the client's operating agency case record to justify or authorize billing for meal alternatives delivered according to this plan.

When frozen or breakfast meal alternates are delivered (i.e. prior to or after a storm/disaster or on holidays), drivers will be instructed to note on the manifest any deviations from the standing client orders (i.e., frozen meal alternate delivered in lieu of frozen meals; breakfast meal alternate delivered in lieu of

breakfast meals). Vendor will retain said manifests and provide copies to Case Manager(s) or the appropriate operating agency or Medicaid upon request.

The same billing code will be used for the 7-pack frozen meals and the 7-pack frozen meal alternates. Likewise, the same billing code will be used for the 7-pack breakfast meals and the 7-pack breakfast meal alternates. However, the invoice sent to the operating agencies will show the number of 7-pack frozen meals, the number of 7-pack frozen meal alternates, the number of breakfast meals, and the number of breakfast meal alternates delivered during the invoice period.

G. Rights, Responsibilities, and Service Complaints

1. The OA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Home Delivered Meal Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency (AMA).
 - a. Complaints which are made regarding the meals or DSP staff will be investigated by the Case Manager and reported to the Meals Services Coordinator for each operating agency. The Meals Services Coordinator will perform an investigation. All corrective action by the Case Manager or the Meals Service Coordinator will be documented and forwarded to the Waiver Coordinator of the OA.
 - b. The DSP will have procedures for the investigation and resolution of complaints.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

H. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the OA within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the OA at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and the OA.
3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the OA and/or the AMA upon request.
5. The DSP Agency must maintain an annual operating budget which shall be made available to the OA and/or the AMA upon request.
6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the OA and/or the AMA.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the OA and/or its agents.
8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.
9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the OA. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the OA contract and Waiver Document. The Policy and Procedure Manual should include the Organization's Emergency Plan regarding service delivery.
11. A performance bond will be required of the DSP in the amount equal to the projected cost of one year's services provided by said DSP.

I. Provider Experience

Providers of Home Delivered Meals must meet all provider qualification requirements prior to furnishing Home Delivered Meals.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

14 MEDICAL EQUIPMENT SUPPLIES AND APPLIANCES

SCOPE OF SERVICE

ACT WAIVER

A. Service Definition (Scope)

Medical supplies include devices, controls and/or appliances, specified in the Plan of Care, which enable waiver participants to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, and to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

B. Objective:

The objective of the Medical Supplies service is to maintain the participant's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization. Medical supplies ensure health and safety for the duration of usefulness of supplies. Medical supplies are necessary for the care and functional capabilities of the recipient in the home.

C. Provider Experience

Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Senior Services. The case manager must provide the participant with a choice of vendors in the local area of convenience.

D. Description of Services to be provided

1. Medicaid will pay for a service when the service is covered under the ACT Waiver and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each participant must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.
2. Medical supplies are necessary to maintain the participant's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization.
3. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-Tips, etc.
4. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.
5. All items shall meet applicable standards of manufacture, design and installation.

Supplies are limited to \$1800.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.

E. Conduct of Service

1. This service will only be provided when authorized by the participant's physician.
2. Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services.

3. Supplies must be indicated on the participant's Plan of Care, they must be medically necessary to maintain the participant's ability to remain in the home and live independently.
4. Reimbursement for medical supplies shall be limited to \$1800.00 annually per participant. Receipt for all supplies purchased must be kept in the participant's case record.
5. The case manager must provide the participant with a choice of vendors in the area. A signed Participant Choice of Vendor form should be placed in the case file and a copy provided to the participant. Services should not be denied due to an absence of the signature of the waiver participant/representative.
6. Any supplies that are covered under the State DME program cannot be billed as a waiver item. It must be billed through the State DME procedure codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Medical Supplies are limited to \$1800.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.

Service Delivery Method: Provider managed

Provider Qualifications

License: *Business License*

Other Standard Providers of this service will be those who have signed provider agreements with the Alabama Medicaid Agency, and the OA. The case manager must provide the participant with a choice of vendors in the local area of convenience.

Verification of Provider Qualifications

Entity Responsible for Verification: OA Certification Surveyor

Frequency of Verification: Prior to contract approval, annually or bi-annually for approved providers based on previous score, or more often if needed based on service monitoring concerns.

15 PERSONAL EMERGENCY RESPONSE SYSTEM AND MONTHLY FEE

SCOPE OF SERVICE

ACT WAIVER

Service Definition (Scope):

This service will cover the monthly fee after the system has been installed.

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The client may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision. By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

A. Objective:

The objective of PERS is to assist the recipients who live alone or who are alone for significant parts of the day and do not have a regular caretaker for extended periods of time.

B. Provider Experience

PERS monthly availability will be provided by individuals who are trained on this device for specific consumers for whom services are being provided.

C. Description of Services to Be Provided

1. The system is connected to a client’s phone and programmed to signal a response center once a “help” button is activated.
2. By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

D. Conduct of Services

1. PERS should be ordered and arranged for by the SAIL Waiver case manager.
2. PERS must be prior authorized, approved by the Alabama Medicaid Agency or its designee and must be listed on the client’s Plan of Care. The maximum is a one-time installation charge. Once the recipient has had one installation, another one cannot be approved.
3. Case managers must assure that the Prior Authorization packet contains the following information:
 - a. Alabama Medicaid Prior Authorization Request form (PA Form 342).
 - b. Approval by the Department of Rehabilitation Services for Vendor Providing the Service
 - c. Price Quotation from the Vendor Providing the Service Specifying the Description of Personal Emergency Response System requested.
 - d. A Prescription from the Physician.

4. Upon completion the client must sign and date a form acknowledging receipt of the service which must be on file. If the client is not pleased with the service, the contractor is required to make adjustments as long as the complaints are within reason.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Price Quotation from the Vendor Providing the Service Specifying the Description of Personal Emergency Requested.

The maximum is a one-time installation charge. Once the recipient has had one installation, another one cannot be approved.

Service Delivery Method: Provider managed

Provider Type: Business Vendor

Provider Qualifications

License (specify): Business license

Certificate (specify): N/A

Other Standard (specify):

Set-up will be provided by individuals who are trained to install this device for specific consumers for whom services are being provided.

Verification of Provider Qualifications/Entity Responsible for Verification:

Operating Agency Case Manager, AMA's fiscal intermediary (HP)

Frequency of Verification:

At initial enrollment and annually

Personal Emergency Response System (Monthly Fee)

Service Definition (Scope):

This service will cover the monthly fee after the system has been installed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: The maximum is a one-time installation charge. Once the recipient has had one installation, another one cannot be approved.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Verification of Provider Qualifications/Entity Responsible for Verification: Waiver Case Manager

Frequency of Verification: As needed