



Independent Choices Procedure Manual

Table of Contents**100.000 IndependentChoices Introduction**

- 100.100 Program Background
- 100.200 Philosophy

200.000 General Administrative Information

- 200.100 Organization Chart
- 200.200 DAAS Program Specialist Caseload Assignments
- 200.300 RN Caseload Assignments
- 200.400 Contracted Agency Assignments
- 200.401 Contracted Counseling Agency
- 200.402 Contracted Financial Management Service
- 200.403 Quality Improvement Organization
- 200.404 CIM

210.000 Outgoing Mail Procedures

- 210.100 Regular Mail
- 210.200 Inter-office Mail
- 210.300 Certified Mail
- 210.400 Mass Mailings
- 210.500 Newsletters
- 210.600 Other Types of Mail Delivery

220.000 Courier Delivery

- 220.100 Preparation for Courier Delivery
- 220.200 Completed Delivery Forms

230.000 Incoming Mail Procedures

- 230.100 General Duties
- 230.200 Categories of Mail
- 230.300 Documents Received from Participant
- 230.301 Enrollment Documents
- 230.302 Cash Expenditure Plan
- 230.303 Personal Assistant Timesheets
- 230.400 Documents Received from IC RN's
- 230.401 Documentation Log
- 230.402 How to Verify Nurse Tracking Entry Requirements
- 230.403 Nurse Tracking Entry Requirements
- 230.404 New Enrollment Visit
- 230.405 Reassessment Visits
- 230.406 Extension of Benefit Assessments and Reassessments

230.407	Monitoring Visits
230.408	Missed Visit
230.500	Database Entry of Receipt of RN Documents
230.600	ElderChoices Plans of Care (EC POC)
230.601	Review of Received POCs
230.602	Current Participant Assessed 14.75 PC Hours or Less
230.603	Entry of Participant Information (Current Cases)
230.604	Entry of Participant Information (Refusal of Closed Code)
230.605	Entry of EC POC
230.606	Entry of Diagnosis
230.607	Entry of Date EC POC Received
230.608	Entry of Directions
230.609	Entry of Physician Information
230.610	Obtaining Physician Authorization
230.700	Current Participant Assessed PC Hrs. Greater than 14.75
230.800	Requests for Increase in Hours in Region 1 Participants

240.000 Referrals

240.100	Eligibility Requirements
240.200	Eligibility Screening
240.300	To Determine Medicaid Eligibility
240.301	EC POCs Received as a Referral
240.400	Entering Referral in the Database
240.500	Notifying Counselor
240.600	Printing Enrollment Forms

250.000 Quality Assurance Reports

250.100	IC Lost Eligibility
250.200	IC LTC Open Eligibility
250.300	IC Deceased
250.400	IC TC Listing
250.500	APD and IC

260.000 Closed Files

260.100	Overview
260.200	Expired PCDC EC POCs

270.000 Protection of Personal and Protected Health Information

270.100	E-Mails
270.200	Faxes
270.300	DHS Information Systems
270.301	Laptops
270.302	Remote Access

270.303	Use of Hardware, Software and Peripherals
270.304	External Storage
270.400	DHS Policy Responsibilities
270.500	Tracking of Released Information
280.000	Purchasing, Equipment, and Travel Reimbursement
280.100	Purchasing Procedures
280.200	Equipment
280.300	Travel Reimbursement
290.000	Fiscal/Employer Agent Reimbursement Checks
300.000	Counselor Section - Overview
300.100	General Duties
300.200	Working Relationships
310.000	Applicant
310.100	The Applicant Process
310.200	Eligibility Screening
310.210	Decision-Making Partner Designation
310.220	Communications Manager Designation
310.300	Obtain Necessary Information
310.400	Information to Provide
310.500	Enter Applicant into System
310.600	Start Forms and IC RN Processes
310.610	The Enrollment Packet
310.700	Case Closure Prior To Self-Direction
320.000	Initial Assessment
320.100	Process Plan(s) Of Care
320.200	ElderChoices 9503
320.300	IndependentChoices DMS-618
320.400	Extension of Benefits
320.410	Utilization Review Extension of Benefits
320.500	QSource Request for Authorization
330.000	Enrollment
330.100	Process Enrollment Paperwork
330.110	Establish Backup Plan
330.120	Explanation of Enrollment Forms
330.130	Prepare Case File
330.200	Determine Agency Billing Status
330.300	Determine Service Start Date

330.400	Develop Cash Expenditure Plan
330.410	Explain Uses of Budget
330.420	Determine Preference of Use and Finalize Budget
330.500	Process Start of New Case
330.510	Prepare Start Service Packet
330.520	Communication Requirements
330.530	Database Updates
330.540	MMIS Updates

340.000 Case Monitoring and Management

340.100	Monitoring Requirements
340.200	Financial Management Services
340.300	IndependentChoices Reports
340.310	Counselor Management Reports
340.320	Compliance Reports
340.330	Error Reports
340.340	Workflow Reports
340.350	Decision Support System Reports

350.000 Change of Information or Status

350.100	Participant
350.200	Personal Assistant
350.300	Decision-Making Partner/Communications Manager

360.000 Closing IndependentChoices Participation

360.100	Reasons to Close (Disenrollment)
360.110	Database Updates
360.120	Communication
360.130	MMIS Updates
360.200	Permanent Case Closure
360.400	Closed Case Re-Activation

400.000 Nurses Section - Overview

400.100	General Duties
400.200	Working Relationships

410.000 Time Management and Visit Scheduling

410.100	Scheduling Visits/Outlook Calendar
410.200	Contacting IC Participants
410.300	Content of Visits (Types)
410.400	Reports
410.500	Nurse Productivity Chart

420.000 Assessments

- 420.100 Enrollment (Initial Visit)
- 420.200 Revision
- 420.300 Renewal
- 420.400 Extension of Benefits (EOB)
- 420.410 Extension of Benefits Phone Monitoring
- 420.500 QSource
- 420.600 Missed Visits

430.000 Documentation

- 430.100 Time Frame and Directions for Submission
- 430.200 Completing DMS-618
- 430.300 ICD-9 Codes
- 430.400 Medications Sheets
- 430.500 Assessments
- 430.600 Narrative
- 430.700 Developing Hours – DAAS-IC-20
- 430.800 Completion of Enrollment Checklist
- 430.900 Participant Files

440.000 Computer Work

- 440.100 Protected Information and Security Issues
- 440.200 MDS-HC
- 440.300 Nurse Tracking
- 440.400 E-mails
- 440.500 Travel Reimbursement

450.000 Peer Auditing Committee**460.000 IC RN Responsibilities and Expectations****500.000 Appeals and Hearings Process**

- 501.000 Appeal Rights
- 502.000 Reason for Appeal
- 502.100 Counselor/Fiscal Agent
- 502.200 Involuntary Closure of IC Case
- 502.300 Change in Number of Personal Care Hours
- 503.000 Format for Hearing of Appeals
- 503.100 Mediation Process
- 503.200 Informal Review
- 503.300 Administrative Review
- 504.000 Timeframes for Appeals
- 504.100 Problem with Counselor or Fiscal Agent

504.200	Involuntary Closure of IC Case
504.300	Change in Number of Personal Care Hours
505.000	Decision Format
506.000	Further Appeal Rights
507.000	Allegations of Discrimination

100.000 IndependentChoices Introduction

As an employee of IndependentChoices, you are part of a revolution in health care delivery. Traditionally health care professionals direct the care of patients, deciding what a person needs and how they receive it. Patients often do not have say in who provides services, how services are provided, what services are provided and when services are provided, especially patients who are getting their care paid for through the government.

IndependentChoices allows an alternative to this traditional delivery system. In IndependentChoices the Participant is the central decision maker. The Participant decides the who, what, when, where and how of care delivery. The Participant receives an allowance based on their needs and decides how best to spend it for their personal assistance services. The Participant hires their own personal assistant(s). The Participant trains the personal assistant on how they like things done. The Participant sets the work schedule of the personal assistant. The Participant fires the personal assistant if he or she is not performing their duties in the way preferred. The Participant decides what other items or services might enhance their independence and quality of life, and may choose to purchase those items with part of their allowance.

This is a major paradigm shift from the traditional model. It empowers participants to take charge of their care. It gives participants their dignity by allowing them to have control of how they receive the most intimate of care. It gives family members an avenue of providing care to their loved ones without becoming impoverished. It saves Medicaid dollars as individual participants do not have the overhead costs of traditional agencies and thus, Medicaid can pay a smaller rate. IndependentChoices is not for everyone. Some people cannot handle the responsibilities that come with the freedom and autonomy IndependentChoices allows, but for those who can, it can be life changing.

Arkansas was the first State to implement a program like IndependentChoices. Because of the work and successes of the IndependentChoices program, it is now available in twelve other States and it is now easier for other States to adapt this revolutionary model. Other States have looked to Arkansas for guidance and training. Be proud that you are part of this model and the work that you do is not just helping the citizens of Arkansas, but others nationally as well.

100.100 Program Background**7-1-09**

In October 1996, the Arkansas Department of Human Services (DHS), the Division

of Aging and Adult Services (DAAS) and the Division of Medical Services (DMS) received a grant from the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE). The purpose of the grant was to develop and implement the Arkansas *IndependentChoices* Demonstration Project, formerly referred to as The Cash and Counseling Demonstration Project. An 1115 Research and Demonstration Waiver was approved by the Health Care Financing Administration (HCFA) (now called the Centers for Medicare and Medicaid Services (CMS)) and IndependentChoices was implemented in December 1998.

The following is a timeline of events leading up to the implementation of IndependentChoices:

January 1996	<p>Governor’s Office received a, “Call for Letters of Intent from States Wishing to Participate in the Cash and Counseling Demonstration.”</p> <p>Then Medicaid Director Ray Hanley was interested in the concept and Barbara Nickerson and Deborah Ellis of the DMS, Program Planning and Development were assigned to the project.</p>
February 1996	<p>First workgroup met consisting of members from the Division of Medical Services, Division of Developmental Disabilities Services, Division of Aging and Adult Services, Division of County Operations, Arkansas Spinal Cord Commission, Arkansas Rehabilitation Services and Advocacy Services.</p> <p>Letter of Intent submitted to the Cash & Counseling National Program Director, Dr. Kevin Mahoney. Seventeen States submitted Letters of Intent. Ten States, along with Arkansas, were asked to submit full proposals.</p>
April 1996	<p>Ray Hanley asked Herb Sanderson, Director of the Division of Aging and Adult Services (DAAS), to take the lead. Suzanne Crisp, Assistant Director, DAAS, was assigned the development.</p>
June 1996	<p>Arkansas hosted a site visit with representatives of the Cash & Counseling Review Committee consisting of the Robert Woods Johnson Foundation, Department of Health and Human Service’s Office of the Assistant Secretary for Planning and Evaluation, Centers for Medicare and Medicaid</p>

Services (CMS) (known as HCFA at the time), University of Maryland Center on Aging, Mathematica Policy Research, Inc., and the National Council on Aging.

- July 1996 Arkansas and New York were selected to become the two states that would implement the National Cash & Counseling Project. New York eventually dropped out and New Jersey and Florida were added.
- October 1996 Grant received.
- December 1998 First Cash and Counseling participant in the U. S. enrolled in Arkansas's IndependentChoices.

Originally, DHS contracted with two entities to provide counseling and financial management services: Phillips County Development Council (PCDC) for 15 eastern counties and Aspen for the other 60 counties. Aspen did not meet the terms of the contract and eventually the Division of Aging and Adult Services (DAAS) took over the counseling functions in the 60 counties and contracted with Palco to provide the financial management services. Later Palco began providing the financial management services for the 15 eastern counties as well, while PCDC continues to provide the counseling services for eastern Arkansas.

The 1115 Demonstration Waiver was renewed in 2003 and again in January 2007. Due in part to the work and experiences of Arkansas's IndependentChoices Project, the United States Congress passed as part of the Deficit Reduction Act of 2005 the option for States to implement programs like IndependentChoices as a State Plan Amendment under section 1915(j) of the Social Security Act. In April 2008, the IndependentChoices Program began operating under the authority of this provision. This gave IndependentChoices more permanence and made the program easier to administer as DHS no longer has to request waiver renewals.

Implementation of IndependentChoices was not easy. The Cash and Counseling philosophy was met with resistance and skepticism by providers. Through strong Arkansas leadership and support from national leaders, the program persevered. Dr. Kevin Mahoney, Cash and Counseling National Project Director, stated:

“Arkansas had, in my opinion, a vision, strong leadership and an excellent team. The members of that team (Suzanne Crisp, Sandy Barrett and Debby Ellis) complemented each others' skills and talents and worked together in a fashion I have rarely had the pleasure to see. Arkansas addressed each issue as a problem to be solved rather than a mystery to be

pondered. Arkansas was the first state to implement the Cash and Counseling approach and, in the process, they developed and tested many of the hallmarks of that option, which later became a national option. But they did not stop there; Arkansas has played a major role in training other states by hosting three ‘orientation sessions’ for new Cash and Counseling programs. Other state leaders were able to see how the option really worked, and meet and talk to participants, family members and key staff. Arkansas has never stopped innovating and looking at how they can improve their program and advance its principles into new arenas, such as an option for people leaving nursing facilities or for recipients of community-based Older Americans Act services.”

Dr. Pamela Doty, Senior Policy Analyst, DHHS Assistant Secretary for Planning and Evaluation (ASPE) described Arkansas in the following way:

“Among the three states that pioneered Cash and Counseling, Arkansas was always in the lead, clearing the path of obstacles for the rest. When I met “Miss Lillie” and some of the other Arkansans who were among the first Medicaid beneficiaries to join IndependentChoices, that role seemed entirely appropriate because these program participants brought to mind our pioneer American ancestors who settled the frontier! As for the Arkansas state officials who designed and managed IndependentChoices, they reminded me of the Fighting Seabees in World War II whose motto went something like, ‘the difficult we do right away, the impossible takes just a little bit longer.’ In all seriousness, Arkansas program administrators did such an excellent job that IndependentChoices was and remains a model program, the ‘gold standard’ for other states to try to measure up to and replicate.”

As of this writing, IndependentChoices has served more than 6400 participants since the beginning of the program with over 2200 currently participating. Those participating in the first three years of the demonstration were able to decrease institutional care by 18% when compared to their counterparts in the control group. A comparative analysis of the costs of IndependentChoices participants over the first nine years of the program against the costs of those receiving services during the same time through an agency was completed. When looking at all Medicaid services for each group, there was a savings of over \$5.5 million for the

IndependentChoices group, although the IndependentChoices group received twice the number of hours received by the agency group. If all of the hours provided through IndependentChoices had been provided by an agency during this period, it would have cost Arkansas Medicaid \$36.8 million more. Even with the significant monetary savings that IndependentChoices has realized, you cannot put a price on the empowerment that a person with a disability or a frail elder feels when given autonomy over their care.

100.200**Philosophy****7-1-09**

The Cash and Counseling philosophy is best described in the following:

The “Cash & Counseling Model” Vision Statement

The Cash & Counseling service model is a form of consumer-direction or self-direction intended to empower individuals to make choices and take control of the community support services that they receive. The goal of the model is to enhance their ability to live the life they wish to in the community. This vision evolved from a tested model which yielded very positive results. Cash & Counseling seeks to create a new model through the inclusion of principles that go beyond what is already possible. The following principles are essential to the Cash & Counseling model.

- A. Cash & Counseling reflects a belief that individuals, when given the opportunity to choose the services they will receive and to direct some (or all) of them, will exercise their choice in ways that maximize their quality of life.
- B. Cash & Counseling is one option among several service delivery models but it should be available for all participants that choose it.
- C. Because participation in Cash & Counseling is voluntary, there should be a seamless process for moving between this option and the traditional system.
- D. Consumer-direction is not used as a vehicle for reducing benefits to recipients.
- E. Cash & Counseling includes participant-centered-planning to ensure that the participant is making personal choices for the spending of the budget based on his or her own goals.
- F. Cash & Counseling requires a flexible individualized budget that the participant may spend on services that assist the individual to meet his/her community support needs and enhance his/her ability to live in the community.

1. The participant may use the individualized budget to choose and directly hire workers to provide the services.
 2. The participant may use the individualized budget to purchase goods, supplies or items to meet community support needs.
 3. A flexible budget means the participant has significant choice in the allocation of their funds between hiring workers and making other purchases.
- G. Cash & Counseling allows participants to select a representative to help them with making decisions and managing their services.
- H. Cash & Counseling provides a system of supports to assist the participant in developing and managing his/her spending plan; fulfill the responsibilities of an employer, including managing payroll for workers he/she hires directly; and obtain and pay for other services and goods.
- I. Cash & Counseling obtains feedback from participants, representatives, and family members (when appropriate) as well as data from support service providers to continuously improve the program.

Ideally the fully flexible budget would allow the participant to hire legally responsible relatives (Note: Arkansas IndependentChoices does not allow the hiring of spouses), purchase goods and services from vendors without Medicaid provider agreements, and receive some part of the budget in cash.

This Cash and Counseling model is the framework for how the IndependentChoices program is designed. This model embraces the DHS Core Values of Compassion, Courage, Respect, Integrity and Trust. It also personifies the DHS Beliefs of:

- Every person matters.
- Our job is to empower people to help themselves.
- Our focus is on our clients' success.
- People and their communities deserve good health and a clean and safe environment.
- We have a responsibility to provide knowledge and services that work.
- Partnering with communities is essential to the health and well being of

Arkansans.

This Procedure Manual serves as a guide to IndependentChoices employees on how to best meet the design of the program, the Cash and Counseling philosophy and the DHS Core Values and Beliefs.

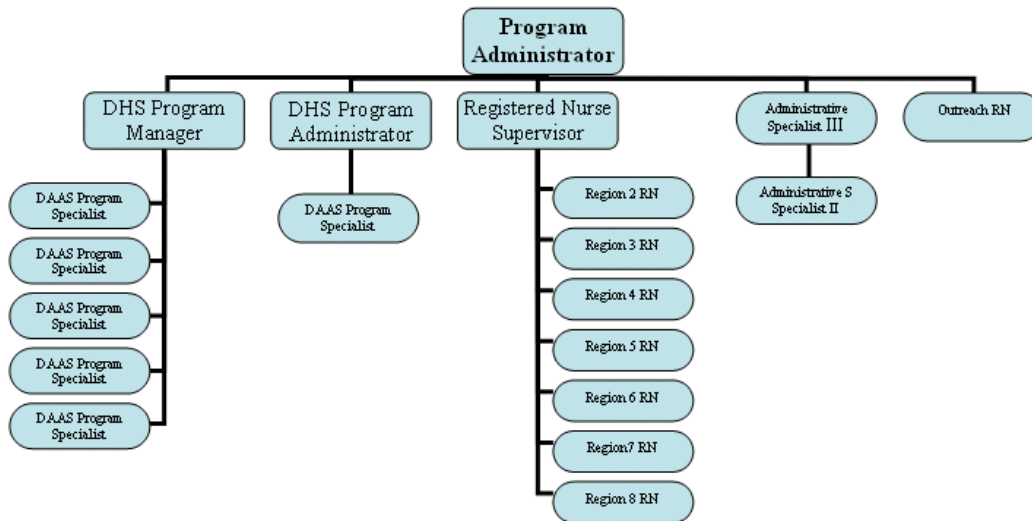
Everything will not always go as we wish that it would. Participants will not always adhere to individual responsibilities. Success will not be possible for every single person who would like to be in the IndependentChoices program. Please recognize the limited educational opportunities that many that we serve have been afforded. Please work and follow up often with these individuals so that they too can succeed in directing their own care.

Our foundation requires us to serve program participants to the very best of our abilities. To remember that it is because of them that we have a job to perform each day. And to remember that at the end of each day that we have worked together to create a better quality of life for those we serve. We know that the stability of this program has helped many avoid institutional care.

200.000 General Administrative Information

200.100 Organization Chart

7-1-09



200.200 DAAS Program Specialist Caseload Assignments

7-1-09

IndependentChoices (IC) Participants are assigned to a DAAS Program Specialist (hereinafter referred to as Counselor) based on the first initial of their last name. These assignments may change at any time at the discretion of the Program Administrator based on factors that are in the best interest of the program and its participants. Currently this assignment is as follows:

Participant Last Name	A – C
Participant Last Name	D – G
Participant Last Name	H – L
Participant Last Name	M – R
Participant Last Name	S - Z

200.300 RN Caseload Assignments

7-1-09

Participants are assigned to an IndependentChoices Registered Nurse (IC RN) based on the county where they reside. These assignments may change at any time at the discretion of the Program Administrator based on factors that are in the best interest of the program and its participants. Currently, the regions for IC RN assignments are as follows:

- Region 1:** Clay, Craighead, Crittenden, Cross, Fulton, Greene, Izard, Lawrence, Lee, Mississippi, Phillips, Poinsett, Randolph, Sharp, St. Francis
- Region 2:** Arkansas, Grant, Jefferson
- Region 3:**
(NW) Benton, Crawford, Franklin, Johnson, Logan, Madison, Montgomery, Perry, Polk, Pope, Scott, Sebastian, Washington, Yell
- Region 4:**
(SE) Ashley, Chicot, Cleveland, Dallas, Desha, Drew, Lincoln
- Region 5:**
(SW) Bradley, Calhoun, Clark, Columbia, Howard, Independence, Lafayette, Little River, Miller, Nevada, Ouachita, Pike, Sevier, Union
- Region 6:** Baxter, Boone, Carroll, Cleburne, Conway, Faulkner, Marion, Newton, Searcy, Stone, Van Buren
- Region 7:** Independence, Jackson, Lonoke, Monroe, Prairie, White, Woodruff
- Region 8:** Garland, Hot Spring, Pulaski, Saline

(See the Region Map in the Appendix Section)

200.400 Contracted Agency Assignments 7-1-09

200.401 Contracted Counseling Agency 7-1-09

A Contracted Counseling Agency (currently Phillips County Developmental Center, hereinafter referred to as PCDC) is responsible for enrollment, medical assessments, and counseling for all IC Participants residing in the following counties:

Clay	Craighead	Crittenden	Cross	Fulton
Greene	Izard	Lawrence	Lee	Mississippi
Phillips	Poinsett	Randolph	Sharpe	St. Francis

200.402 Contracted Financial Management Service 7-1-09

A Financial Management Service agency contracted to serve as a vendor Fiscal/Employer Agent (currently Paladino Company, Inc., hereinafter referred to as PALCO), shall provide all payroll services for the Participant, review and processing of timesheets and/or receipts received, sending and receiving employer

and employee documentation required for enrollment, withholding and payment of State and Federal Taxes, processing year end close out reports, and posting and refunding taxes when threshold not met.

200.403 Quality Improvement Organization

7-1-09

A Quality Improvement Organization (QIO) (hereinafter referred to as QSource), is responsible for review and authorization of personal care service plans for IndependentChoices Participants below the age of 21. The QIO is contracted by the Division of Medical Services (DMS).

200.404 CIM

7-1-09

The Center for Information Management (hereinafter referred to as CIM) is contracted to maintain a secure data system for scoring the iHC once synced by the IC RN. Once the iHC is scored, the result will classify the participant's medical needs by a Resource Utilization Group (RUG) and provide a Client Assessment Protocol (CAP) report.

210.000 Outgoing Mail Procedures

All DHS employees are responsible for following the procedures outlined in DHS Administrative Procedures Manual, Chapter 907, Mail Services. The procedures for proper preparation of mail procedures can be found on the DHS Share website.

Outgoing mail can be placed in the designated baskets in the hall or can be brought to the Mailroom between 7:30 a.m. and 2:30 p.m., Monday through Friday.

210.100 Regular Mail**7-1-09**

It is important that the proper procedures specified below be followed for all outgoing mail:

- A. Use all upper case (capital) letters.
- B. Avoid ALL punctuation (exception: enter a hyphen between the zip code and the four digits that follow).
- C. Enter two spaces between the city and the state.
- D. Enter two spaces between the state and the zip code.
- E. Use simple fonts (ex., Arial or Univers) and point size 11.
- F. Justify the margin on the left side.
- G. Affix NO ancillary stamps (first class, etc.), slogan, logos, or attention lines beside or below the address.
- H. If using address labels, ensure the labels are on straight. (Mail processing machines have difficulty reading crooked or slanted information.)
- I. If the address appears inside a window, ensure there is at least 1/8" clearance around the address and that ONLY address information appears in the window.
- J. Reserve the last three lines of the address for:
 - 1. Person/Company Name
 - 2. Box or Street Address, including apt. or suite #
 - 3. City State Zip Code

- K. When using a Large Envelope, affix the return address and slot number in the upper left-hand corner of the envelope on the end away from the opening flap.

210.200 Inter-office Mail

7-1-09

Any piece of mail going to an office within DHS or to another State Agency is considered inter-office mail. Units should place such mail in an inter-office envelope. To ensure proper delivery, address the inter-office envelope with the name of the sender as well as the receiver's name and address (including slot number) and the receiver's agency name.

210.300 Certified Mail

7-1-09

The Administrative Specialist II is available to assist IndependentChoices (IC) staff in the preparation of certified mail for the IC Program. Mail shall be prepared in compliance with DHS Administrative Procedures Manual, Chapter 907, Mail Services. If Counselors complete the Certified Mail Endorsement (CME), they shall give the prepared mail to the Administrative Specialist II due to the requirements of when to use the Firm Log Book.

The CME shall be applied to the front of the envelope at least 2" to the left of the postage area. (Postage area is at the top right hand corner.) The tag shall be removed from the CME if using the Log Book.

The tape from the certification (green) card will be removed. The completed card will be placed on the back of the envelope. (Slot number must be included on the card.)

If three or more pieces of certified mail are being sent, the Administrative Specialist II will complete the Firm Log Book. No more than 8 items may be listed per sheet. The tag from CME will be removed if using the Firm Log Book.

210.400 Mass Mailings

7-1-09

An increase in the hourly rate or a modification to the program guidelines will require a mailing to all Participants or their Decision-Making Partner/ Communications Manager (if applicable). Any required printing, folding, stuffing, and sorting of the documents will be the responsibility of the Administrative Specialist III and the Administrative Specialist II with assistance of the other IC staff as required. The procedures outlined in DHS Administrative Procedures Manual, Chapter 907, Mail Services will be followed. The Counselors are required

to maintain accurate addresses on all parties involved in a case and are required to insert all addresses in the IC database in accordance with Section 210.100.

The Administrative Specialist III shall notify the Mailroom a minimum of 24 hours in advance when there is going to be a special mailing of 500 pieces or more.

210.500 Newsletters

7-1-09

To keep the IC Participants, Decision-Making Partners, Communication Managers, and/or Personal Assistants aware of procedures and/or to inform them of changes in the IndependentChoices Program, a newsletter will be distributed as deemed necessary by the Program Manager.

The Program Manager will designate the staff members responsible for the preparation and mailing of the newsletter.

210.600 Other Types of Mail Delivery

7-1-09

For other types of mail delivery options such as Fed-Ex or Packages, the procedures outlined in DHS Administrative Procedures Manual, Chapter 907, Mail Services should be followed. The procedures are located on the DHS Share website.

220.000 Courier Delivery

Documents needing to be delivered to PALCO are sent by courier each Monday and Wednesday at 11:00 a.m. This service is shared with the Alternatives Program. If the Alternatives Programs has documents to send, they are responsible for placing them on the Administrative Specialist II's desk the morning of delivery.

220.100 Preparation for Courier Delivery**7-1-09**

The Counselors are responsible for having any documents that are to be delivered to PALCO placed in the tray located in Cubicle # 5185 or placed on the Administrative Specialist II's desk by 10:45 am.

The Administrative Specialist II will complete the following steps for preparation of the delivery package as follows:.

- A. Prepare the original Delivery Receipt and the Delivery Receipt marked "copy"
- B. Stamp CONFIDENTIAL on envelope (cover with tape to avoid smearing)
- C. Collect the documents from the designated in-tray located in Cubicle # 5185
- D. Copy each completed Document Log if a copy is not provided by the Counselor
- E. Secure each original Document Log with the appropriate documents and insert in envelope
- F. Deliver the envelope to the Receptionist's desk in the Lobby by 11:00 a.m.

220.200 Completed Delivery Forms**7-1-09**

At some point that afternoon, the Administrative Specialist II will pick up the signed receipt from the Receptionist's desk in the Lobby.

Staple the copy of the Delivery Receipt and copies of the Document Log(s) together and place in the file located in the Program Manager's cubicle.

Faxes received from PALCO indicating receipt of a delivery are attached to the related copy delivery in the file located in the Program Manager's cubicle.

Documents returned from PALCO as incomplete or unacceptable are given to the Program Manager so that they can be reviewed with the appropriate Counselor for correction and resubmission.

230.000 Incoming Mail Procedures

Processing the IndependentChoices mail is one of the earliest quality assurance measures in the operation of the IndependentChoices (IC) Program. There are no phases of the operation of the IndependentChoices program that are more or less crucial than any other is. Incoming mail is significant in that it allows an opportunity for someone in the community to have their needs met by being served well by the IndependentChoices program. How the mail is handled is a reflection of how well our program operates.

The IndependentChoices Database (IC Database) and the IndependentChoices SharePoint site on your computer are where many of the work activities for tracking incoming mail are located. The instructions on the following pages are for clearly informing what is required to process the IndependentChoices mail accurately. Attention to detail with accuracy is more highly valued than speed in the completion of mail processing.

The IndependentChoices link on DHS Share is:

<https://dhsshare.arkansas.gov/DAAS/IndependentChoices/default.aspx>

If you experience trouble accessing IC link or need assistance in getting a short cut installed on your desktop for direct access to the IC database, contact the Program Manager.

230.100 General Duties

7-1-09

The Administrative Specialist II is responsible for processing all mail received for IndependentChoices. Mail will be opened; date stamped, and processed within one day of receipt according to the sentence order instructions on the following pages. “Normal” delivery time is around 9:30 a.m. Be sure to check each envelope when taking the mail out to make sure a document is not left inside, (e.g., copies of Arkansas Drivers License (ADL) or Social Security Number (SSN) cards). The first step is to date stamp the first page of every document. *(Be sure to change the date on the stamp each morning).*

There are several programs under the Aging & Adult Services umbrella; some of their mail may be mixed in with the IC Program. If that happens, deliver to the appropriate section.

NOTE: The new enrollment procedures implemented effective July 1, 2009 will adjust who submits some of the following documents.

230.200 Categories of Mail**7/1/09**

Sort the following types of IndependentChoices mail received into the following categories for processing:

- A. Enrollment Forms – This currently comes from Participants/Decision-Making Partners/Communications Managers that are making changes or in the process of enrolling in the IC program. (These will come from the IC RN on Applicants enrolled effective 7/1/09).
- B. Signed Cash Expenditure Plan (CEP) – These will be tracked in the IC database and placed in the appropriate counselor's in-box. (See Section 203.302 for instructions)
- C. Time Sheets – These will be placed in the appropriate counselor's in-box,
- D. Home Visit Documentation - This comes from our nurses; (See Section 230.400 for instructions)
- E. Extension of Benefit (EOB) Request - These are from an IC RN for participants who need more than 14.75 hours of personal care per week; (See Section 230.406 for instructions)
- F. QSource Notices – These will be placed in the IndependentChoices Registered Nurse Supervisor's (IC RN Supervisor) in-box for review.
- G. ElderChoices Plan of Care (EC POC) - These come from the ElderChoices nurses; (See Section 230.60 for instructions on how to process these documents)
- H. Referral Cards/Referral Contact Sheet - (See Section 240.000 for instructions)
- I. Request for an increase in Personal Care Hours for Participants in PCDC Counties; (See Section 230.800 for instructions)
- J. All other mail such as travel reimbursement forms (TR-1), invoices, leave requests, correspondence for the Administrator, letters of complaint, correspondence from contractors, etc. go to the Administrative Specialist III for distribution.

230.300 Documents Received from Participant**7-1-09**

230.301 Enrollment Documents**7-1-09**

These documents are received from the Participant, the Decision-Making Partner, the Communications Manager, or the IC RN due to the transition to the new enrollment procedures taking effect July 1, 2009.

If the cover page and instruction page is mailed in, these may be taken off and recycled. Date stamp the **first** page of each document in the bottom right hand corner. Staple together all documents received regarding each participant and place them in the appropriate counselor's in-box. Make sure you sort the documents by Participant's Last Name and not the Personal Assistant's Name.

NOTE: Documents received from the IC RN regarding an Enrollment Visit completed beginning 7/1/09 will be received stapled together with the IC RN Enrollment Checklist on top. (See Section 420.100 (H)(A) for reference.)

230.302 Cash Expenditure Plans**7-1-09**

When the Counselor and the Participant have developed the Cash Expenditure Plan (CEP), the CEP will be sent to the Participant for his/her signature. This document must be signed and returned. When received, the following steps will be followed:

- A. Open the IC database through a shortcut on your desktop.
- B. Find the participant record the CEP refers to by entering the Palco # (the hyphen is not necessary, (e.g. 5423) or the first name, a period, and then the last name (or any portion of either) (e.g. Jane.Doe or Jo.Nich). Either press "enter" twice from your keyboard or click on the binoculars and the participant's record will open. Verify the correct record is open (several participants may have the same name).

The screenshot shows the 'IndependentChoices Client Records' software interface. At the top, there is a menu bar with options: Home, Create, External Data, Database Tools, and Add-Ins. Below the menu bar, the title bar reads 'FrmAllClients - IndependentChoices Client Tracking'. The main form is titled 'IndependentChoices Client Records' and displays client information for 'Jane.Doe'. A red box labeled 'Search bar' points to the search field at the top right of the form. The form includes fields for client details (Name, Address, Phone, Medicaid #, Social Sec #, Date of Birth, etc.), a list of 'Authorized Contacts', and a section for 'Current Hours' and 'Daily Rate'. There are also buttons for 'Open Check Registry' and 'PC Services Listing'. The bottom of the form shows a status bar with 'Record: 1480 of 6536' and a search filter set to 'Unfiltered'.

- C. Open the Tracking Tab. (Note: it is anticipated that the tracking screen in the IC database will be modified in the near future. All applicable sections of the IC Procedure Manual will be revised and distributed to IC staff when that occurs.)
- D. Go to the record that relates to the CEP received. For accurate tracking purposes, the Counselor is responsible for entering a date anytime a CEP is prepared and mailed to the Participant. This will be noted by a “Date CEP Mailed to Participant”. If the Counselor has failed to complete that field, go to the record that is closest to the received CEP. This could be indicated by date of assessment or date enrollment packet received.
- E. Verify that the Participant (or Decision-Making Partner/Communications Manager) signed the CEP. If the document was signed by anyone else, enter a contact note and forward to the Counselor.
- F. If properly signed, enter “Date Signed CEP Received” with the date the signed CEP was received.

- G. Make a copy of the CEP for the Counselor and provide the original CEP to PALCO. Record the CEP on the document log for delivery to PALCO. (See Section 220.100).
- H. Place the copy in the appropriate counselor's tray.

Tracking Tab

Date Sent

Base ID: ☐ New Enrollment ☐ Reassessment ☐ EOB Request Nurse Concerns:
 IC Nurse: ☐ Home Monitoring ☐ Phone Monitoring
 Req. Authorization Begins: Req. Authorization Ends:
 Home Visit: To DAAS: Hours Requested: 0
 Date Enrollment Packet Sent: 11/15/2008 Date Stamped In:
 Date Enrollment Packet Recvd: 11/30/2008 Counselor Received:
 Date Stop Agency Letter Faxed: Date To Doctor:
 Date CEP Mailed to Participant: 12/05/2008 Date From Doctor:
 Date Signed CEP Received: To DAAS/Stamped Delivered/To Dr
 Sent to PALCO ☐ Update MMIS: Stamped/Delivered To/From Dr
 Enrollment Sent/Rec: 15
 Involuntary Closure Letter Sent: Written Request to Appeal Due: Outcome of Appeal:
 Date Revised EC POC Requested:
 Date Received Revised EC POC:
 EOB Request Is:
 To UR: From UR:
 UR Status:
 Authorized Hours: 0
 Comments:

230.303 Personal Assistant Time Sheets

7-1-09

Time sheets completed for payment of the Personal Assistants of participants enrolled in IndependentChoices are supposed to be sent directly to PALCO. However, occasionally they are sent to IC central office. If this occurs, date stamp the document(s) and place in the appropriate Counselors in-box. Make sure these are sorted by the Participant's last name and not the Personal Assistant's last name.

230.400 Documents Received from IC RN's

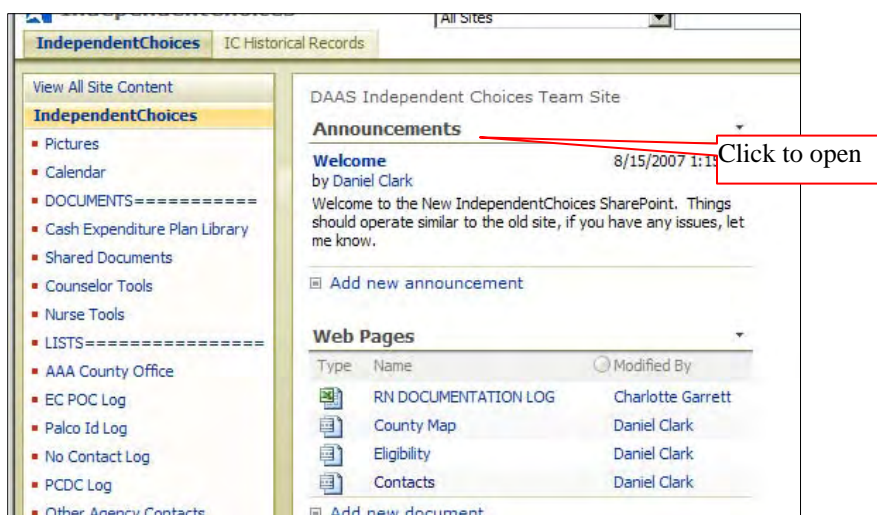
7-1-09

230.401 Documentation Log

7-1-09

The IC RN's are required to submit their documentation within five (5) working days of the home/phone visit. The number and types of documents received must be manually documented on the RN Documentation Log when received by the Administrative Specialist II. This log may be accessed from the IC SharePoint site. Follow the instructions below for completing the log. If you need assistance in accessing or completing the log, check with the Administrative Specialist III.

DOCUMENTATION RECEIVED FROM NURSES WEEK OF ____ / ____ /2009									
RN NAME	NO. OF ASSESSMENTS RECEIVED	DATE OF HOME VISIT	NO. OF MDS-HC RECEIVED & DATE PREPARED	MISSSED VISIT INFORMATION	MONITORING DOCS RECEIVED	RN TRACKING COMPLETED	NOTATION OF OMISSIONS WITH DOCUMENTS OR LOGGING RN TRACKING	TR1 WEEK ENDING	TR1 REC'D DATE



The IC RN Documentation Log is to be completed by the Administrative Specialist II as she/he is verifying the IC database tracking outlined below. Complete one form for each week by placing slash marks to represent the number of assessments, iHCs, Missed Visits, Monitoring Visits documents or TR-1s received from each IC RN in the respective columns along with the date of the visit on the document.

If the documents are not received within 10 days of the date of the visit, note First Initial & Last Name of that participant as indicated on the inserted example.

DOCUMENTATION RECEIVED FROM NURSES WEEK OF DEC / 8 /2008							
	NO. OF ASSESSMENTS RECEIVED	DATE OF HOME VISIT	NO. OF MDS-HC RECEIVED &	MISSSED VISIT INFORMATION	MONITORING DOCUMENTATION RECEIVED	RN TRACKING COMPLETED	NOTATION OF OMISSIONS WITH DOCUMENTS OR
Nurse Name	////	12/5	/ 12/5		/ 12/5	///	S. Smith - No Tracking J. Doe - No Diagnosis
* J. Doe 11/12							
* S. Smith 11/14							
*							

230.402 How to Verify Nurse Tracking Entry Requirements**7-1-09**

NOTE: It is anticipated there will be modifications in the IC database in the near future. Until those revisions are completed, the following procedures will be followed. All IC staff will be provided a copy of the revision to the manual when completed.

- A. Open the IC database.
- B. Open the participant's record.
- C. Open the Tracking Tab.
- D. Make sure the IC RN has keyed in the appropriate information in the Nurse Tracking section. (See following pages for required information). If nurse tracking included all required updates, indicate with a slash mark under "RN Tracking Complete" on the log. Repeat with each document received.
- E. If the IC RN did not record the information in the database, enter a notation on the Documentation Log with the participant's 1st initial & last name along with a brief notation of what was missing (for example: J Doe; no tracking, no begin or end date, no diagnosis, etc.).
- F. Enter the missing information and make a note in the Nurses Comment section "RN Tracking enter by "your initials".

230.403 Nurse Tracking Entry Requirements**7-1-09**

The following pages indicate how the IC RN's are required to complete the tracking for each type of document submitted and are included as a reference of those requirements for the Administrative Specialist II.

NOTE: Applicable screen shots will be provided when the tracking section of the IC database is updated and the IC Procedure Manual revised.

230.404 New Enrollment Visit**7-1-09**

Following a new enrollment home visit the IC RN will complete the Tracking record as follows:

- A. Nurse Name
- B. Type of visit entered using the drop down box

- C. Date of Visit
- D. Requested Authorization Begin Date (the date of the assessment)
- E. Requested Authorization End Date (six months from date of enrollment visit unless assessment is for more than 14.75 hours)
- F. Total Hours Requested
- G. Date to DAAS – the date the IC RN **mailed** the document to IC central office
- H. Appropriate boxes regarding the participant is checked (Person is Well Cared For, etc.)
- I. Principal Diagnosis
- J. If participant is also a EC participant, applicable boxes should be checked
- K. Notation of any concerns or other information in “Concerns Noted Below” box (if applicable)

230.405 Reassessment Visits

7-1-09

The IC RN must initiate the reassessment no more than sixty days prior to the Reassessment Date (as indicated in the upper left hand corner of the Participant’s record) and must be completed and received in IC Central Office a minimum 3 weeks prior to the end of the current Personal Care Service Plan.

Following the Reassessment visit, the IC RN will complete the following areas of the Nurse Tracking Screen:

- A. Nurse Name
- B. Type of visit entered using the drop down box
- C. Date of Visit entered
- D. Requested Authorization Begin Date - the day of the “Reassess Due” date indicated at the upper left hand of the Participant Record Screen)
- E. Requested Authorization End Date is six months from the Requested Authorization Begin Date unless assessment is for more than 14.75 hours

- F. Total hours of personal care requested
- G. Date to DAAS - the date **mailed** to IC Central Office
- H. Appropriate boxes regarding the participant is checked (Person is Well Cared For, etc.)
- I. Principal Diagnosis entered
- J. If participant is also an EC participant, applicable boxes should be checked
- K. Notation of any concerns or other information in “Concerns Noted Below” box (if applicable)

(NOTE: If not received within 3 weeks of the “Reassess Due” date, the assessment documents will be placed in the IC RN Supervisor’s in-box for review).

230.406 Extension of Benefit Assessments and Reassessments

7-1-09

Extension of Benefit (EOB) assessments are required for personal care hours in excess of 14.75. They may continue for one year if the Participant’s condition is not expected to improve.

The IC RN must initiate the reassessment no more than sixty days prior to the Reassessment Date (as indicated in the upper left hand corner of the Participant’s record) and must be completed and received in IC Central Office a minimum 3 weeks prior to the end of the current Personal Care Service Plan.

These assessments require the completion of the iHC. The nurse tracking must include the iHC RUG level.

Following the EOB home visit, the IC RN will complete the following areas of the Nurse Tracking Record:

- A. Nurse name
- B. Date of Visit
- C. Type of visit entered using the drop down box
- D. Requested Authorization Begin Date - The date of the “Reassessment Due” date indicated at the upper left hand of the Participant Record Screen

- E. Requested Authorization End Date - One year from the Begin Date (if the participant's condition is not expected to improve)

NOTE: If the authorization end date is less than one year due to an anticipated change of circumstances, a contact note will be entered in the IC database and emailed to the Counselor and the RN Supervisor confirming the End Date on the DMS-618 is correct.

- F. Total Hours Requested entered
- G. Date to DAAS - the date **mailed** to IC central office entered
- H. Appropriate boxes regarding the participant is checked (Person is Well Cared For, etc.)
- I. MDS RUG Category entered
- J. Principal AND Secondary Diagnosis entered
- K. If participant is also an EC participant, applicable boxes should be checked.
- L. Notation of any concerns or other information in "Concerns Noted Below" box (if applicable)

230.407 Monitoring Visits

7-1-09

Phone Monitoring visits are required for IC Participants currently receiving personal care services in excess of 14.75 hours per week through IndependentChoices.

Following the Phone Monitoring visit, the IC RN will complete the Nurse Tracking record as follows:

- A. Nurse Name
- B. Date of visit entered
- C. Type of visit entered using the drop down box
- D. Date Monitoring form actually mailed to DAAS entered
- E. Appropriate boxes regarding the participant is checked (Person is Well Cared For, etc.)

- F. If the IC Participant is also an EC participant, applicable boxes should be checked
- G. Notation of any concerns or other information in “Concerns Noted Below” box (if applicable)

230.408 Missed Visit

7-1-09

The IC RN is required to contact the Participant (or Decision-Making Partner/ Communications Manager if applicable) **the day prior** to traveling to a scheduled home visit to verify the appointment to avoid waste of work hours and travel expense. If the IC RN appears for the home visit and the Participant and any other required party is not available, the IC RN should complete the Missed Visit document and will complete the Nurse Tracking record as follows:

- A. Nurse Name
- B. Date of visit
- C. Type of visit entered using the drop down box
- D. Date, time and name of person contacted to confirm the appointment should be entered in the Nurse’s Concerns section.
- E. Date to DAAS - date **mailed** to IC Central Office entered

A contact note will be entered in the IC database and emailed to the IC RN Supervisor with an explanation if prior contact was not made the day preceding the scheduled appointment.

A contact note will be entered in the IC database and emailed to the Counselor so a “No Contact Letter” can be sent to the Participant.

230.500 Database Entry of Receipt of RN Documents

7-1-09

NOTE: It is anticipated that there will be modifications in the IC database in the near future. Until that revision is completed, the following procedures will be followed. All IC staff will be provided a copy of the revision to the manual when completed.

Open the Tracking Screen and enter the date the document was received from the IC RN in IC Central Office.

230.600 ElderChoices Plans of Care (EC POC)

7-1-09

This is a Plan of Care (POC) prepared by the ElderChoices nurse to identify service, frequency, and duration of Medicaid Services for participants enrolled in the Elderchoices waiver program and sent to our office either as a referral, requested by IC, a revision of a current plan of care, or a continuation of a previous care plan.

230.601 Review of Received POC's

7-1-09

Make sure all the general information is completed on the first page of the ElderChoices Plan of Care (EC POC). If not, review to see if this is a Provisional Plan (usual reason). If so, send an email to the EC RN informing him/her that Provisional Plans cannot be entered in the IC database as the referral is not yet Medicaid eligible, which is a prerequisite for participation in IC. Inform the EC nurse the EC POC will be destroyed pending receipt of a plan with a comprehensive start and end date.

GENERAL INFORMATION			
Client Name		Phone	
SS #		Medicaid #	
Date of Birth		County	
Address and directions to the home or Assisted Living Facility:			

If the Medicaid number is not listed, email EC RN

230.602 Current Participant Assessed 14.75 PC Hours or Less 7-1-09

If the EC POC is for a participant currently entered in the IC database and the personal care (PC) hours are for 14.75 hours or less, complete all of the following procedures.

230.603 Entry of Participant Information (Current Cases) 7-1-09

Open the IC database and search for the correct participant by verifying the date of birth and the social security number with the name.

With the correct record open, verify that the participant information on the EC POC such as address and phone number is correct with the IC database record. A contact note will be entered in the IC database regarding any differences, e.g. address, phone number, etc. and e-mailed to the Counselor. The Counselor will be responsible for contacting the Participant and verifying any discrepancy in the information and, if applicable, will update the IC database and notify the IC RN and PALCO of any change.

NOTE: Counselor's assigned to participants residing in counties contracted to PCDC will be requested to send an email verifying any discrepancy in the information in the IC database to the Administrative Specialist II who will update the IC database. The Administrative Specialist II will forward the automatically generated email regarding any contact information change to PALCO.

Complete the procedures outlined in Section 230.605 through 230.610.

230.604 Entry of Participant Information (Refusal or Closed Code) 7-1-09

An EC POC received regarding a participant previously entered in the IC database that has been marked with a Close or Refuse code, verify Medicaid eligibility (See Section 240.300). If eligible, update the IC database with the current information regarding address and telephone number(s). If the Applicant is residing in a different county, correct the name of the IC RN in the IC database, as this field does not automatically populate.

Enter a contact note noting the original Referral Date, Home Visit Date, Self Directed Date, Closed Date and reason for Close and/or Refuse code. Once this information is entered in the contact note, the dates will be removed and the current date will be entered as the Referral Date. If there are entries for "Current Hours", "Daily Rate", "Current Assmt", "Reassess Due", remove those dates as well. Add to the contact note that new referral has been entered. Include a notation of any contact names and telephone numbers on the EC POC. Forward this email to the Counselor.

230.605 Entry of EC POC

7-1-09

Open the EC POC tab and turn to Page 3 of the EC POC. Pay close attention to the dates of the plan. NOTE: If this is a revised plan that does not adjust the Personal Care hours or adds ACS hours do **NOT** enter as a new EC POC. (See Section H below)

If there is information from a previous EC POC in the IC database, verify that there is a date received for the entered EC POC. If not, insert a date approximately 2 weeks after the “authorized start date” and then “click” “Log New POC” in the bottom right hand corner. The collected data will be automatically stored.

If Hospice is indicated and Personal Care hours are assessed, do **not** enter the plan without consulting with the Counselor or Program Manager.

IndependentChoices Client Records Jane.Doe

Authorized Contacts: **OPTIONS**
 All Cases
 My Current Cases
 My Pending Cases
 My Cases to Review

JANE A DOE Medicaid #: 1234567891
 Phone: (123) 456-7890 Cell: Social Sec #: 123-45-6789
 Waiver: 2 Cammie Mallard SEX: 2 Palco# A Date of Birth: 01/01/1900

Current Hours: Complete Referral Date: 12/18/2008
 Daily Rate: Mailing: 123 ANY STREET Home Visit:
 Current Asmt: City: ANY TOWN Self Directed:
 Reassess Due: Review: No State: AR Zip Code: 12345- Closed Date:
 Counselor: PCDC Nurse: PCDC County: PHILLIPS 54-1 Close/Refuse:

Participant Personal Assistant(s) Physician CONTACTS TRACKING EC POC

Date Current POC Received: 15/01/2009
 EC POC Start Date
 EC POC End Date
 Homemaker Hours: 0
 PERS
 Home Delivered Meals
 Respite - In Home: 0
 Short Term Facility
 Long Term Facility
 ADC - Adult Day Care
 Adult Day Health Care
 Chore: 0

AFC
 Adult Companion
 ACS First Effective:
 IC Personal Care
 TCM
 Home Health
 Medical Transportation
 Prescription Drugs
 Incontinence Supplies
 Hospice
 Clients Choice
 Other

EC Nurse:
 Email
 Phone1
 Phone2
 Fax

Previous POC Information Log New POC
 EC Nurse:
 Date Received:
 AC Hours: 0
 PC Hours: 0

1st To Doctor: 2nd To Doctor: 3rd To Doctor: From Doctor: To Counselor:

Records: 14 1480 of 6536 Unfiled

Annotations:
 - The start date is the date signed by the RN. The end date is found on the first page next to the Comprehensive POC Exp. Date.
 - Click on the EC POC tab so you can key in the plan received from the EC RN
 - If plan is revised, enter revision information here
 - If Hospice is checked and PC hrs is not included, **DO NOT** enter. Send an e-mail to the Counselor or if a PCDC case, to the Program Manager

- A. Enter the date the EC POC was received and then enter (or change if applicable) all information on the plan (see example above) as follows:
- B. PERS, Home Delivered Meals, Short Term Facility and/or Long Term Facility will only be a check mark if applicable.
- C. Adult Day Care and Adult Day Health Care will be what is noted (i.e. 3 days/wk x 6-8 hrs/day). **DO NOT JUST** enter “YES OR NO”.
- D. For Respite, take the number of SFY (State Fiscal Year) units and divide that number by 12 then by 4.33 to get the weekly amount. (600 hrs = 11.55 or 1200 hrs = 23.09) **NOTE:** If the RN specifies SFY benefit limits, enter that.
- E. If there is a range such as 8-10, you will key in the highest number the EC nurse assessed for that service.
- F. Pay close attention to any notation the EC Nurse might make regarding a different number of PC hours once IC is started and make sure you enter that number. Make notation in the “Other” box.

G. For Targeted Case Management (TCM) enter provider name, dash, and then amount. (e.g. – 40 Units/Mth) or SFY Benefit Limit.

H. ACS hours **NOT** provided by IC **MUST** be entered in “Other” box.

CLIENT NAME: _____			
CLIENT ID#: _____			
ELDERCHOICES PLAN OF CARE			
Waiver Service (CIRCLE)	Provider	Amount/Frequency/Duration	Comments, N/A, or Refused, if appropriate
IDE		Total _____ Hrs/Wk; Min. Freq. _____ Visits/Wk	Not to exceed Medicaid maximum of 40 hrs/mo
PIGS		24 Hrs/Day	
IDE - Hot		Min/Max/Wk	
	From _____	Min/Max/Wk	Has the means of storage? Yes/No
RESPIRATORY* In-Home		Not to exceed _____ Hrs per SFY (P/N)	If more than 50 hrs/mo, must be prior approved by DAAS RN
RESPIRATORY* Short Term Fac. Long Term Fac.		Not to exceed _____ Hrs per SFY (P/N)	
Payment for Respite may not be made for respite furnished at the same time as other services that include care and supervision.			
ADULT COMPANION SERVICES*		Total _____ Hrs/Wk; Min. Freq. _____ Visits/Wk	
*Benefit limit for any combination of In-Home Respite, Facility-Based Respite or Adult Companion Services cannot exceed 1,200 hours per SFY			
AIDC		Days/Wk; _____ Hrs/Day	
AIDC		Days/Wk; _____ Hrs/Day	
CHORE			
AFT		1 unit of service = 1 day; maximum 31 units/month	
Other Non-Waiver Service (CIRCLE)	Provider	Amount/Frequency/Duration	Comments, N/A, or Refused, if appropriate
Personal Care		Total _____ Hrs/Wk; Min. Freq. _____ Visits/Wk	
TCM		Not to exceed SFY benefit limit (P/N)	
Home Health			Per MD Order
Medical Trans.	Per Medicaid Contract	(P/N)	
Prescription Drugs	Client's Choice	(See DHS-703)	
Incontinence Supplies	Client's Choice	Not to exceed Med. Max./Mth, (P/N)	
Hearings			
Other	Client's Choice		
ElderChoices Plan of Care is recommended for one year and is designed specifically for each participant to assist in reaching individual goals enabling them to remain in the community.			
TO THE EXTENT PERMITTED UNDER STATE LAW			
<input type="checkbox"/> Provisional <input type="checkbox"/> Comprehensive			
DHS RN Signature _____ Date _____			

- I. Use the drop down to enter the EC RN name that completed the assessment. The contact information will populate. IF that RN is different from the RN assigned to that area, when you send the contact note email, enter a cc to the RN assigned to that area.
- J. If the EC POC received is a revised plan (same start and end date as already in the IC database), make your entries as follows:
 1. If it does NOT change PC or ACS hours, do NOT log as a new plan. Edit the appropriate fields and enter a notation of date changed and the revisions in the “Other” box. (e.g. 12/13: discontinued respite)

2. If the revision is increasing the number of PC hours, log as a new POC received, edit the appropriate fields and enter physician information. (See Section 230.609)
3. Obtain Physician authorization until the IC RNs complete as assessment and the Counselor obtain authorization from the physician. The goal currently set is November 1, 2009 to have all currently enrolled participants assessed by the IC RNs. (For instructions on Obtaining Physician Authorization see Section 230.610)
 - a. EC POC's received beginning 7/1/09 on referrals - no physician authorization obtained by the Administrative Specialist II.
 - b. EC POC's received on participants without a current DMS-618 authorized by a physician – authorization will be obtained.

NOTE: The Administrative Specialist III will provide specific details to the Administrative Specialist II during this transition period.

4. If the revision decreases PC hours or adds or decreases ACS hours, log as a new POC received, edit the appropriate fields, enter a contact note in the IC database, and email the Counselor of the revision. Place the EC POC in the Counselor's in-box. The Counselor will be responsible for procedures to implement the change in the plan, including determining if an authorization by the physician is required.

230.606 Entry of Diagnosis

7-1-09

Start with the first nurse tracking record that has a Primary and Secondary Diagnosis entered. Verify that the diagnosis found on page 2 of the EC POC is the same. If different, continue viewing the records indicating the diagnosis. If there is not the same diagnosis as indicated on this EC POC, enter it on the last nursing tracking record.

230.607 Entry of Date EC POC Received

7-1-09

Enter the date the EC POC is received in IC Central Office. (See screen shot in Section 230.605)

230.608 Entry of Directions**7-1-09**

Open the Participants tab and enter the directions the EC RN has written on page 1 of the plan. If the handwriting is not legible at all, indicate that. If it is just one word, put (?) in that space. You do not have to repeat the physical address.

230.609 Entry of Physician Information**7-1-09**

Open Physician tab and key in the physician information from the EC POC or, if already entered, verify address and phone numbers and that he/she is marked “Active” in the database.

PhyFName	PhyLName	PhyAdd	PhyCity	PhySt	PhyZip	PhyPhone	PhyFax	Medicaid ID#	Active	Comments
JOSE	ABISEID	VA MED CTR 4300 W	NORTH LI	AR	72205	(501) 745-2515	(501) 745-8864		<input checked="" type="checkbox"/>	
DAVID	BOURNE	VA MED CTR 2200 FC NO			72114	(501) 257-1000			<input type="checkbox"/>	

If the physician is a different, unclick active on the old one and click active on the new one entered.

Many times the EC RN's do not provide the physician's fax number. If there is not a fax number for the physician, complete the following steps:

IndependentChoices Client Records Jane Doe

ANE: [] A: [] DOE [] Medicaid #: 1234567891

Phone: (123) 456-7890 Cell: [] Social Sec #: 123-45-6789

Owner: 2 Cammie Mallard SEX: 2 Palco#: [] Date of Birth: 01/01/1900

Current Hours: [] Complete [] Referral Date: 12/18/2008

Daily Rate: [] Mailing: 123 ANY STREET Home Visit: []

Current Asmt: [] City: ANY TOWN Self Directed: []

Assess Due: [] Review: No State: AR Zip Code: 12345- [] Closed Date: []

Counselor: PCDC Nurse: PCDC County: PHILLIPS 54-1 Close/Refuse: []

Participant | Personal Assistant(s) | **Physician** | CONTACTS | TRACKING | EC POC | CEP | REPORTS

Nurse Reports **Couns Reports** **Edits** **Tools**

Nurse Client Directory - All Cases No Physician Info in Record Warning: These fields will edit the primary client information, and should be used with care.

Nurse Client Directory - Active No Backup Info in Record

Nurse Client Directory - Pending No Worker Info in Record

Nurse EC Directory- Monitoring Visits No PALCO ID in Record

County Client Directory - Active No Contact Note in 90 Days

County Client Directory - Pending

Reassessments Past Due (Days and Months)

Assmt Letter Sent: [] Administrative Review [] 09 CEP Returned []

Update EC Nurse Contact Info

Update EC Nurse Regions

Update Physician Information

View Pending No Contact Letters

View Palco ID Log

Update Contacts List

Update AAA Agency Information

Update Other Agency Information

Missing CEPs Report-DAAS

Missing CEPs Report-PCDC

Print CEP By Company

Physician Update Information

PhyFName	PhyLName	PhyCity	PhyPhone	PhyFax
	SMITH		(501) 686-5311	(501) 686-5935
Cheet	SMITH	CONWAY	(501) 329-3824	(501) 327-2957
JAMES	SMITH	RUSSELL	(479) 968-2345	(479) 890-7103
LANDER	SMITH	CONWAY	(501) 329-3824	(501) 327-2957
LANDER	SMITH	CONWAY	(501) 329-3824	(501) 327-2957
LANDER	SMITH	CONWAY	(501) 329-3824	(501) 327-2957
LANDERS	SMITH	CONWAY	(501) 329-3824	(501) 327-2957
MALCOLM	SMITH	TEXARKANA	(903) 798-7240	
RON	SMITH	BLITHEVILLE	(870) 763-4541	(870) 762-2390

- A. Open the “Report” tab (see screen shot on previous page)
- B. Click on “Update Physician Information
- C. Enter Physician’s Last Name and press OK
- D. Locate the physician’s fax number in another case and copy and paste it into the participant’s record. NOTE: Also hand write the fax number on the EC POC.
- E. Close reports by clicking the lower “X” in the upper right corner.
- F. Re-open the Physician tab. The previous step should have populated the fax number into the participant’s physician record. If not, enter it.

If the physician (or fax number) has not been previously entered in the database, call the physician’s office to obtain the fax number and enter in the database as previously indicated.

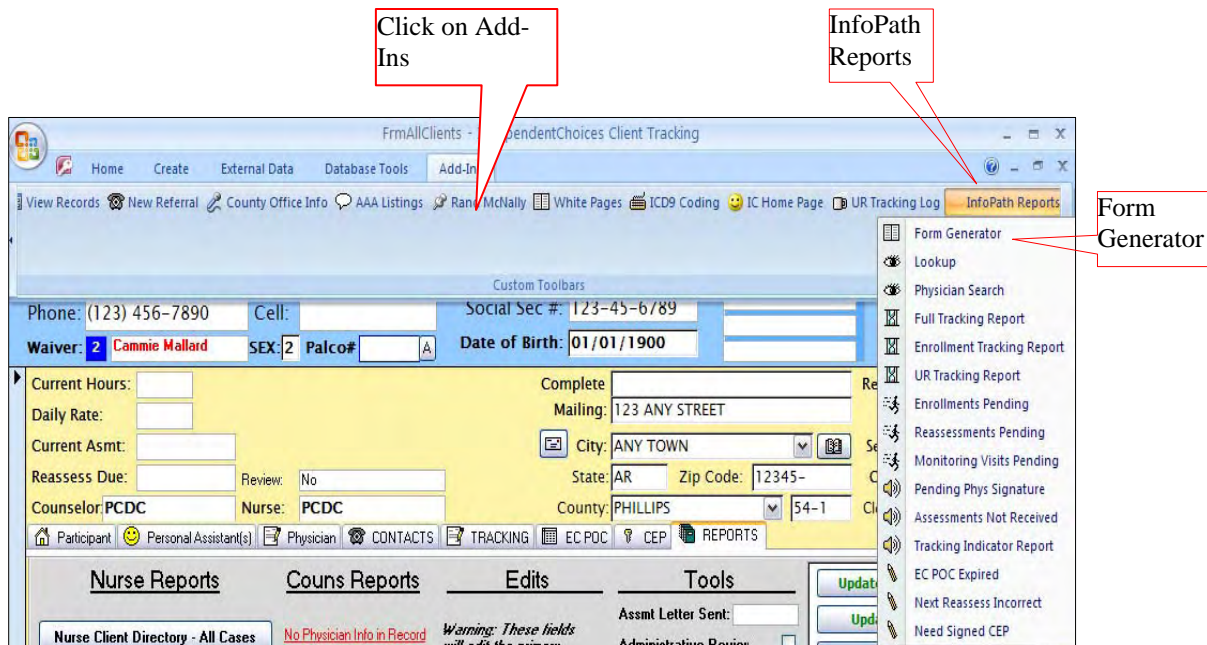
230.610 Obtaining Physician Authorization

7-1-09

NOTE: Due to the requirement the IC RN’s must complete an assessment on all IC Participants, the procedures in this section will no longer be followed after all IC Participants have been assessed by the IC RN. (Goal is November 1, 2009) Until such time, the following procedures will be followed.

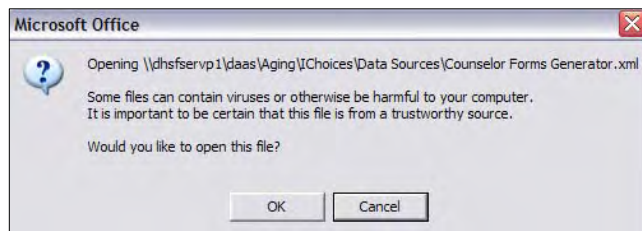
Physician Authorization is required on all EC POC's for Participants with personal care hours assessed for 14.75 or less.

Look at page 2 of the plan. If there is not a physician's signature, proceed with the following steps. If a physician has authorized this plan, skip to Section "V" below.



To generate a Physician Authorization form and complete the steps to obtain authorization of the plan, the following procedures must be followed:

- A. Click on the "Add-Ins" link located at the top of the Client Record screen of the database (*only required if you are using Microsoft 2007*)
- B. Click on InfoPath Reports.
- C. Click on Form Generator.
- D. Click "OK" to the Microsoft Notice.
- E. Click "Yes" to the InfoPath Security Notice.

The IndependentChoices application interface. At the top, there are input fields for "MC#:", "PALCO ID:", and "FIRST & LAST NAME:". To the right of these fields is a "Retrieve Client Data" button. Below these fields are three sections: "Letters:" with a "GO!" button, "Faxes:" with a "GO!" button, and "Data:" with a "GO!" button. Each section contains a list of options. The "Letters:" section includes "START SERVICES", "NO CONTACT", "ENROLLMENT PACKET", "CHANGE IN HOURS", and "OTHER LETTERS". The "Faxes:" section includes "PHYSICIAN AUTHORIZATION", "STOP AGENCY SERVICES", and "OTHER FAXES". The "Data:" section includes "QSource Cover", "EOB Cover", "Timesheets", "Timesheets-With Companion", "Change Reporting Form", and "View Client Data". At the bottom, there is a "Help:" section with a "GO!" button, a "Select Help Topic" dropdown, and a "Go to Label Page" button. There are also buttons for "Add Address to Label Page" and "Generate IC Forms". Annotations with red boxes and arrows point to the "Retrieve Client Data" button (labeled "Click to Retrieve Client Data"), the "Data:" "GO!" button (labeled "Click EC"), and the "GO!" button under "Letters:" (labeled "Then GO"). Another annotation points to the "MC#" field (labeled "Enter client information").

F. Enter Participant's Medicaid number, Palco ID, or First and Last Name.

G. Click "Retrieve Client Data".

- H. Select “EC” and click “GO” to generate the form to fax to the physician. This form will auto populate from data you recently entered in the EC POC and physician tabs. If any omissions occurred or errors were entered, they will display on the fax you are creating.
- I. Verify that the participant’s name, physician name, telephone numbers and authorized hours are correct before you print the document. If any of the information is incorrect, correct the entries made in the IC database, save the record, and repeat the above steps.

***** CONFIDENTIAL *****			
		ARKANSAS DEPARTMENT OF HUMAN SERVICES Division of Aging and Adult Services PO Box 1437 Slot S530 Little Rock AR 72203 Telephone: Fax: 501-683-4180	
To:	DR. JOE PROFESSIONAL	From:	Counselor, IndependentChoices
Fax:	555-555-1111	Date:	12/10/2007
Phone:	555-555-1112	Pages:	1
Re:	JANE DOE		
<p>We need your authorization for personal care assistance for this client.</p> <p>We appreciate your help.</p>			
<small>PHYSICIAN'S ORDERS ELDERCHOICES/ALTERNATIVES/ASSISTED LIVING PROGRAM</small>			
To: Dr. JOE PROFESSIONAL		Patient Name: JANE DOE	
Return To: (501) 683-4180 (FAX)		Patient DOB and/or SS#: 01/01/1940	
Address: Department of Health and Human Services Division of Aging and Adult Services IndependentChoices PO Box 1437 Slot S530 Little Rock AR 72203		Patient Address (optional):	
Date Ordered	Date Discontinued	ORDERS	
01/01/2008	01/01/2009	Authorize 14.5 Hrs/Wk of Personal Care Assistance per ElderChoices Assessment	
Receiving Nurse/Waiver Counselor Signature		Date:	Signature of Physician
<i>Caring Nurse</i>		12/10/2007	
ORIGINAL COPY – Physician. Please Sign and Return within 48 hours			
<i>Sign & Date Here</i>			
<small>AAS-5604 (R.05/03) PROTECTED HEALTH INFORMATION NOTICE - PRIVACY WARNING "Confidentiality Notice: The information contained in this fax message is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to whom this fax is addressed. If you are not the intended recipient, you are hereby notified that reading, copying, or distributing this transmission is STRICTLY PROHIBITED. The sender has not waived any applicable privileges by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachments from your system."</small>			

After you have verified the Physician Authorization form is accurate:

- A. Fax the “Request for Authorization” page to the physician. Verify the result of the fax is “Successful TX Notice”. If not, verify fax information is correct and refax. If a 2nd failure is received, call the physician’s office. Make any applicable changes and refax until successful or mail. If you are required to mail, enter a contact note with that information.

- B. Enter Date faxed to Physician in the EC POC tab
- C. Take the successful fax notice and the fax cover sheet and staple together with the EC POC. The Administrative Specialist II is required to maintain the faxes in the Date Folder to insure that follow up is completed within the required period.
NOTE: It is recommended the Counselors follow the same procedure on obtaining physician authorization on any plan of care unless they have a comparable tracking system in place.
- D. Place the documents in the date section **5** days from the days date sent (**weekends included**.) If the 5th day falls on a weekend, place it in the date section for the following Monday.
- E. The Date Folder must be checked each morning to see if follow up is required.
- F. If in 5 days you have not received authorization from the physician, take the original fax cover sheet, mark through original sent date and write in the current date – write or stamp 2nd request on the fax cover sheet and resend to the physician.
- G. Enter the date for the 2nd request sent in the EC POC tab. Repeat as above.
- H. If in 5 days you still do not have an authorization, take the fax cover sheet from the second request, mark through the 2nd date and write 3rd, Final Request, and resend to the physician.
- I. Enter the date for the 3rd request sent in the EC POC tab.
- J. Enter a contact note in the IC database and email the Counselor and EC RN that the physician has not responded to the Request for Authorization of the plan of care. If the Participant resides in Region 2 through 8, place the EC POC in the Counselor's in-box. The Counselor will be responsible for the specific procedures to obtaining the authorization and/or closing the case.
- K. For participants residing in Region 1 counties (currently PCDC), call the physician's office and verify the Request for Authorization has been received. You must enter a contact note regarding the communication.
- L. If the physician has just failed to send back the authorization, verbally request that they do so immediately and inform physician's office that without authorization services will end (or not start) for the participant.

- M. If the problem is because the participant is no longer a patient, enter a contact note and e-mail the EC RN and the Counselor requesting assistance with the identification and coordination of a new physician. Once information on a new physician is obtained, go into the IC database and update the Physician Tab with information about the physician's office. A contact note will be made in the IC database indicating the original dates of submissions to the physician.
- N. Remove the dates previously entered. Repeat all of the above Steps.
- O. If the problem is because the participant has not been seen for 60 days or more, contact the participant and inform them that they must make an appointment before the doctor will sign the authorization and that they are required to contact you regarding the date and time of the appointment. Enter a contact note regarding this contact to include the information requested and/or information received from the participant.
- P. Forward the contact note to the Counselor and EC RN requesting their assistance as well.
- Q. Maintain the request for follow-up until the information is received. When information is received that the visit is scheduled, resend the Request for Authorization to physician to coordinate with scheduled appointment. Indicate on the fax that the Participant has informed us of a scheduled appointment (indicate date and time of the appointment) and note that authorization is required immediately. Repeat process from the beginning.
- R. If your follow-up indicates that the participant failed to keep the appointment, enter a contact note and e-mail Program Manager and Counselor to disenroll participant due to failure to comply and lack of physician authorization.
- S. When all attempts to gain authorization from the physician are exhausted, enter a contact note and email the EC nurse, Counselor, and Program Manager, informing them that authorization from the physician has not been obtained and that the case should be closed or marked as a refuser.
- T. NOTE: Only a Counselor or the Program Manager should mark a case closed or refused to insure that appropriate entries are made in MMIS to stop payment for services.
- U. Failure to inform the Program Manager or the Counselor allows a person enrolled in the IndependentChoices program to continue without an authorization, which is a violation of Medicaid policy and program operation of the IndependentChoices Program.

- V. When the physician's authorization is received:
- W. Enter date received in the "Date from Doctor" field in the EC POC tab.
- X. Enter a contact note stating that Physician Authorization has been received and email the EC RN and the Counselor.
- Y. A copy of the Physician Authorization shall be made and placed in the EC RN's "in box" located on the 5th Floor of DPS.

If this authorization is for a participant residing in Regions 2 through 8, place the EC POC with the signed Physician Authorization on top in the appropriate counselor's in-box.

If this authorization is for a participant residing in a county served by PCDC, the following must be completed:

- A. Complete the fax cover sheet to PCDC making sure you accurately check the applicable boxes. (See document below.)
- B. Copy the back of page two of the EC POC
- C. Fax to PCDC and verify "Successful TX Notice". Refax if "TX Failure Notice" is received.
- D. When the successful transmittal document is received, staple the EC POC, the Physicians authorization with the Successful TX Notice to PCDC on top. Properly dispose of all other documents obtained during the process
- E. File the documents in the monthly folder maintained in the file cabinet located in the Administrative Specialist II's cubicle.

Charlotte Garrett Administrative Assistant P. O. Box 1437 Slot 5-630-IC Little Rock, AR 72203 501 682-8622 Fax: 501 683-4180	State of Arkansas Department of Human Services Division of Aging & Adult Services IndependentChoices Program
<h2 style="margin: 0;">C o n f i d e n t i a l</h2>	
To: PCDC - INDEPENDENTCHOICES	From: Charlotte Garrett
Fax: 1-870-572-4459	Pages:
Phone: 877-572-4410	Date:
Re:	CC:
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> NEW REFERRAL</div> <div style="width: 33%;"><input type="checkbox"/> EOB</div> <div style="width: 33%;"><input type="checkbox"/> COMPANION SERVICES</div> <div style="width: 33%;"><input type="checkbox"/> ENROLLED IN IC</div> <div style="width: 33%;"><input type="checkbox"/> EOB</div> <div style="width: 33%;"><input type="checkbox"/> COMPANION SERVICES</div> <div style="width: 33%;"><input type="checkbox"/> REVISED EC POC</div> <div style="width: 33%;"><input type="checkbox"/> EOB</div> <div style="width: 33%;"><input type="checkbox"/> COMPANION SERVICES</div> <div style="width: 100%;"><input type="checkbox"/> PHYSICIAN AUTHORIZATION</div> </div>	
CLIENT/PARTICIPANT NAME:	
Comments:	
PROTECTED HEALTH INFORMATION NOTICE – PRIVACY WARNING <small>"Prohibition of Redisclosure: This information has been disclosed to you from records that are confidential. You are prohibited from using the information for other than the stated purpose; from disclosing it to any other party without the specific written consent of the person to whom it pertains; and are required to destroy the information after the stated need has been fulfilled, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose."</small>	

230.700 Current Participant assessed PC Hrs Greater than 14.75. 7-1-09

If the EC POC received is for a participant currently entered in the IC database and the personal care hours are greater than 14.75 the assigned IC RN will be required to conduct a home visit and complete the necessary assessment for an Extension of Benefit request. All procedures outlined in Section 230.600 – 230.609 shall be completed.

If the plan is for a participant in Region 2 – 8, place in the Counselor's in-box after completing above.

If the plan is for a Participant residing in a county served by PCDC:

- A. Complete the fax cover sheet to PCDC making sure you mark the appropriate fields and add a comment that an EOB is required. Note the number of PC hours assessed by the EC RN.
- B. Copy the back of page two of the EC POC
- C. Fax to PCDC and verify "Successful TX Notice". Refax if "TX Failure Notice" is received

- D. When the successful transmittal document is received, staple the EC POC, with the Successful TX Notice to PCDC on top. Properly dispose of all other documents obtained during the process.
- E. File the documents in the monthly folder maintained in the file cabinet located in the Administrative Specialist II's cubicle.
- F. Enter a contact note that the EC POC has been received, IC database updated and faxed to PCDC requesting an EOB home visit. E-mail the contact note to the PCDC Counselor and the EC RN.

When a PCDC case requires an Extension of Benefits (EOB), the PCDC RN will complete the required documentation and will mail all required documentation to the Registered Nurse Supervisor with a Cover Sheet. The packet should include the following:

- A. Cover sheet
- B. Assessment
- C. iHC documents
- D. Applicable EC Plan of Care. NOTE: If the applicable EC POC is not included, retrieve from our files and attach a copy.
- E. Using your MMIS password go into the MMIS and print out a MMIS Recipient Eligibility (RE) screenshot. (See Section 240.300)
- F. Place the documents from PCDC with the RE screenshot (and copy of EC POC if copied from our files) in the in-box of the Registered Nurse Supervisor for final submission to Utilization Review and required tracking.

230.800 Requests for Increase in Hours in Region 1 Participants

7-1-09

If a PCDC RN in Region 1 assesses personal care hours for a participant enrolled in the Elderchoices waiver program different from the EC POC on file, the PCDC RN must contact the Elderchoices nurse to discuss the assessment. If both agree, a change of hours is justifiable; the IC RN will proceed with what was agreed to by both parties.

If the assessment does not require an EOB, (less than 14.75 personal care hours and the Participant is less than 21 years of age), the DMS-618 and DAAS-IC-20 shall be submitted to the IC RN Supervisor for review with a cover sheet. The coversheet will

state the date he/she contacted the EC RN and if the change was agreed to by the EC RN.

Notation will be written on the cover sheet. The original will be returned to the Administrative Specialist II. The Administrative Specialist II will make two copies of the cover sheet. One copy will be provided to the Counselor assigned to entering MMIS information for the PCDC area. The other copy will be provided to the Program Manager for his records. The Administrative Specialist II will mail the original to PCDC.

240.000 Referrals

Referrals are received in various ways. The three primary ways are:

- Phone Contact through the toll free number
- Web Requests
- EC POC's

240.100 Eligibility Requirements**7-1-09**

Eligibility on any referral must be determined. To enroll in the IndependentChoices Program, the Applicant must:

- A. Be 18 years of age or older
- B. Eligible for Medicaid in a category that covers personal care or eligible for ElderChoices and determined in need of Adult Companion Services or Personal Care Services by the DAAS Registered Nurse
- C. Be receiving personal assistant services or be medically eligible to receive personal care services that require “hands on” assistance such as:
 1. Bathing
 2. Dressing
 3. Eating
 4. Toilet needs
 5. Grooming
- D. Be authorized to received Adult Companion Services by the ElderChoices RN based on ElderChoices Policy (Not required for Personal Care services)
- E. Not be living in a home or property owned, operated or controlled by the Personal Assistant unless related by blood or marriage. See Section 200.200(D) of the IC Provider Policy Manual.
- F. Be willing to participate in IndependentChoices and understands the rights, risks and responsibilities of managing his/her own care with a cash allowance; or, if unable to make decisions independently, has a willing Decision-Making Partner/Communications Manager to do so on his/her behalf.

240.200

Eligibility Screening

7-1-09

Referrals received through the IndependentChoices website (<http://Independentchoices.com/ICHome.htm>) and the toll free number primarily will be handled by the Administrative Specialist II and the Administrative Specialist III as needed.

When a request for enrollment in the IndependentChoices Program is received, the Referral Screening Questionnaire shall be completed. This form will be finished either on paper or in the IC database. If a paper form is used, it will be maintained in the case file and a copy will be sent to the assigned IC RN with the enrollment papers for his/her review prior to the enrollment visit. These same procedures shall also apply to any other IC staff receiving a referral directly from an IC Applicant.

The screening information shall only be obtained from the IndependentChoices Applicant. If the Applicant is not physically or mentally capable of completing the screening process, it is imperative that you inform the caller that the person who will be designated as the Decision-Making Partner or Communications Manager for the Applicant is the only person you can communicate with due to the Employer/ Employee relationship of the IndependentChoices Program. You are **not** to complete the screening process with the person who is likely to be the paid personal assistant.

To be enrolled in IndependentChoices the Applicant must have a telephone in their home. This does not have to be a “land line”. A cell phone is acceptable as long as there are not any restrictions on its use. A “message phone” at another residence does **NOT** meet the requirements. If we cannot communicate with the Applicant due to cognitive ability or communication barriers and a Decision-Making Partner or a Communications Manager has been designated, a telephone number where that person can be reached at all times must be provided. That number is to be entered as the primary phone number in the IC database.

For consistency, the name and telephone number of the person verbally designated as the Decision-Making Partner or the Communications Manager will be entered in the IC database in the “Representative” field. Do **NOT** check active at this time. The purpose of this is to provide the IC RN and other IC staff with information during the application phase.

NOTE: When the enrollment documents are received, the Counselor will enter the authorized information of any designated person and will check the active status. At this time, the Counselor will also enter the name of the Designee in the address field (e.g. C/O JANE DOE. The address will be changed IF all written correspondence should be sent directly to the designee at a different address. If this

address is different from the physical address of the Participant, the Counselor will be responsible for entering that address in the appropriate field.

When completing Section B, if the response provided is “Yes” to Bathing and Dressing, **STOP** the questions because the Applicant is **NOT** eligible for enrollment in the IC Program, as they do not meet the minimum guidelines for personal assistance services. Generally speaking, when the person is capable of bathing and dressing themselves, they are looking for other services such as housekeeping and/or transportation services, which do not meet the requirements for enrollment in the IC Program.

Section C addresses the CMS requirement that a person is not eligible for the IC Program if they are residing in the home of a non-relative who will be their paid personal assistant.

An example of the Referral Screening Questionnaire is shown below. A copy is in the Forms Appendix. It is anticipated that this document will be incorporated in the IC database in the near future and will populate the Participant record when completed.

REMINDER: This form is to be completed on every referral until the IC database is modified. A copy is located in the Appendix Form Section.

Arkansas IndependentChoices Referral Screening Questionnaire	
SECTION A: REFERRAL INFORMATION	
Date of Call: <u>Month/Day/Year</u>	Referral Received by (Name): _____
Caller Name: _____ Phone: _____	
Referred by: <input type="checkbox"/> Resource Center <input type="checkbox"/> CEC POC <input type="checkbox"/> County Office <input type="checkbox"/> Agency <input type="checkbox"/> Brochure <input type="checkbox"/> Internet <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Other	
Relationship of person referred: <input type="checkbox"/> Self <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Not related	
1. Do you make your own decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If no, who will help you make them for the IC Program? (CAN'T BE YOUR PAID PERSONAL ASSISTANT)	
Name: _____ Daytime Phone Number: _____	
2. Client Mental Status: <input type="checkbox"/> Clear <input type="checkbox"/> Somewhat Confused <input type="checkbox"/> Moderately Confused <input type="checkbox"/> Requires Decision-Making Partner	
3. Do you have difficulties with? <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Reading and Writing	
Will you need help understanding or completing forms or documents sent to you OR verbally communicating with IC staff? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who will help you with this for the IC Program. (CAN'T BE YOUR PAID PERSONAL ASSISTANT)	
Name: _____ Daytime Phone Number: _____	
STOP INTAKE PROCESS IF CALLER IS THE POTENTIAL PAID PERSONAL ASSISTANT	
Medicaid Number: _____ Social Security Number: _____	
Last Name: _____ First Name: _____ MI: _____	
Address: _____ Apt. #: _____ City: _____ State: <u>AR</u>	
Zip Code: _____ Telephone (Home): _____ Message Phone: _____	
DOB: <u>Month/Day/Year</u> Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female County: _____ County # _____	
SECTION B: CARE NEEDS INFORMATION	
What is your disease diagnosis? _____	
Are you able to do this by yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NOTE: If Yes on Bathing or Showering or Dressing, stop intake. Do not meet the requirements of the program.	
Bathing or Showering	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Prepare Meals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Feed Self	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Shampoo Hair	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Daily Hair Care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Brushing Teeth or Taking Care of Dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
SECTION C: REFERRAL QUESTIONS	
going to Toilet	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Washing Care of Your Nails – Hands	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Washing Care of Your Nails – Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
Talk by Yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
“No” do you use a cane or walker?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
“No” do you get around in a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
If “Yes”, can you push your wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
If “Yes”, can you get in and out of your wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needs Some Help
“No” are you:	<input type="checkbox"/> Bedbound and can reposition and transfer self <input type="checkbox"/> Bedbound and cannot reposition and transfer self
Check and send automated e-mail to Veniece only if questions remain as to whether the person is eligible for IndependentChoices.	
SECTION C: REFERRAL QUESTIONS	
Do you know who you will hire to provide your care? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, need to discuss with _____)	
Who do you live with? <input type="checkbox"/> Alone <input type="checkbox"/> With Legal Guardian <input type="checkbox"/> With Spouse <input type="checkbox"/> With Child <input type="checkbox"/> With Family Member (sibling, grandparent, uncle/aunt, nephew/niece, cousin) <input type="checkbox"/> With Someone Not Related to You	
Who owns the home that you live in? <input type="checkbox"/> I own my home (If owned – stop question) <input type="checkbox"/> I rent my home or share rental cost (stop question) <input type="checkbox"/> I do not pay rent and the Response to Question # 2 is “With Someone Not Related to Me” ask: Will This Person Not related to You <input type="checkbox"/> Be your paid live-in caregiver (System will flag with error message “This employer/employee relationship is not permissible by CMS) <input type="checkbox"/> Will not be your paid live-in caregiver	
Are you currently receiving? <input type="checkbox"/> Hospice <input type="checkbox"/> ElderChoices <input type="checkbox"/> Agency sends someone to help me with bathing or housekeeping <input type="checkbox"/> Home Delivered Meals	
When was your last doctor’s appointment? _____ <input type="checkbox"/> I don’t know. <input type="checkbox"/> Send letter that referral will need to see their doctor.	
Do you have regularly scheduled dialysis, chemo, day care, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday What do you have scheduled on these days? _____	
REMARKS:	

240.300 To determine Medicaid eligibility**7-1-09**

Reserved for future procedures.

240.301 EC POC's Received as a Referral**7-1-09**

EC POC Referrals are entered in the IC database based upon the information on the EC POC. The Administrative Specialist II will enter "Not Yet Determined" (NYD) as to whether the Applicant lives in his own home, the home of a relative, or the home of a non-relative. The Counselor will be responsible for obtaining the accurate information regarding residency and verifying all information entered in the IC database is accurate when they communicate with them and will be responsible for updating the IC database.

If the EC POC received is a referral (Participant not in the database) refer to Section 230.605 and then following the procedures outlined in Section 240.500.

If the Medicaid number is not listed on the EC POC, review the plan to see if it is a Provisional Plan. If so, e-mail the EC RN and let him/her know that we cannot proceed with enrolling the EC Participant until he/she is receiving Medicaid and that the provisional plan will be destroyed.

240.400 Entering Referral in the Database**7-1-09**

Note: the following procedures will change when the IC database is modified to incorporate the referral-screening questionnaire. All IC staff will be provided a copy of the revision to the procedures manual when completed.

The IC database will be searched for the Applicant/Participant to verify if he/she has previously been referred. Verify the record by DOB and SSN. If the Applicant is not in the database, his/her information will need to be entered as a referral.

If the information received is based on an EC POC, the Administrative Specialist II will first verify through MMIS that the Medicaid Number on the EC POC is the **Medicaid Base ID number**. (See Section 240.300) If not, the **Medicaid Base ID number** will be noted on the EC POC.

At the main Participant Record Screen click "Add Ins" (if using Microsoft 2007) and then click, "Create New Record. Key in the new Applicant's information. For EC POC referrals if part of the diagnosis is based on a mental condition (e.g. Alzheimer's), indicate "Needs Representative" unless the RN indicates something more specific.

The screenshot shows the 'IndependentChoices Client Referral' form. A red box at the top right contains the text: 'After notifying the Counselor, click the “Save” tab and the add the record by clicking “Close”'. A red box on the left side contains the text: 'Click “Create New Record” and key in Participant information.' The form itself has a title bar 'REFERRAL - IndependentChoices Client Tracking' and a menu bar with 'Home', 'Create', 'External Data', 'Database Tools', and 'Add-Ins'. The main form area includes fields for 'Caller Name', 'Caller Phone', 'Referred By:', 'Client Mental Status:', 'BASE ID', 'Client First Name', 'Client Middle Initial', 'Client Last Name', 'SSN', 'Primary Phone', 'Secondary/Cell Phone', 'DOB', 'Client Sex', 'Mailing Address', 'County Number', 'County', 'Physical Address (If not same as Mailing)', 'City', 'Zip', 'State', 'IC Nurse', 'Counselor', 'Waiver Indicator', 'EC Nurse:', 'Client Residence', and 'Notes/Comments'. There is a 'Create New Record' button at the top left and a 'Notify Counselor of Referral' button at the bottom right.

For consistency and DHS mail procedure requirements, put cap locks on and enter all information in upper case in all fields other than “Notes/Comments”. Fill in all fields highlighted in green. It is mandatory that the “Referred By”, “Client Mental Status”, and the “Client Residence” fields are completed using the drop down boxes. Specific fields automatically populate based upon entry of a prior field. The Notes/Comments section is for specifics of the referral such as “EC POC referral” or factors the RN or Counselor should be informed of based on any notations on the EC POC. Make sure the contact names and phone numbers are provided and relevant information to start the application process and schedule the enrollment visit are entered.

240.500

Notifying Counselor

7-1-09

Once a new record has been added, the “Notify Counselor” button **MUST** be “clicked” to generate an email automatically that will then be send to alert the Counselor of the referral. On Applicants residing in Region 1 counties, (currently PCDC), add the Applicant’s telephone number (and the contact names and telephone numbers to the email since they disconnected from the IC database.

After sending the email you must click the “Save” tab and then the “Close” tab located at the top of the screen. Return to the Client Record Page of the IC database. You will need to click on the “Refresh” tab in the right hand corner to complete the save process.

240.600**Printing Enrollment Forms****7-1-09**

If the referral received is for an Applicant in Region 2 through 8 and is entered in the IC database by the Administrative Specialist II or the Administrative Specialist III, they will print the appropriate enrollment documents. A contact note will be entered in the IC database indicating that a referral has been entered and the documents printed. That contact note will **not** be sent to the Counselor because they have already received a prior email that the case was entered. The Counselor is responsible for retrieving the documents from the printer, preparing and mailing the enrollment packet to the IC RN and entering the tracking information in the IC database.

NOTE: If circumstances arise, which prevent the printing of the enrollment documents by the Administrative Specialist II or the Administrative Specialist III, they will notify the Counselor.

250.000 Quality Assurance Reports

Quality assurance (QA) checks will be performed by the IC Program Manager each Monday to ensure that persons who lose Medicaid eligibility will not continue to receive services through the IndependentChoices program. Three reports are run each Monday using Medicaid's data warehouse through the Decision Support System (DSS) to identify participants who lost eligibility for IndependentChoices through death, nursing home placement or loss of Medicaid eligibility. Refer to "Business Objects Decision Support System Training Manual" as needed when using the DSS.

Follow these instructions to refresh the reports described in 250.100, 250.200, and 250.300. Enter the DSS using these instructions:

- A. Double-click the Business Objects icon on your desktop.
(<http://arkxixs11/businessobjects/enterprise11s/InfoView/logon.aspx>)
- B. System = arkxixs11. Enter your user ID and password to log in.
- C. The folder's toolbar is on the left. Navigate as follows:
 1. Public Folders
 2. DHS DAAS
 3. Debby Ellis
 4. A Inquiry Folder
 5. IC QA REPORTS
- D. Once you enter the "IC QA Reports" run the Web Intelligence version of these three reports:
 1. IC Deceased
 2. IC Lost Eligibility
 3. IC LTC Open Eligibility

The reports only require being refreshed. Click the refresh icon on the top right of the report pane to get the current report.

After each report is refreshed, print and distribute to each Counselor and to PCDC. Provision of the reports to the counselors supports the IndependentChoices Quality Management Plan by identifying those who no longer meet Medicaid eligibility for the IndependentChoices program. The closing of the RN and database segments ends eligibility for the IndependentChoices program. Contractors and program participants are notified by the Program Manager or by a counselor of such closings.

Below are examples of the reports.

250.100**IC LOST ELIGIBILITY****7-1-09**

Full Recipient Name	Recipient Base ID	Aid Category	Eligibility Begin Date	Eligibility End Date	IC End Date	IC Provider Name and ID
DOE, JANE	1234567001	43	06/01/94	11/21/07	12/31/99	1234568087 - IndependentChoices
DOE, JOHN	7654321001	11	01/01/97	12/10/07	12/31/99	1234568087 - IndependentChoices
SMITH, SAM	2468135001	20	07/01/01	12/31/07	12/31/99	1234568087 - IndependentChoices
COUNT:	3					

250.200**IC LTC OPEN ELIGIBILITY****7-1-09**

Full Recipient Name	Recipient Base ID	IC Begin Date	IC End Date	LTC Eligibility Begin Date	LTC Eligibility End Date	Last Service Date	IC Provider ID
DOE, JANE	1234567001	05/29/90	12/31/99	06/01/94	11/21/07	12/06/07	135507787
DOE, JOHN	7654321001	04/27/80	12/31/99	03/22/07	04/23/07	04/01/07	135507787
SMITH, SAM	2468135001	08/01/04	12/31/99	11/20/06	01/10/07	01/01/07	135507787
COUNT:	3						

250.300**IC DECEASED****7-1-09**

Full Recipient Name	Recipient Base ID	Date Of Death	Eligibility End Date	IC End Date	IC Provider ID
DOE, JANE	1234567001	11/13/07	11/21/07	12/31/99	1234568
DOE, JOHN	7654321001	11/07/07	12/10/07	12/31/99	1234568
SMITH, SAM	2468135001	10/13/07	12/31/07	12/31/99	1234568
COUNT:	3				

250.400 **IC TC Listing**

Reserved for future procedures.

250.400 **APD and IC**

Reserved for future procedures.

260.000 Closed Files**260.100 Overview****7-1-09**

When a participant's case is closed, the Counselor will make sure all relevant IC database entries are complete and that all documents are filed in the case file. A notation will be made by the Counselor as to the date of closure and the reason. The Counselor should make sure the case file contains all documentation related to Personal and Protected Health Information of the participant.

The Counselor will maintain the case files alphabetically in an area they specify in their workstation pending removal to the storage area.

Each Friday afternoon the Administrative Specialist II will collect the closed case files from the Counselors and will file them in the file cabinets located in the storage room.

Once a case file has been placed in the storage area file cabinets, the Counselor will be responsible for filing any documents not originally placed in the disposed case file.

Currently, case files of deceased clients are maintained in the storage area for one year after which they will be defined as "inactive" and sent to storage. Files related to cases closed due to other reasons are maintained in the storage room for two (2) years after which they will be defined as "inactive" and sent to storage. In accordance with DHS Policy 1083, Document and Record Disposition, these documents will be retained for a minimum of six years from the date of closure.

Each December, the Administrative Specialist III and the Administrative Specialist II will be responsible for pulling closed files from the storage area and will prepare them for permanent storage. The Administrative Specialist III will be responsible for insuring that all procedures are followed and required forms are prepared and submitted in accordance with DHS Administrative Procedures Manual, Chapter 706, Record Storage, which is located on DHS Share.

260.200 Expired PCDC EC POC's**7-1-09**

On a monthly basis, the Administrative Specialist II will review the folder of ElderChoices (EC) Plans of Care (POC's) in the contracted counseling region (currently Phillips County Development Center [PCDC]) and will shred the old plan if a new one has been received.

If it is discovered that a current EC POC has not been received and processed, the Administrative Specialist II will contact the EC Nurse assigned to that area via e-mail requesting a current POC or information as to the status of the EC waiver case.

In any case, in which the Administrative Specialist II is notified that there is not a current EC POC for a participant served by PCDC; the Administrative Specialist II will inquire if the participant is still eligible for the EC program from the EC RN.

If the participant is still active with the EC program, the Administrative Specialist II will request an EC POC be forwarded and inform the Program Manager accordingly.

If the EC RN indicates that the person is no longer eligible for the EC program, the Administrative Specialist II should inquire if the loss of eligibility is permanent. If the eligibility is permanent, the Administrative Specialist II should check the Medicaid Management Information System (MMIS) to determine if the former ElderChoices participant remains Medicaid eligible. The Administrative Specialist II will enter a contact note and forward to the Program Manager the status of the former ElderChoices participant's Medicaid eligibility.

The Program Manager will coordinate with PCDC the need for an immediate assessment. If the assessment cannot be completed timely, the Program Manager will document a contact note in the IC database with a recommendation for closure until the assessment can be completed.

270.000 Protection of Personal and Protected Health Information

Act 1526, Personal Information Protection Act (PIPA) is an Arkansas statute which requires DHS to protect Personal Information (PI) and Protected Health Information (PHI). The Health Insurance Portability and Accountability Act (HIPPA) is a federal protection regulation to safeguard private health information of individuals. Personal Information (PI) is information that includes the first and last name of an individual in combination with either the SSN, DL or valid ID card, financial information, or medical information of an individual.

Protected Health Information (PHI) is Personal Information as described above created by a covered entity wherein the medical information relates to a person's physical or mental condition, provision of health care, or payment of health care.

Examples of PHI: First and last names; geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code; Dates, including birth date, admission date, discharge date, date of death, all ages over 89; telephone numbers, fax numbers, e-mail addresses; Social Security numbers; medical record numbers; health plan beneficiary numbers; account numbers; Certificate/license numbers; vehicle identification numbers, serial numbers, driver's license numbers, license plate number; Device identifiers and serial numbers; Web Universal Resource Locators (URLs); Internet Protocol (IP) address numbers; Biometric identifiers, including finger and voice prints; Full face photographic images and any comparable images; Any other unique identifying number, characteristic, or code.

Sensitive Information is the loss, use, modification or unauthorized access to sensitive information, which can adversely affect the privacy of an individual. Case files, medical records, print screens, eligibility forms, etc. contains Sensitive Information.

All DHS employees are responsible for safeguarding sensitive information. Such materials include data recorded in case files, on computer hard drives, and computer peripherals. **All violations are subject to disciplinary action as outlined in DHS Policy 1084 – Employee Discipline.**

- A. Keep PI and PHI information in case files, logs, folders, etc, secured in locked cabinets when you are away from your desk.
- B. Documents to be destroyed should be placed in the locking bins in your facility or shredded if your facility does not have locking bins as soon as possible or at the end of each day at a minimum.

- C. Place bags of shredded documents in the proper location designated at your facility.
- D. Limit the use of sensitive information
- E. Identify forms that could be changed to eliminate the use of a full SSN or where the SSN is not necessary
- F. Use the encrypted DHS Email system to transmit sensitive information instead of faxing.

270.100**Emails****7-1-09**

DHS reserves the right to monitor and log all network activity with or without notice, including E-mail and all web site communications. Users have no reasonable expectation of privacy in the use of these resources. All violations are subject to disciplinary action as outlined in DHS Policy 1084 – Employee Discipline and Policy 1085 – Minimum Standards of Conduct. For complete information, employees are required to review DHS Policies located DHS Share.

Any messages destined for somewhere other than @arkansas.gov that appear to have sensitive data in them will be encrypted before being sent to their destination. DHS staff may force the E-mail to be encrypted by putting the word “SENSITIVE” in the subject of the E-mail.

Content Requirements: Any E-mail message generated by DHS staff that contains PHI shall conform to the following requirements:

- **E-mail Subject Line:** For messages containing PI or PHI, the subject line shall state, in whole or in part, “SENSITIVE”.
- **E-mail Addressees:** E-mail messages may be sent, copied, or forwarded *only* to those persons who have a *need to know* the patient information. Global, group, or broadcast addresses *should not be used* when sending E-mail messages that contain PI. The purpose of this requirement is to avoid inadvertent disclosure to addressees who lack a need to know the PI.
- **E-mail Message:** At the bottom of the message the following privacy warning must be displayed: “Confidentiality Notice: The information contained in this email message and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to which this email is

addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distribution of this transmission is **STRICTLY PROHIBITED**. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachment(s) from your system.”

270.200**Faxes****7-1-09**

Faxes that come in for the Counselors are placed in the “In Tray” located near the fax machine in 5186. Counselors should periodically check for faxes sent to them throughout the day.

Approved Methods of Conveyance: All Fax messages, containing PI and sent by DHS staff to any destination, must be safeguarded for confidentiality and privacy in accordance with federal and state law, and must employ privacy safeguards outlined in this section. Faxes may be sent only to a specific person for whom such release has been determined to be authorized. It should be established, by prior telephone contact, that a specific person is present to receive the transmitted fax.

Content Requirements: Fax messages shall utilize a cover sheet with the word **CONFIDENTIAL** appearing in bold letters near the top of the form. Further, all such Faxes must include a statement regarding prohibition of disclosure of identifying PHI. The statement shall read as follows:

“Prohibition of Redisclosure: This information has been disclosed to you from records that are confidential. You are prohibited from using the information for other than the stated purpose; from disclosing it to any other party without the specific written consent of the person to whom it pertains; and are required to destroy the information after the stated need has been fulfilled, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.”

Fax Transmission Reports: These reports generated by the fax machine show a list of all phone numbers sent faxes or faxes are received from. These reports will be maintained for one year and kept in the folder marked “Fax TX Log Reports” in the tray above the fax machine with the most current in front. They will be destroyed at the end of the one-year time period.

270.300**DHS Information Systems****7-1-09**

IndependentChoices granted access to DHS Information Systems to complete job assignments through mobile computing, remote access, and/or use of peripherals must comply with all DHS policies related to such access. Failure to comply with any policy and associated standards can result in restriction or suspension of all network access to DHS information. DHS employees are subject to disciplinary action, as provided in DHS Policy 1084 and 1085, for violations of this policy.

DHS Information Systems is defined as: DHS Network services (Network, access, E-mail, Internet, etc.), DHS applications (client-server, web-based, mainframe, etc.), or any third-party software legally acquired and installed on the DHS devices for which it was intended. Also, any computer file, on any device in use by DHS or its agents that is shared across the DHS network or requires DHS support or contains DHS-related information, the privacy of which must be safeguarded.

Usage must be approved for each device by completing the DHS Mobile Device Agreement and shall be used only by the person, or persons, explicitly authorized by completion of the Mobile Computing Device Agreement. Compliance with standards pertaining to security of Mobile Computing Devices is mandatory.

Users must immediately notify the DHS IT Security Officer if a device is suspected to be lost or stolen within one business day by utilizing the IT Security Incident Reporting Form located at <http://www.arkansas.gov/DHS/security>

Supervisors of employees with mobile computing devices will notify OST immediately upon termination of employees.

Any device, regardless of ownership, used to process information belonging to DHS or to access DHS Information Systems, is liable to audit and remote monitoring.

270.301**Laptops****7-1-09**

The device must be connected to the DHS Network at least every two weeks to allow for updating of system software.

The device must be joined to a DHS enterprise domain.

The device must be fully encrypted using DHS enterprise approved encryption software.

The device must be kept in a secure location at all times to ensure access by authorized users only.

270.302 Remote Access

7-1-09

Any employee who has been granted access to any DHS information system is accountable for the security of such access.

Remote Connection includes a variety of technologies that enable a user to connect to the DHS Network from devices not directly linked to DHS's Network. For DHS purposes, Virtual Private Network (VPN) technology is preferred where deployed. A VPN is a secure, private network that uses a public network (usually the Internet) to connect hosts (such as DHS's network) with remote users. This is the connection that is currently in use by the IC RN's to complete the MDS-HC.

It is the responsibility of remote access users to ensure that connection to DHS Information Systems is not used by unauthorized persons who may have access to their devices. Users must be made aware that remote access connects from their remote site (e.g., Home, facility, travel locations, etc.) to the DHS Network, so that their device becomes an extension of the network and can provide a path to expose DHS's most sensitive information. The user must take every reasonable measure to protect DHS Information Systems from intrusion and exposure.

All users will be held accountable for remaining familiar with all security requirements.

270.303 Use of Hardware, Software, and Peripherals

7-1-09

A peripheral is a piece of computing hardware that is added to a host computer in order to expand its abilities. The term is used to describe those devices that are optional in nature, as opposed to hardware that is required. Typical examples include joysticks, printers, scanners, USB flash storage devices, thumb drives, and external hard drives.

Any device, regardless of ownership, used to process information belonging to DHS or to access DHS Information Systems, is liable to audit and remote monitoring.

270.304 External Storage

7-1-09

External Storage Media is defined as devices designed with the purpose of storing data in digital form which can be readily removed from a computing device to

which it is attached. (Examples include: CD, DVD, CD-R, CD-RW, DVD-R, DVD+R, DVD-RW, DVD+RW, DVD-RAM, BluRay, floppy diskettes, flash drives, CF media, SD media, MMC media, XD media, magnetic tape, Iomega Zip media, Iomega Jaz media, external media players that allow for file storage, and external hard drives)

Any external storage media removed from any DHS facility must be encrypted utilizing a DHS approved encryption method. This includes but is not limited to CDs, DVDs, any optical storage media, flash drives, portable music players, zip disks, jaz cartridges, backup storage tapes, and portable hard drives.

No external storage media, including privately owned media, may be introduced into any DHS facility without complying with this standard. Commercially recorded, purchased, and stamped CDs and DVDs are allowed in the facility but may not be attached to a DHS Information System.

Storage media that is no longer in use must be securely transported to a DHS CIO-designated location for secure destruction.

270.400 DHS Policy Responsibilities

7-1-09

All DHS Security Policies and Best Practices are accessible on DHS Share under the Privacy and **Security** Tabs. Employees are responsible for regularly reviewing and complying with all applicable DHS policies.

Any compromise in the privacy or security of DHS data must be reported as soon as possible by going to the following link:

<http://dhs.arkansas.gov/reporting/itsec.php>

270.500 Tracking of Released Information

7-1-09

The Administrative Specialist III is the designated HIPPA Facilitator for the IC Program.

Required Tracking is explained in DHS Policy 4011, which is located on DHS Share.

A. You must track PHI provided pursuant to a court order.

B. You do not need to track:

1. Disclosures made for treatment, payment or operations,
 2. Disclosures to the client or made pursuant to a valid authorization of the client or
 3. Disclosures made subject to the client's opportunity to object, including persons who ask for the individual by name.
 4. Disclosures covered by DHS Policy 4011.10, which must be tracked, include
 - a) abuse reports,
 - b) audit reviews,
 - c) PHI provided to avert a serious threat to the health or safety of a person(s),
 - d) PHI provided from a client related to licensure, certification or regulation of a provider or licensee involved w/ the provision of care or services to the client;
 - e) PHI provided pursuant to a court order
 - f) PHI provided to a law enforcement official pursuant to a court order; or PHI provided to a law enforcement official concerning a fleeing felon or client subject to an arrest warrant;
 - g) PHI concerning a deceased client;
 - h) PHI provided to a public health official for the reporting of disease or injury or for the conduct of a published health study or investigation;
 - i) PHI disclosed pursuant to a public record request without the client's authorization;
 - j) PHI provided for research purposes using a waiver of authorization provided by an Institutional Review Board.
- C. You should not be disclosing PHI to anyone not specifically named in a court order or for which you have received an authorization to disclose from the

owner of the PHI or someone for whom an authorization is not required (See 45 CFR Section 164.512 or DHS Policy 4009).

280.000 Purchasing, Equipment, and Travel Reimbursement**280.100 Purchasing Procedures****7-1-09**

In addition to the IndependentChoices internal procedures outlined below, P-Card purchases shall be made in accordance with DHS Policy Number 1097 - "Utilization of Credit Cards for Small Order Purchases", Chapter 607 of the DHS Administrative Procedures Manual, Arkansas Code Annotated Section 19-4-1007, and the State of Arkansas Purchasing Card (P-Card) Program Policies and Guidelines. For the most current state guideline manual, please refer to:

http://www.arkansas.gov/dfa/procurement/pro_purchcard.html.

All purchases should be made electronically whenever possible. If this is not possible, a written request should be submitted to the Program Administrator explaining why an "in-store" purchase is necessary.

Cardholders should check as many sources as reasonable for non-contract items to assure the price and quality is in the best interest of the State, shall ensure the selection is an allowable purchase, and does not exceed the limit set for the P-Card.

Cardholders shall maintain a P-Card Transaction Summary report for all transactions including returns and refunds. They shall submit this along with valid documentation (receipt, transaction slip, invoice, P-Card slip, etc.) regarding each item purchased to the division reviewer (currently Eileen Hood) in accordance with division guidelines. The billing cycle ends on the 15th of each month. Per written communication on 10/29/07, it has been requested that everyone refrain from making any P-Card purchases between the 13th and the 18th of each month if possible. All documentation submitted must include the following information at a minimum: Merchant (vendor) name; date of purchase; description and quantity of each item; cost per item, if available from merchant; total cost of the transaction, cardholder name and card number. This information must be handwritten on the documentation if it is not on the original documentation.

Cardholders shall verify the accuracy of the charges on the issuing bank website as soon as the charges are visible on-line (usually within 48 hours after purchase). They shall immediately report to the division reviewer any discrepancy.

IndependentChoices personnel needing envelopes or forms should submit specific information about the items necessary by email to the Administrative Specialist III. (e.g. 25 large postage paid reply envelopes).

For all other purchases, Requisition Form (DHS 1914) should be completed and submitted to the Administrative Specialist III for completion of a purchase either by use of the P-Card or preparation of a Purchase Requisition in accordance with AASIS procedures and submitted for approval to the designated Assistant Director. Any item not normally purchased must be approved by your Supervisor.

When items purchased through a purchase order are received, the Administrative Specialist III shall post them in AASIS. Purchase information (i.e. vendor, requisition #, purchase order #, goods receipt #, date received, etc.) should be promptly recorded by the Administrative Specialist III on the PO Tracking Log.

280.200 Equipment

7-1-09

The Administrative Specialist III is responsible for maintaining a log of all equipment assigned to the IndependentChoices staff, insuring that the appropriate permissions and approvals are obtained and submitted, and for maintaining a copy of all forms required by DHS.

It is recommended that you “Restart” your computer at the end of the day before going home rather than just logging off in order to clear your memory. Do **NOT** shut down your computer so that system updates generated during the evening hours can be automatically installed on your workstation computer. It is also recommended that each Monday morning you Shut Down and then re-start your computer to allow a more complete clearing of the memory.

Anyone assigned to a laptop or tablet should log on at least every two weeks to receive system generated updates.

Everyone **should** close out of the IC database if they are going to be away from their workstation for any length of time (e.g. home visits or lunch periods) in case modifications need to be made. This is also important in case an unexpected incident occurs which prevents you from returning to your workstation. **Under no circumstance should anyone leave the database open when they leave their workstation for the day.**

To properly close out of the IC database, do not click “X” in the top right hand corner to close out the database. Go to the top left hand corner, click “file – close, then exit. Just “X”-ing out could cause the IC database to fail.

Any suggestions for changes in the database should be submitted to the Program Manager.

All personnel are required to be familiar with and adhere to all DHS policies related to Internet Access and use of equipment. See Section 260.000.

280.300 Travel Reimbursement

7-1-09

IndependentChoices staff seeking reimbursement for work related travel expenses shall comply with the procedures outlined below and shall comply with the procedures outlined in DHS Administrative Procedures Manual, Chapter 304, Travel Reimbursement. All IC staff is responsible for review and compliance of these procedures, which are located on DHS Share.

- A. Travel must be verified before it can be approved and submitted for payment. If you have not completed the TR-1 correctly and/or followed any procedures for verification and approval of the travel, a substantial delay may occur in the approval.
- B. Travel completed after April 1, 2009, which does not include other expenses, must be completed on-line.
 1. To complete an electronic TR-1, you must be logged onto your computer (or another available computer) using your System ID and password.
 2. Open DHS Share and click on the link located on the home page and follow the instructions provided. If you cannot access the DHS Share website, go to Internet Explorer and enter the following website in the navigation field <https://dhsshare.arkansas.gov/dhstr1>
 3. Click on ACTIONS – Fill out a New TR-1 Mileage Form and complete the form making sure you specify required information to support the travel.
- C. A TR-1 submitted for approval is subject to being rejected if supporting documentation or if information is not correctly submitted
- D. **The TR-1's should be completed and submitted each Friday of the week following travel or at least by the end of the month the travel occurred.** IC staff will be advised of dates affecting submission in accordance with end of the year fiscal procedures.

- E. You must write “Direct Deposit Please” in the top right hand corner of a hard copy of a TR-1 is one is submitted if you do not want your check mailed to you.
- F. The IC Program’s Cost Center is 417012. Use the drop down box on the TR-1 form to enter the correct Internal Order Number.
- G. To use your personal vehicle, the “Authorization to Operate a State or Private Vehicle on State Business” is required with a copy submitted to the IC central office.
- H. The goal for submission to Accounts Payable Unit is five days from receipt. Keep in mind that improper completion, holidays, meetings, conferences, auditing and other work activities can affect this goal.
- I. Reimbursement for allowed meals limited to actual expenses for meals within the limitations set by law and policy. The maximum must not be claimed unless expenditures equal or exceed the amount claimed.
- J. Reimbursement for lodging is limited to the single room rate. If more than one person occupies a room, the single room rate must be noted on the receipt. Sales tax rates must be stated on the TR-1 in instances where the sales tax causes the maximum rates to be exceeded.
- K. Reimbursement for lodging must be supported with a hotel document indicating the lodging specifics. The receipts must verify the place of lodging, type of expense, must have claimant signature (initials are not acceptable) and the date expense was incurred. The traveler is responsible for obtaining receipts to support the items listed on the TR-1.
- L. The shortest distance to the destination should be claimed. If the shortest distance is from the official station, that distance should be listed on the TR-1. If the shortest distance is from the employee's residence and the employee departs from his or her residence, that distance should be listed on the TR-1.
- M. Three weeks should be allowed after proper submittal of the TR-1 before inquiries are made to the Payables Unit pertaining to reimbursement of travel expenses. Inquiries should be routed through the travel supervisor who should then contact the Payables Unit if necessary. If the Payables Unit finds errors on the TR-1 or attachments, the TR-1 will be returned for correction to the travel supervisor attached to a Reason for Return Memorandum, Form DHS-1015, indicating the reason(s) for return.

290.000 Fiscal/Employer Agent Reimbursement Checks

All reimbursement checks received from the contracted Fiscal/Employer Agent (PALCO) shall be given to the IC Program Manager.

The IC Program Manager will total all checks and prepare a report based on the refunded amounts.

This report showing the refunds to the individual participant accounts will be sent electronically to EDS to enable them to insure they are correctly deposited.

The IC Program Manager will provide a hard copy of the report and the original checks to the Administrative Specialist III.

The Administrative Specialist III will prepare a Cash Receipt Log to comply with Office of Finance and Administration guidelines on depositing funds as follows:

- A. Open the IC Historical Records tab of the main IC SharePoint site.
- B. Click on Check Register on the right hand side list.



C. Open the 00-Template



D. The Administrative Specialist III will key in the checks according to the template design.

	A	B	C	D	E	F	G	H	I	J	K
1				AGING AND ADULT SERVICES CASH RECEIPTS LOG							http://dhssshare/DO/DDJ
2	Source of Receipt	Save to SharePoint		Check Information			Suspension		Disposition		
3							Signed Out By		To DAS Cash Receipts		
4	Received From	Date	Check Maker	Check Number	For	Amount	Date	Name	Comments	Date	Delivered By
5	Ind. Choices	11/23/2007	Palco	241719	Prov Refund	\$ 9.55	11/05/2007	C. Garrett	Mcaid Prgrm	11/05/2007	C. Garrett
6	Ind. Choices	11/23/2007	Palco	241732	Prov Refund	\$ 408.90	11/05/2007	C. Garrett	Mcaid Prgrm	11/05/2007	C. Garrett
7	Ind. Choices	11/23/2007	Palco	241737	Prov Refund	\$ 198.95	11/05/2007	C. Garrett	Mcaid Prgrm	11/05/2007	C. Garrett
8	Ind. Choices	11/23/2007	Palco	241784	Prov Refund	\$ 219.98	11/05/2007	C. Garrett	Mcaid Prgrm	11/05/2007	C. Garrett
9	Ind. Choices	11/23/2007	Palco	241821	Prov Refund	\$ 168.07	11/05/2007	C. Garrett	Mcaid Prgrm	11/05/2007	C. Garrett
10	Ind. Choices	11/23/2007	Palco	241822	Prov Refund	\$ 21.70	11/05/2007	C. Garrett	Mcaid Prgrm	11/05/2007	C. Garrett
11											
12	TOTAL					\$ 1,027.15					

- E. Verify that the total received matches with the total of the Program Manager's report.
- F. Save the document by clicking on "Save to SharePoint."
- G. Print the document; make a copy of the document and the checks (if not already copied).
- H. The original report prepared by the Program Manager, the original Cash Receipt Log, a copy of the Cash Receipt Log, with the original checks are to be hand carried to the Accounts Receivable Department, which is located in the basement of Donaghey West, as soon as all checks are recorded and the documents copied.
- I. The Accounts Receivable staff will verify the checks with the Cash Receipt Log.
- J. Request that your copy of the Cash Receipt Log be date stamped and initialed.
- K. A copy of the report prepared by the IC Program Manager, the photocopy of the Cash Receipt Log that has been date stamped and initialed, and a copy of the

checks are hole-punched and filed in binders labeled PALCO REFUNDS by date with the most current one on top.

300.000 Overview**300.100 General Duties****7-1-09**

The counselors are often the first contact the public has with program staff. They perform a program mentoring role for the program participants.

Consumer-directed counseling is not traditional case management. Consumer-direction offers greater choice and control over all aspects of service provision, from developing cash expenditure allowance plans to hiring an assistant, defining the assistant's duties, and deciding when and how specific tasks or services are performed.

Consumer-direction fosters greater choice and control along several different dimensions. Participants in IndependentChoices are afforded as much independence and autonomy as possible in deciding on their cash expenditure plan, and the types, amounts and sources of personal assistance services they receive. Counseling must be available to the extent the participant desires. If the well being of a participant is compromised because of the poor choices made by him/her or the representative, the Counselor will work to resolve those situations in a manner respectful of the independence and integrity of the participant.

IndependentChoices Counselors are responsible for performing:

A. Orientation to the project and the concept of consumer-direction

1. Teach the participant about program responsibilities, empowerment and the philosophy of consumer-direction.
2. Assist the participant in understanding their role as the employer and the payroll process.
3. Assist the participant in understanding fraud and its consequences.
4. Explain policies to the participant which may affect the participant's eligibility.

B. Enrollment of new participants

1. Assist the participant/representative with the completion of the enrollment forms and development of a Cash Expenditure Plan detailing the use of their

budget.

2. Assist with obtaining MD signature, if needed.
3. Work with the participant to help determine the start date of the participant.
4. Submit billing through MMIS in a timely manner.

C. Offer skills training (to the degree necessary) on how to recruit, interview, hire, evaluate, manage or dismiss assistants.

1. Assist the participant in consumer direction (hire/terminate/supervision).
2. Offer methods the participant can use to keep up with worker hours and time keeping, and his or her role in appropriate billing practices.

D. Consumer-directed counseling support services;

1. Front line support to the participant or their representative.
2. Work with the participant to problem solve when needed.
3. Communicate with participant regarding any problems or need for changes.

E. Case Management and Counseling Support Tasks

1. Work with participant/representative to instate and modify the CEP upon request or as necessary.
2. Monitor participant eligibility and service delivery.
3. Work with the IndependentChoices and Waiver nurses regarding participant.
4. Coordinate agency services prior to any discontinuation of IC services.
5. Ensure integrity of Personal Health Information and follow proper disclosure guidelines.

300.200 Working Relationships**7-1-09****A. Adult Protective Services**

All DHS employees are mandated reporters of adult abuse; therefore, any cases of suspected abuse should be reported immediately to APS field staff or to the APS abuse hotline at 1-800-482-8049. Refer to the appendix for details on reporting guidelines.

B. Alternatives for Adults with Physical Disabilities (AAPD) Waiver

An Alternatives participant is not automatically precluded from receiving IndependentChoices services. Medically necessary IndependentChoices services may be provided, but only if it is included in the evaluation and plan of care and it is not a duplication of services. The Alternatives (AAPD) RN/counselor must first utilize all of the hours included in Alternatives benefit limit (8 hours). Then, if more services are necessary, they can refer those hours to IC.

C. Arkansas Department of Health (ADH) and Other Personal Care Agencies

The counselor should work closely with any existing agency to coordinate service transition to avoid duplication of services. The IC staff should check with the Department of Health contacts to ensure services are stopped prior to IC service initiation, as well as checking through MMIS. The counselor should also work with these agencies to begin delivering services to the participant after IC participation ends, if necessary.

D. Counseling Contractor

IndependentChoices contracts some counseling services in order to handle the volume of cases that exist in the state. This contractor's obligations are outlined in Section 620. Counselors will coordinate and communicate with this contractor regarding new referrals, eligibility, billing, active participants, quality issues, and contractor concerns.

E. Choices in Living Resource Center

The Choices in Living Resource Center is a working unit within DAAS that receives many calls for information on DAAS services. They provide information on the various programs available, and make referrals as necessary. Counselors take referral information from this unit, and clearly indicate those referrals in our system. This allows us to provide information to the Resource Center to follow up on referral progress.

F. Developmental Disabilities Services (DDS) Waiver

The DDS waiver is a home and community based program offered through the Division of Developmental Disabilities Services. Under the IC state plan guidelines, DDS waiver participants may receive their personal care through

IndependentChoices if residing outside of a congregate setting.

G. ElderChoices (EC) Waiver

ElderChoices waiver participants are eligible for IndependentChoices. These participants will receive the level of care designated on the EC Plan of Care. Each county has at least one specific nurse assigned for EC. Some counties have several nurses that divide the caseload.

H. Financial Management Services Contractor

IndependentChoices contracts financial management services in order to process payroll, withhold and report federal and state tax information, and manage the participants budgeted funds. This contractor's obligations are outlined in a Section 610. Counselors will coordinate with this contractor to ensure funds are provided by EDS, that all enrollment forms are completed, and that timesheets are submitted correctly and processed properly.

I. Hospice Care

The receipt of Hospice Care automatically precludes an individual from receiving IndependentChoices services. The receipt of Hospice Care includes the provision of personal care services. This is considered duplication of services and the individual is not eligible for IndependentChoices. There is one exception that exists, which only applies to ElderChoices Waiver (EC) participants. An EC participant who is receiving Hospice Care may receive Adult Companion Services (ACS) through IC, without personal care. This is also the only situation where adult companion services can be provided without personal care through IC.

310.000 Applicant**310.100 The Applicant Process****7-1-09**

The Applicant is the first step toward becoming a participant in the IndependentChoices program.

- A. Interested parties call the IndependentChoices program toll free number - (888) 682-0044.
- B. The phone system will instruct the caller to select an option, directing them to the appropriate staff member. The staff member will discuss the program with the caller, confirm eligibility, and enter the information into the IndependentChoices Database, if eligible. The Applicant screening questionnaire will be used to obtain this information.
- C. If the appropriate staff member is not available, the voicemail system instructs the caller to leave their name and telephone number, the person's name they are calling on behalf of and that person's Medicaid number. Their telephone call will be returned within one working day of the date the message was received.
- D. Each staff member has a voicemail system, and they will record all calls on a Telephone Log. They will call back those requests for enrollment and forward other calls to the appropriate staff member, if necessary.
- E. All newly entered Applicants transfer immediately into a Pending Enrollment List that the IC Registered Nurses (IC RNs) access.
- F. Applicants for applicants in the PCDC contract region should be informed that their information will be transmitted to the contractor, who will follow up with them. These Applicants are entered the same, but forms are not sent out by the counselor. The counselor will stop processing them after entering the record into the IC Database. The Applicant will then be sent on the following Friday to the contractor to process.

NOTE: Some cases will be referred through the ElderChoices program via submission of an EC POC and Applicant. These Applicants are processed by the administrative staff. (see Section 204.000)

310.200 Eligibility Screening**7-1-09**

To be eligible for IndependentChoices, a participant must:

- A. Be 18 years or age or older;
- B. Be eligible for Medicaid (confirmed by MMIS);
- C. Be receiving personal care or be medically eligible to receive personal care;
- D. Be willing to participate in IndependentChoices and understand the rights, risks, and responsibilities of managing their own care with an allowance; or, if unable to make decisions independently, have a willing decision-making partner who understands the rights, risks and responsibilities of managing the care of the participant with an allowance.

310.210 Decision-Making Partner Designation**7-1-09**

- A. A decision-making partner will be required if the individual interested in participating has a court appointed legal guardian, or if he/she has a diagnoses of Alzheimer's or dementia.
- B. Further, a decision-making partner will be required for any potential enrollee who is unable to understand his/her own personal care needs; make decisions about his/her own care; organize his/her life style and environment by making these choices; understand how to recruit, hire, train and supervise personal care assistants; understand the impact of his/her decisions and assume responsibility for the results; or when circumstances indicate a change of competency or ability to self-direct demonstrated by non-compliance with the IC Responsibilities and Agreements. The potential enrollee, nursing staff, counseling staff, or representatives of the Counseling/Fiscal Agency may request a decision-making partner.
- C. A decision-making partner may be a legal guardian, other legally appointed representative, an income payee, a family member, or friend. The decision-making partner must demonstrate a strong personal commitment to the participant; demonstrate knowledge about the participant's preferences; agree to a predetermined frequency of contact with the participant; be willing and capable of complying with all criteria and responsibilities of participants; be at least 18 years of age; obtain the approval from the applicant and a consensus

from other family members to serve in this capacity and be willing to become payee of the potential enrollee's income sources.

- D. A decision-making partner may NOT be paid for this service; be hired by the potential enrollee; be known to abuse alcohol or drugs, or have any history of physical, mental or financial abuse.
- E. All decision-making partners will be required to complete and sign a Decision-making partner Screening Questionnaire and Designation of Decision-Making Partner Form.

310.220 Communications Manager Designation

7-1-09

If the participant is able to make their own decisions, but requires assistance communicating, they may appoint a Communications Manager. The Communications Manager will be able to sign forms, speak with IndependentChoices, and otherwise assist in communicating at the direction of the participant. This person cannot be paid for their service, and cannot be the paid personal assistant.

310.300 Obtain Necessary Information

7-1-09

The Applicant must be called in by the participant or the person responsible for them. The Applicant may NOT be called in by the person seeking to be employed by the participant. The person taking a Applicant should obtain all of the information listed on the Applicant screen of the IC Participant Database. Part of this information is available through MMIS, but should be confirmed with the caller. If the participant cannot or does not wish to make their own decisions, a decision-making partner may be designated.

310.400 Information to Provide

7-1-09

Once eligibility has been established, the staff member receiving the call should provide the caller with details about the program and how enrollment will proceed. Details to provide include:

- A. A summary of the enrollment process.
- B. An explanation of the IC RN home visit.

- C. The requirement of a doctor's visit within 60 days.
- D. What paperwork to expect, and when to expect it.
- E. Their obligation to keep in contact and respond to requests from DAAS.
- F. Program responsibilities and expectations.

310.500 Enter Applicant into System

7-1-09

Once the caller understands the program obligations and wishes to enroll, the applicant's information needs to be entered into the IC Participant Database. All highlighted fields must be entered, or the database will not accept the Applicant. Upon completion, the basic information should be e-mailed to the relevant staff using the e-mail button on the Applicant screen.

310.600 Start Forms and IC RN Processes

7-1-09

Once the Applicant is entered and saved in the database, the next step depends on the position of the staff taking the Applicant as follows:

A. Administrative staff takes Applicant:

Staff member prints out forms and e-mails counselor to continue with mailing out forms, informing PALCO and following up with the IC RN.

B. Counselor responsible for new case takes Applicant:

Counselor prints out and mails forms to the IC RN. The counselor then informs the IC RN and PALCO.

C. Counselor not responsible for new case takes Applicant:

Counselor e-mails information to the counselor responsible for the new case. That counselor will then mail out the forms and follow up with the IC RN and PALCO.

PALCO will then follow up with the participant regarding completion of the employee/employer paperwork. The IC RN will schedule a home visit and obtain the enrollment paperwork at the time of that visit.

310.610 The Enrollment Packet**7-1-09**

The Enrollment Packet consists of the following forms for enrollment:

<u>Enrollment Forms*</u>	<u>Communication Forms*</u>
Participant Responsibilities and Agreements	Disenrollment Form
Backup Worker	Participant Address and/or Phone Number Change
Authorization to Disclose Health Information	Changing or Adding a Worker
<u>Designation Forms</u>	<u>Additional Forms (If Requested)</u>
Communications Manager / Decision-Making Partner Fact Sheet	Media Consent
Designation for Decision-Making Partner	Consent to Use Name, Photograph & Biographical Data
Designation for Communications Manager	Arkansas State Police Individual Record Check

**These forms are required to be sent to all applicants.*

The remaining forms will be obtained by PALCO.

310.700 Case Closure Prior to Self-Direction**7-1-09**

- A. **Applicant declines during initial conversations:** If the Applicant is not interested in enrolling during the initial telephone conversations with the Counselor, the Counselor will code the appropriate Refuser Code into the Applicants case file in the database, which will remove the Applicant from the pending list. The counselor should then make a contact note to document the specific reasons for closure.
- B. **Applicant declines during home visit:** If the Applicant is not interested in enrolling at the home visit, the RN will notify the IC RN Supervisor. The IC RN Supervisor will look up the Applicant's case file in the database and key the appropriate Refuser Code and the date of the home visit or telephone call. This will remove the participant from the Pending Enrollment List. The counselor should then make a contact note to document the specific reasons for closure.

- C. **Applicant does not return enrollment paperwork:** If the Applicant does not return the paperwork within the allotted 14 days from the date the paperwork was sent, PALCO will attempt to resolve any problems over the phone. If PALCO is unable to obtain the missing paperwork, they will then send out a letter to indicate that we must have the paperwork back to continue with enrollment. If a response is not received to this letter within 14 days, PALCO will inform the counselor. The counselor will enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.
- D. **Applicant cannot be contacted:** If the Applicant does not maintain a way to be contacted, the counselor will send out a letter requesting current contact information. This letter will allow 10 days for the Applicant to respond. If no contact is received at the end of this time period, the counselor will enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.
- E. **Applicant loses Personal Care eligibility:** If the Applicant loses Medicaid eligibility, or if their category changes to an ineligible category, then the Applicant is no longer eligible for IndependentChoices. The counselor will contact the family to inform them of the reason, and encourage them to work to get it corrected, if possible. The counselor will then enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.
- F. **Applicant moves into a Nursing or Assisted Living Facility:** If the Applicant moves into a nursing or assisted living facility, they will no longer be eligible for IndependentChoices. The counselor will enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.
- G. **Applicant receives Hospice services:** If the Applicant receives Hospice services, they are not eligible for IndependentChoices Personal Care. It is considered a duplication of services. The counselor will enter the appropriate

Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.

NOTE: There is a special allowance for Adult Companion Services (ACS) involving ElderChoices (EC) participants. EC participants receiving Hospice may receive their ACS care through IC, but not any Personal Care. ACS is allowed to be delivered at the same time as Hospice.

H. Applicant enters into Alternatives for Adults with Physical Disabilities

(AAPD): If the Applicant enrolls into the AAPD program, they are generally not eligible for IC Personal Care. The counselor will enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.

NOTE: There is an exception to this rule. If an AAPD participant is receiving the maximum allowable hours through the AAPD program, AAPD waiver staff can refer them to IC for additional hours. This is only allowable in very special circumstances and must be coordinated with the IC Nursing Supervisor and waiver staff.

I. Applicant passes away: If the Applicant passes away, the counselor will enter the appropriate Refuser Code into the case file in the database. No notice or correspondence to the family is necessary. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.

J. IndependentChoices IC RN determines lack of physical need for personal care: If the IC IC RN determines that personal care is not necessary, the IC RN will inform the Applicant and the IC counselor. This decision is not subject to appeal. The counselor will send a letter to officially inform the Applicant that they are not eligible for Personal Care. The counselor will then enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.

K. Applicant's physician will not authorize personal care: If the Applicant's

primary care physician (PCP) will not authorize the Applicant's personal care, they cannot enroll onto the IndependentChoices program.

1. If this is because the Applicant has not seen the physician within 60 days, the Applicant must schedule an appointment. If the Applicant schedules a new appointment, the counselor will resubmit the paperwork to the physician at that time.
2. If the physician will not sign because he/she disagrees with the need for personal care, the Applicant is not eligible for services. If they change PCPs, the assessment can be submitted to the new physician after a visit to that physician has occurred.
3. If the Applicant is still unable to get physician authorization, the counselor will send a letter informing the participant of the reason they are ineligible. They will then enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure.

L. Change in Applicant's status and other reasons: If the Applicant has a change in status that will make them ineligible for services, the counselor should send out a letter explaining the reason the Applicant is ineligible. The counselor will then enter the appropriate Refuser Code into the case file in the database. This will remove the case from the pending list. The counselor should then make a contact note to document the specific reasons for closure. The following is a list of some possible reasons a Applicant's status could make them ineligible for services:

1. Applicant moves out of state.
2. Applicant home environment unsuitable for home services.
3. Lack of family support.
4. APS findings indicate Applicant not appropriate for participant-directed care.
5. Program too complicated for participant/decision-making partner.

320.000 Initial Assessment**320.100 Process Plan(s) of Care 7-1-09**

As soon as the Counselor logs receipt of the Plan of Care (POC) into the tracking tab of the database, the Counselor will review the information to determine the next step in processing. The POC can include any of the following:

- A. ElderChoices POC (9503)
- B. IndependentChoices POC (DHS-DMS-618)
- C. MDS-HC Packet

The following sections outline the processing of these different kinds of assessments.

320.200 ElderChoices 9503 7-1-09

When an ElderChoices Plan of Care (EC POC) is received, it is logged in the EC POC tab. The services provided and the trackings for authorization are all tracked on this tab. The diagnoses are listed in tracking. This is all done by the administrative staff prior to the counselor receiving it.

All ElderChoices participants must have a home assessment conducted by an IC RN using the DHS-DMS-618 form. They must also receive physician authorization of the services on the DHS-DMS-618. If the personal care hours requested on the EC POC are above 14.75, then the IC RN must complete an MDS-HC in order to request an EOB. If the IC RN does an assessment on an EC participant and determines a need for hours different than the hours listed on the EC POC, the two IC RNs must decide the number of hours that would be appropriate.

320.300 IndependentChoices DMS-618 7-1-09**A. Initial Receipt and Processing**

When a Personal Care Assessment and Service Plan (DHS-DMS-618) are received, there are several things that must be considered.

1. Upon receipt of the DMS-618 from the IC RN, the DMS-618 receipt date should be logged into tracking by the counselor. The DMS-618 should then

be looked over to ensure everything has been received.

2. If the hours requested exceed 14.75 or the participant is under 21 years of age, there must be an MDS-HC assessment packet included. The MDS-HC should be comprised of a: Summary sheet; Resource & Utilization Group (RUG) report; Client Assessment Protocols (CAP) report; Medications Listing; and detailed report listing results of assessment.
3. The physician information should be updated based on any data provided on the DMS-618 about the physician, and the current physician should be marked as Active in the database on the physician tab.
4. The physician must be a Medicaid Provider and must have seen the applicant within 60 days of the Assessment. (IC RN's have been asked to have the family contact the physician at the enrollment visit to obtain the physician's fax number and list it on the Assessment Form for ease of faxing)
5. If the physician's fax number is not listed on the Assessment, the physician phone number should be. The Counselor will have to call the physician's office number and obtain the fax number. Alternatively, the counselor can use the physician lookup tool in the database to identify a current fax number for the physician. **NOTE:** The physician information must be keyed into the database case file of the applicant.
6. Once the Counselor has confirmed that everything necessary is included, the packet can be disassembled to retrieve the relevant forms to be submitted to the physician. Only the DMS-618 (with narrative) must be sent to the physician. In order to complete the authorization, the following must be received from the Medicaid Primary Care Physician: Signed DMS-618 (Page 6); Date of Exam within 60 days of physician signature; Valid Medicaid ID. This request should be faxed to the doctor using the cover sheets that can be created in the Counselor Forms Generator (CFG) program in InfoPath. All items being requested should be marked, and the number of pages being sent should be indicated.
7. If the authorization is not received within 5 days of the initial request, another request should be made. At this point, contacting the physician's office or the participant can often speed up the process. The new request should be indicated so as to be noticed upon receipt. If there is no response to the

second request within 5 days, then a third request should be made. The third request has its own fax in the CFG. This fax should be used to give official notice that the participant cannot receive services without authorization, and allow up to 10 days to receive the completed forms before denying services. The applicant/participant should be notified by phone or mail of the situation, so they can assist in obtaining the authorization. When the required items are received from the physician, the date should be logged into tracking in the database.

B. Physician Not Authorizing Assessment for New Applicant

If the physician declines to sign the Assessment, the Counselor will contact the applicant to notify him/her that without physician authorization for personal care they cannot enroll in the IndependentChoices program. The applicant may choose to make an office appointment with a different Medicaid certified physician. If they do, this physician will be the contact for authorization. If this physician declines to sign the Assessment also, the applicant must be notified that his/her enrollment into the IndependentChoices program has stopped. They cannot enroll in the IndependentChoices program without physician authorized personal care. The Counselor will key in the appropriate Refuser Code for tracking purposes. See 310.700 for refuser code descriptions.

C. Physician Not Authorizing Assessment for Continuing Participant

If the physician declines to sign the Assessment, the Counselor will contact the participant to notify him/her that without their physician's authorization for personal care they cannot continue to participate in the IndependentChoices program. This information should be communicated to the Program Manager, so a decision can be made regarding the care. The participant may choose to make an office appointment with a different Medicaid certified physician. If they do, this physician would be the contact for authorization. If this physician declines to sign the assessment also, the participant must be notified that his/her participation in the IndependentChoices program will be stopped. They cannot be a participant in the IndependentChoices program without physician authorized personal care. The Counselor will key in the appropriate Disenrollment Code for tracking purposes. The Counselor must then officially notify the participant through certified mail of their disenrollment, and complete the MMIS updates to close the case. See section 370 for details on case closure.

D. Authorization for applicants under the age of 21

Requests for any personal care for applicants under the age of 21 must be approved by Qsource, regardless of hours requested. The process for this is detailed in section 320.500.

E. Authorized Assessment <=14.75 hours per week

Once the physician has signed the Assessment, the physician's office will normally fax it to the number listed on the fax cover sheet faxed by the Counselor. It is requested that they do so. (There are rare times when the physician will mail it in to the IC Central Office or mail it to the UR address listed on the Assessment. It is one of the Counselor's duties to make sure that the Assessment is received timely, as described in Section 320.300)

The assessment authorization dates and tracking must be updated to reflect the new authorization. The assessment should then be filed in the participant's case file.

If the assessment is for a new applicant, the Counselor should check on the status of the enrollment paperwork (See 330.100) and proceed with enrollment if the paperwork is completed.

F. Authorized Assessment >14.75 Hours Per Week

When a physician has signed (authorized) an assessment that provides more than 14.75 hours per week of IndependentChoices personal care, the next step is to send the assessment for Extension of Benefits (personal care hours >14.75) approval. There are two entities that process extensions of benefits.

320.400 Extension of Benefits**7-1-09**

- A. If the Authorization requires an extension of benefits (above 14.75 hrs), and the applicant is age 21 or older, then a packet must be assembled to go to Utilization Review (UR.)

1. Requests made to UR must be submitted within 60 days of the date of home visit. Non-compliance can result in a delay of effective date, or a denial.

2. The requested authorization period for a new enrollment should be from the date of the physician authorization to one year from that date.
 3. The requested authorization period for an active participant with a currently authorized extension of benefits (within 60 days of expiration) should be from the expiration of the prior authorization to one year from that date.
 4. The requested authorization period for an existing participant without a currently authorized extension of benefits should be from the date of the physician authorization to one year from that date.
- B. Authorizations for applicants under the age of 21 are processed according to the guidelines outlined in Section 320.500.

320.410 Utilization Review Extension of Benefits

7-1-09

A. Utilization Review (UR)

1. UR approval is required for any hours exceeding 14.75 per week for personal care under the Medicaid Personal Care Program requirements (for those applicants over the age of 21). The following should be submitted, in order, to UR to obtain approval:
 - a) UR Extension of Benefit Request Cover Sheet
 - b) RE screenshot of participant MMIS
 - c) The DMS-618, with Medicaid ID and Date of Exam (within 60 days of signature) on page 1, the ICD9 codes on page 2, the physician signature on page 6, and the authorization hours and dates on page 7
 - d) The MDS-HC assessment, RUG, CAP, and medications reports.
 - e) If the applicant is an ElderChoices participant, the matching EC Plan of Care must also be included. See below for directions on requesting a matching Plan of Care if the IC RN assessment hours differ.
 - f) Optional: P1 screenshot from MMIS of PCP provider information.

2. Once the Counselor has gathered all the documents required for UR, the Counselor will record the date taken to UR in the database and give the assessment to the RN Supervisor. The date and type of request (i.e. First Request, Increase, or Continuation) should then be logged into tracking in the database.
3. According to the Medicaid Personal Care Manual, UR has 15 days to approve or disapprove the UR Request for Extension of Benefits (hours over 14.75).
4. Once UR makes a decision, they will deliver the completed packet to their outbox. The status of the request should be logged (approved, denied, or partially approved); along with the date received back and any notes the UR physician may have written. UR will notify the participant of any kind of denial or partial approval, so they know their appeal rights. The counselor should notify the IC RN (and EC RN, if applicable) of the decision.

B. Requesting ElderChoices Approval >14.75

If the assessment is for an ElderChoices participant and if, during the IndependentChoices home visit the IC RN has determined that 14.75 hours of care per week are necessary, the IC RN will perform an Extension of Benefits assessment. If the assessed hours are not the same as the hours on the EC POC, the IC RN must discuss the assessment with the EC RN. Once an agreement is reached regarding a level of care, the counselor should obtain a revised plan of care for any plan of care that was changed as a result of the decision. If RNs cannot agree on a level of care, the EC RN has the final say on the level of care. If the EC RN agrees to the change, the assessment is then sent to the physician for authorization.

C. ElderChoices Disapproval of Assessment Hours

If the ElderChoices RN (EC RN) determines that the personal care hours requested by the IC RN and authorized by the physician exceed what they deem needed by the applicant the EC RN may choose to continue with the POC currently in place by emailing the Counselor and notifying the Counselor that they will not authorize the hours. In this case the hours noted on the EC POC are what the applicant will receive per week. **NOTE:** The EC POC is what determines the personal care hours for the applicant who is on the ElderChoices program. If the IC and EC nurse cannot agree on a level of care, the EC RN

decision takes precedence over what the IC RN determines on the Assessment.

Upon calling the participant/applicant with the amount of hours the participant/applicant may choose to contact the EC RN and discuss the hours which may or may not result in a change of EC RN approved hours.

D. ElderChoices Approval of Assessment Hours

The Counselor sends an EC POC Revision Fax Form request to submit a revised EC POC indicating the needed hours to the EC RN. If the EC RN determines that the personal care hours requested by the IC RN and authorized by the physician are needed by the participant/applicant, the EC RN will send the Counselor a revised EC POC indicating the revised hours or services. Upon receipt of the UR Packet (includes the revised EC POC, the physician authorized Assessment, the UR Cover Sheet and a copy of the RE Screen of the MMIS system for the applicant), the Counselor will log the date the UR request is sent into the tracking in the database, then give the completed packet to the IC RN Supervisor for review and submission to UR.

E. UR Approval

If UR approves the Extension of Benefits request, the Counselor will log the date received from UR and the hours approved. The authorization dates must then be updated in the main record. The Counselor will continue with the enrollment process, if the assessment was for a new applicant.

F. UR Disapproval

If UR disapproves the Extension of Benefits request, the counselor will check the reasons given for the disapproval. The counselor will then inform the participant/applicant of the denial and the reasons. The counselor should explain the appeals process and their right to appeal to obtain the originally requested hours. The participant/applicant is responsible for submitting an appeal if they choose to contest the decision.

If UR still disapproves the hours, the Counselor will update the IC Database record with the final decision from UR and update the hours and authorization. If the assessment was for a new applicant, the Counselor will continue with the enrollment process allowing 14.75 hours per week for personal care (or the

partially approved hours, if applicable).

The counselor should inform the IC RN of the decision from QSource.

320.500**QSource Request for Authorization****7-1-09****A. QSource Request**

1. QSource approval is required for any requested personal care hours for anyone under the age of 21. It should be noted that QSource will not accept a request unless it is received within 30 days of the initial visit. This is very important. The following should be submitted, in order, to Qsource to obtain approval:
 - a) QSource Cover Sheet requesting 6 months of authorization.
 - b) RE screenshot of participant MMIS
 - c) The DMS-618, with Medicaid ID and Date of Exam (within 60 days of signature) on page 1, the ICD9 codes and Special Administrative Section on page 2, and the physician signature on page 6.
 - d) The MDS-HC with the summary sheet on top should also be included.
2. Once the Counselor has gathered all the documents required for QSource, the Counselor will record the date sent to QSource in the database and fax the request directly to QSource. The date and type of request should then be logged into tracking in the database.
3. Once QSource makes a decision, they will send a letter detailing the level of care approved. The status of the request should be logged (approved, denied, or partially approved), along with the date received back and any notes QSource may have included. The units approved can be converted to weekly hours using the QSource Approval Converter on SharePoint.

B. QSource Disapproval

If QSource disapproves the request, the Counselor will check the reasons given for the disapproval. If the reasons given are reasons that the Counselor feels can

be disputed, he/she should discuss the assessment with the RN Supervisor. If the RN Supervisor agrees, the counselor will write a narrative of the reasons requesting reexamination of the Assessment. The narrative will be submitted to QSource along with the Assessment. The Counselor will re-log the UR date of the reexamination.

If QSource still disapproves the hours, the Counselor will update the IC Database record with the final decision from QSource and update the hours and authorization. If the assessment was for a new applicant, the Counselor may only continue with the enrollment process if some level of care was approved.

C. QSource Approval

If QSource approves the request, the Counselor will log the date received from QSource and the hours approved. If the assessment was for a new applicant, the Counselor will continue with the enrollment process.

330.000 Enrollment

330.100 Process Enrollment Paperwork

7-1-09

The Enrollment Process

- When the referral process is complete (see section 310), the counselor will send the enrollment packet out to the IC RN.
- The counselor will notify PALCO by e-mail of the referral. PALCO will then send out the tax forms to be completed.
- The IC RN then calls and schedules a home visit meeting. If the referral is still interested at the home visit, the IC RN will perform a medical services assessment for program eligibility. They will also collect the enrollment and designation forms. The assessment and other forms will be mailed by the IC RN to the counselor.

Enrollment Packet

The Enrollment Packet sent by the counselor consists of the following forms:

<u>Enrollment Forms*</u>	<u>Communication Forms*</u>
Participant Responsibilities and Agreements	Disenrollment Form
Backup Personal assistant	Participant Address and/or Phone Number Change
Authorization to Disclose Health Information	Changing or Adding a Personal assistant
<u>Designation Forms</u>	<u>Additional Forms (If Requested)</u>
Communications Manager / Decision-Making Partner Fact Sheet	Media Consent
Designation for Decision-Making Partner	Consent to Use Name, Photograph & Biographical Data
Designation for Communications Manager	Arkansas State Police Individual Record Check

**These forms are required to be sent to all applicants.*

NOTE: It is mandatory that each enrolled participant have a backup personal assistant, a decision-making partner (if necessary), and a current employment packet on file for the employee who will primarily perform the personal assistance services for the participant. If the participant's backup personal assistant is to be a paid personal assistant an employment packet must also be received on that personal assistant. If this is the case, PALCO should be notified to send out an additional employee hire packet.

Tax Forms Packet

The Tax Forms Packet sent by PALCO consists of the following forms:

Employer	Employee
Limited Power of Attorney	Employment Application*
Application for Employer Identification Number (SS-4)	Participant Personal Assistant Agreement
Employer Appointment of Agent (2678)	Employee's Withholding Allowance Certificate (Federal W-4)
Tax Information Authorization (8821) -2 Copies	Employee's Withholding Exemption Certificate (State AR4EC)
	Employment Eligibility (I-9)
	Earned Income Credit Advance Payment Certificate (W-5)
	Provider Agreement**

* PALCO will provide IC CENTRAL OFFICE with a copy of this form.

** PALCO will provide IC CENTRAL OFFICE with the original of this form.

Incomplete Enrollment Packets

Upon receipt of the enrollment forms or tax form copies, the Counselor will record their receipt in the database and examine each packet for completeness. If the Enrollment Packet is missing mandatory forms the Counselor will contact the participant/partner/manager and mail out the necessary forms.

330.110 Establish Backup Plan

7-1-09

A. Policy and procedure in tracking and monitoring through the database

those who are without a backup personal assistant. Each enrollment packet received must include a backup personal assistant form and, if the participant's backup personal assistant is to be paid, an employee application and Participant/Employee Agreement on file. This information is keyed into the IndependentChoices database. Reports of participant backup personal assistants can be obtained through the report panel in the IC Database.

- B. The period of time a participant is allowed to continue in the program without a backup personal assistant.** During the contact calls, the Counselor must be assured that the participant's backup personal assistant is still available. If the participant's backup personal assistant is not going to be available as needed, a new backup personal assistant must be found immediately and the Backup Personal assistant form must be filled out and signed and in the case file within 10 days of the contact call or the participant will be disenrolled from the program.

330.120 Explanation of Enrollment Forms

7-1-09

A. IndependentChoices Enrollment Forms

1. Designation

First determine whether or not the participant will need a decision-making partner or communications manager. If the participant does need assistance, they or their family will need to determine who that will be. Ensure that the prospective partner/manager understands the requirements of the position as outlined in the packet. The designee will then fill out the forms and sign the authorization. If the participant cannot sign to designate the person, a witness signature is required. Be sure to get a good daytime phone number for the designee.

2. Enrollment

- a) Responsibilities and Agreements: Must be signed by participant, communications manager, or decision-making partner per signing instructions.
- b) Backup Personal assistant: Make sure the participant has a backup personal assistant (not the primary personal assistant). Be sure they indicate whether or not that person will be paid, and if they can discuss

the case with us. If they indicate that they can discuss the case, make sure they are listed on the DHS-4000.

- c) DHS-4000: The participant will need to designate everyone who we can speak with about the case and sign.

B. Tax Forms

1. Employer

- a) Limited Power of Attorney: Needs physical address, date and signature.
- b) SS4: This needs the participant's name (7a), SSN (7b), and signature/date (bottom of page).
- c) 2678: This only needs the participant's printed name, signature and date.
- d) 8821: This form requires the SSN, current phone number, printed name, and signature. One should have the signature dated, and the other should be undated.

2. Employee

- a) Employee Application: Employee should fill out all information and sign the second page.
- b) Participant Personal assistant Agreement: Should be signed by the participant/rep (yellow) and personal assistant (blue).
- c) W-4: The personal assistant needs to fill out the blue area and sign.
- d) AR4EC: This must be completely filled out and signed by the personal assistant.
- e) I-9: The blue highlighted parts of Section 1 should be filled out and signed/dated by the personal assistant. The yellow areas of Section 2 should be filled out and signed/dated by the participant/rep.
- f) W-5: This should only be filled out if the personal assistant uses the Earned Income Credit.

- g) **Provider Agreement:** The personal assistant should fill in their information and sign. You should then sign as the DHS Representative at the bottom of the page.
- h) **Photocopies:** Be sure that we get a photocopy of the personal assistant's identification (typically Drivers' License) and proof of eligibility to work (typically SS Card). See the Pg. 3 of the I-9 form for more details.

C. Note on Signatures

If a participant has a designee, there are special rules on how the IRS requires these signatures to be completed. The way the forms are signed by the designee is based on the physical ability of the participant to sign. It is not based in any way on their mental status. There are three possibilities.

1. If the participant can legibly sign their name, then they do not need a witness and can sign just like they would without a designee.
2. If the participant cannot sign legibly, but can make a mark, they should do so. In this case, the designee should write "Witnessed by:" and sign their name **AT THE BOTTOM OF THE PAGE.**
3. If the participant cannot make a mark, the designee may sign the participant's name. In this case, the partner/manager must write "By:" and sign their name **AT THE BOTTOM OF THE PAGE.**

330.130

Prepare Case File

7-1-09

When the forms are completed, they must be filed. Case files are maintained by the assigned Counselor for each participant. They are organized alphabetically by Participant Last Name and housed in locked files at the Counselor's desk.

Each participant should have a paper file with their case documentation. This file labeled 'Last Name, First Name', and should be organized in the following manner:

<u>Left Side</u>	<u>Right Side</u>
Case Closure Documentation*	Copies of Correspondence/ Other Forms
Current CEP and MMIS Billing	Participant Responsibilities and Agreements
Current Authorized Assessment	Backup Personal assistant Form
Previous CEP and MMIS Billings	DHS-4000
Previous Authorized Assessments	Copies of Tax Forms/Employee Forms

*This is only required when a case has been inactivated.

330.200 Determine Agency Billing Status

7-1-09

A. Checking for Agency Personal Care Services

The Counselor must check the MMIS claims system to see if a personal care agency has been billing for personal care services for the applicant. The Medicaid provider number for a personal care agency provider # ends with the number 32.

B. How to Check for Agency Services:

1. First, use the HR screen in MMIS to look up billing for your participant.
2. Type in the ACTIVE Medicaid Id in 'RECIPIENT', set the DOS RANGE to at least one year from today until present, then press enter.

ARKANSAS PAID CLAIMS INQUIRY PAGE 1

SYSTEM ACTION R MESSAGE MORE DETAILS REMAIN--USE PF4 KEY TO PAGE FORWARD

RECIPIENT	NAME	PROV/NO	NAME
DOS RANGE	TO	PAID DATE	CLAIM TYPE SELECTION

ICN	PROVIDER NAME	BEGIN	END	BILLED	PAID	EOB
REL CLM	REL BILLED	REL PAID	PAYDT	RA NO		

0504219138835 150829715 MEDIC 033004 033004 1882

082604 6475409

3. Search these records for any PROVIDER REL # that ends in 32

4. If there are any 32 records, that means this person has received agency services within the last twelve months, and may still be receiving services.
5. To look up information on a provider, you can write down the number, then go to the P1 screen and type it into PROVIDER.

ARKANSAS PROVIDER ELIGIBILITY PAGE 1

SYSTEM ACTION 1 MESSAGE PROVIDER NUMBER MUST BE ENTERED

PROV/NO [REDACTED] RECORD ACT 1 [REDACTED] LCHNG

NAME [REDACTED] APP/TYP [REDACTED] AD/USE [REDACTED] NM/TY [REDACTED]

ADDR 1 [REDACTED] MED/CROS NO [REDACTED]

2 [REDACTED] PREV MEDICAID NO [REDACTED]

3 [REDACTED] PHONE [REDACTED]

CORP IND [REDACTED] CORP NAME [REDACTED]

CNTY A/BEDS LT/BEDS SPEC/PRO FAC/CL GROUP NO

[REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] GRP/NM

[REDACTED] NO/GRPS

SPEC	EFF/DTE	STOP/DTE	TYPE	CERT XIX BEDS	CERT XVIII BEDS	CERT CAID/CARE BEDS
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

IND ABC DEF GHI JKL MNO

6. This will list the phone number and full name and address of the provider.
7. If it is a AAA or the Department of Health, the contact information is automatically included when a fax is generated from the Counselor Form Generator. If not, you can use the blank fax to fill in the information once you get it.
8. Be sure to give the agency seven days notice to stop services, and always make sure that the participant understands that their agency services will cease.

330.300 Determine Service Start Date

7-1-09

The service start date must be determined by the counselor. It is affected by the circumstances of existing care and the authorization period, as follows:

A. Agency Billing within 365 Days

1. Contact the agency that has been providing service to determine if services are still being provided.
2. If services have ceased, obtain confirmation of the date services stopped. The start date would then be the latest of the following dates:
 - a) The date the physician signed to authorize personal care.
 - b) The date after agency services stopped being provided.
 - c) The date the personal assistant started providing services.
 - d) If the personal assistant has not yet started providing services, the start date should be the beginning of the next pay period.
3. If services are still being provided, the agency must receive seven days notice. The start date would be the day after the agency services stop.

B. No Agency Billing within 365 Days

1. Check with the Department of Health to confirm no late billing for services exists.
2. If no current billing exists, then the start date would be the later of the following dates:
 - a) The date the physician signed to authorize personal care.
 - b) The date the personal assistant started providing services.
 - c) If the personal assistant has not yet started providing services, the start date should be the beginning of the next pay period.

330.400 Develop Cash Expenditure Plan**7-1-09**

The Cash Expenditure Plan (CEP) is a tool utilized to outline the participants' personal care allowance that is based on their personal care needs. Although a participant may be eligible for a set amount of personal care hours they have a choice on how to actually spend their monthly personal care allowance. The CEP is based on a daily allowance rate, which is based on the assessed hours. The CEP is

developed during telephone calls with the applicant or their decision making partner.

330.410 Explain Uses of Budget

7-1-09

A. Uses of Cash

The intended use of the cash is to purchase personal care services. Purchase of items or services related to personal care, assistant care or any other medically related item or service will be allowed. Most uses of cash will be outlined on the Cash Expenditure Plan (CEP). However, up to ten percent (10%) of the cash allowance (not to exceed \$75/month) will be considered discretionary funds and may be used without receipts, but with summary reporting as requested by the assigned counselor. Requests to purchase non-traditional or unusual items over \$50 will require the approval of the counselor.

NOTE: If the participant is using funds to cover other expenses, the counselor should ensure that informal care will be provided to meet the participant's needs.

The following is a list of suggestive, not restrictive uses of the cash allowance:

1. Personal Care Services
2. Discretionary Cash
3. Prescription Medication (Not covered by insurance)
4. Over-the-counter Drugs
5. Personal Hygiene
6. Home Modifications
7. Transportation
8. Environmental Equipment
9. Chore Service
10. Safety Devices

11. Education
12. Communication Devices
13. Service Animal Purchase and Maintenance
14. Adaptive Equipment (Purchase or Rental)
15. Technology (Computers)
16. Housing (Only Emergency w/ Supervisor Pre-Approval)
17. Utilities (Only Emergency w/ Supervisor Pre-Approval)
18. Food and Clothing (Only Emergency w/ Supervisor Pre-Approval)
19. Pest Control (Only Emergency w/ Supervisor Pre-Approval)

B. Savings

Cash may be accumulated to purchase specific, approved items. These items must promote personal independence or increase accessibility or mobility. The participant may elect to have the fiscal agent maintain the savings or may maintain his/her own account. If the latter is chosen, the IndependentChoices funds must be kept in an account separate from the participant's general funds and may not, at any time, be co-mingled with usual monthly income.

At no time are IndependentChoices cash payments considered as income to the participant. Any accumulated IndependentChoices money will not be considered as an asset for the participant or the immediate family. However, should the participant employ a family member(s) as a personal assistant, the salary paid to that person will be considered income and any savings resulting from this salary will become an asset.

330.420 Determine Preference of Use and Finalize Budget

7-1-09

- A. Determine the participant's preferences for utilizing their budget
 1. Hourly rate of pay
 2. Amounts reserved for cash expenses

3. Amount of discretionary cash
4. Number of hours of service per pay period
- B. Summarize and confirm use of budget with participant.
- C. Ensure correct Palco ID is entered from information received from PALCO.
- D. Print CEPs and distribute.
 1. Three copies of the completed CEP are printed.
 2. Two copies are sent to the participant/partner.
 - a) They are instructed to sign, date and return one copy in an enclosed self-addressed postage paid envelope and to keep one copy for their records.
 - b) One copy is sent to Palco through the courier service.
 3. The Counselor will log in the database the date the CEP was mailed to the participant/partner. When the signed CEP is received, a copy should be made and placed in the file. The original should be forwarded to PALCO. If the participant/partner does not sign and return the CEP within two weeks, the participant may be disenrolled from the program.

330.500 **Process Start of New Case** **7-1-09**

330.510 **Prepare Start Service Packet** **7-1-09**

Once the start date has been determined and the CEP has been developed, the counselor will assemble the paperwork necessary to get the participant started on the program. This packet is mailed to the participant or designee. This packet will consist of the following:

- A. A letter explaining the participant's start date, authorized care, and how to get started. This letter comes from the letter generator in the IC Database.
- B. A checklist describing what to do with the contents of the packet.
- C. One copy of the CEP to be signed and returned to IC Central Office.
- D. One copy of the CEP with a corresponding calendar for the participant to keep.

- E. Timesheet instructions and payroll schedule.
- F. Timesheets designated for the POG funds, if applicable.
- G. Blank timesheets for future use.
- H. IndependentChoices decal with IC RN and Counselor names listed.
- I. Postage paid return envelope for signed CEP.

330.520 Communication Requirements 7-1-09

The counselor will inform the IC RN and Palco of the effective date, authorized hours, and daily rate upon enrollment. This information will automatically be generated when the database updates are completed.

330.530 Database Updates 7-1-09

The counselor must ensure that all necessary information is in the IC Database record for a newly enrolled participant. The counselor must enter the authorization period, all associated personal assistant, partner, manager, physician, backup and other contact information, in addition to the tracking of the paperwork, authorization and enrollment process. The exact process for updating these fields will be detailed at a later time, pending future process changes.

330.540 MMIS Updates 7-1-09

IC RN Screen Updates

In order to start generating the participant's monthly budget, the Medicaid system must be updated to include the new participant, or to make any changes in the participant's budget amount.

After you have everything entered into the database, the agency notified (if applicable) the CEP developed and everything else set up, you will need to update MMIS to start billing for services. Every new participant will have to have an IC RN segment created. Any participant who is starting prior to the 1st day of the current month must have a POG created in the PA screen. Below are some directions on how to go about these processes.

IC RN SCREEN INSTRUCTIONS

SYSTEM ACTION RN

RECORD ACTION A USER

*For record action: A- Add; C- Change; I- Inquiry.

RID: (Enter Base ID here first, then enter record action and USER above, then create segment below.)

*** WAIVER INDEPENDENT CHOICE SEGMENTS ***

NO	A	C	WI	RDM DATE	EFF DATE	END DATE	CP UNITS	BENEFIT	PROVIDER	CHG DATE
01	A		WA	YYYYMMDD	YYYYMMDD	YYYYMMDD	###	DAILY RATE	147999787	

NO: DETAIL NUMBER: (AUTOMATIC) SCREEN ALLOWS MAXIMUM OF 24 DETAILS

A: ACTION CODE: I- INQUIRY C - CHANGE A - ADD OR F - CANCEL EXISTING SEGMENT. USE CANCEL SPARINGLY.

WI: WAIVER INDICATOR: OVER 65 = WA UNDER 65 = WB

RDM DATE: Must equal Eff Date for first record, does not change with new records. This keeps the original start date. However, if upon keying the new enrollment you find a previous segment with a Waiver Indicator of WE, WF, WG, or WH you will use the new effective date as the randomization date. This is the only scenario where the waiver RDM date changes.

EFF DATE: Start date of participation in IndependentChoices program (first record), or date the rate changes. If effective date is prior to the first date of the previous month approval must be obtained from program manager.

END DATE: End date of participation in Independent Choices. Will be 99991231 for actively enrolled. Old segments need to be closed as of the day prior to the effective date of the new segment.

If a participant returns to agency care at the beginning of a new month the end date is the last day of a month and not the first day of a month.

If the participant begins agency care after the first day of the month the end date is the date services with IC ended and not the day that agency services began. Loss of Medicaid eligibility, death and nursing home placement also represent the exact date for the End Date.

CP UNITS: This is the total hours authorized per week times four (Medicaid measures in quarter hours.) Ex. 14 hrs is represented by a three byte numeric value of 056 CP Units.

BENEFIT: This is the client's daily rate for the segment. Must contain two decimal value.

PROVIDER: This will always be 147999787.

WHEN COMPLETE, DOUBLE CHECK ALL INFORMATION, PRESS ENTER, THEN F6 TO FINALIZE RECORD.

After Completing the IC RN update, you will need to determine if a POG is needed.

A POG is a term that means “Pot of Gold”. Literally, a POG is a Prior Authorization. and the ability to create a POG is essential to a claims processing system that allows Electronic Data Systems, Inc. (EDS) to create the IndependentChoices participant payments on the last working day of each month. These payments created by EDS are prospective payments to the participant. When EDS creates these claims it can only create claims as they are identified on the IC RN screen on the last working day of each month.

It is only necessary to create a POG if the effective date of the start/change occurs during or prior to the end of the current month.

The database CEP screen will automatically determine the POG amount, if applicable. To ensure that this calculates correctly, the counselor should ensure that the effective date is correct, that the current daily rate is correct, and that the prior daily rate is correct (in the case of a new start, this should always be 0).

Once you have determined the need for a POG, you must create a PA segment.

ARKANSAS PRIOR AUTHORIZATION

SYSTEM ACTION PA MSG PLEASE ENTER A PA NUMBER USER
 PA-NUM 7013018029 PLAN CODE ZZZ RECORD-ACTION A**** RETENTION 24
 RID-NUM 0000000001 RQST-PROV 147999787 PROV/RECIP NOTIFIED 011607 VID
 ORIG-RID AUTH-PROV 147999787 ADD-DTE LCHNG CLRK
 RID NAME PROV NAME USED
 NO A C PROC TOS M1 M2 M3 M4 START STOP POS UNIT / DOLLARS UNITS / DOLLARS
 A Z2513 0 00 00 00 00122506 013107 500.00

ALL HIGHLIGHTED FIELDS WILL ALWAYS HAVE THE HIGHLIGHTED VALUE

PA-NUM -	Year	Julian Date	ID	Number
Ex. 7003018029:	7	003	01	8029

*ID is the user ID

*Number starts at 8009 for each day, and goes up by 0010 with each entry anyone makes into the system during the same day.

*Example PA: This is the third entry into the system(8029) on January 3rd, 2007(7003).

Note: Press enter after typing in the PA number to ensure that that PA number has not already been used.

RECORD ACTION- I- INQUIRY C- CHANGE A- ADD

RID-NUM - This number is the most current ACTIVE Medicaid number for the recipient, not necessarily the base id. Check RE Screen to make sure correct number is used.

PROV/RECIP NOTIFIED -Current date in mm/dd/yy format.

COLUMN 'A' - Same as Record Action Code.

COLUMN 'START' - Effective date of POG, in mm/dd/yy format.

COLUMN 'STOP' - POG end date, in mm/dd/yy format (end of current month)

COLUMN 'DOLLARS' - (Tab twice to arrive) Enter amount of POG as calculated.

TO COMPLETE: PRESS ENTER. ENSURE THERE IS NO ERROR AND DOUBLE CHECK ALL INFORMATION. PRESS F6 TO COMPLETE.

340.000 Case Monitoring and Management**340.100 Monitoring Requirements****7-1-09****A. How new participants in their first six (6) months of consumer-direction are identified in the database for monitoring.**

A report is provided to Counselors to make a monthly contact for participants in their first six months of consumer-direction or a quarterly contact if in consumer direction for more than six months. With each telephone contact, the Counselor will record in the Narrative section of the database the contact dates.

B. Monitoring the standard that all new participants must receive a monthly contact.

Management will generate Monthly Enrollment Contact reports for review by the 10th of each month.

C. Examples of questions that will be asked during the monthly contact to assure that the participant understands the risks, rights and responsibilities of consumer direction. This list only provides examples and is not a comprehensive listing.

1. What is your understanding of consumer-direction or consumer-directed care?
2. Are you satisfied with the services you are receiving?
3. Do you have any concerns about your role as boss/employer?
4. Do you understand the importance of keeping a working phone in your home so that we may communicate with you?
5. What is the hardest part of directing you own care?
6. How would you describe the care that you are receiving?

7. Does your employee provide the services you need?
8. Do you currently have someone acting as a Power of Attorney for you?
9. If so, do you have a family member or someone to act as your decision-making partner for Independent Choices or can that same person serve as your decision-making partner for IC? Do you understand that this person may not be a paid personal assistant?
10. Are you able to assist in training someone to provide personal care services?
11. Can you communicate your needs to your assistant?
12. Are you able to dismiss the personal assistant if they are not providing services for you? Are you able to dismiss the personal assistant even if they are a family member?
13. Are you willing to assist in hiring a personal assistant if you need to?
14. Are you willing to receive training and/or assistance in hiring, dismissing and supervising personal assistants?
15. Do you understand that IC uses Medicaid funds to operate and IC is governed by Federal and State regulations?
16. Are you willing to follow the Federal and State regulations that govern IC?

340.200**Financial Management Services****7-1-09****Role of Fiscal Agent – PALCO, Inc.**

The IndependentChoices program has contracted with PALCO, Inc. to provide all payroll services for the participant/ decision-making partner. Timesheets and/or receipts are submitted to PALCO for processing. PALCO then calculates and deducts the appropriate tax from each reimbursement, and mails the checks directly to participants and their personal assistant(s) based on a set schedule.

The personal assistants should allow the postal system up to four days from the date

of mailing before inquiring about a check.

If the counselor receives a timesheet from a participant, it should be forwarded to PALCO. The counselor should then remind that participant to send the timesheets to PALCO and explain the delay that can occur by sending it to the IC Central Office.

Payroll Functions

PALCO, Inc. performs all payroll functions when the participant or participant's decision-making partner hires a personal assistant. The participant becomes the "employer of record," and PALCO, Inc. becomes the participant's fiscal vendor/ employer agent. PALCO, Inc. prepares payroll checks for personal assistants and withholds all applicable state and federal employer/employee taxes. PALCO also sends out participant's discretionary funds.

A W-2 is issued by PALCO to each personal assistant no later than January 31 of each year. PALCO, Inc. will NOT issue a W-2 to employees (personal assistants) that did not earn the threshold for the year—currently at \$1,600 in wages during the calendar year. All withheld taxes are returned to the employee (personal assistant) by PALCO, Inc., if a W-2 is not issued.

All questions regarding payroll or other funds should come from the participant/decision-making partner/communications manager. Inquiries of this nature should be directed to PALCO, as they have the information more readily available to respond.

340.300 **IndependentChoices Reports** **7-1-09**

340.310 **Counselor Management Reports** **7-1-09**

Active Needs Assessment – All cases that are active (End Date = 12/31/9999) that have an authorization expiring within 60 days. This will only report cases that do not have a reassessment tracking record within 60 days of the current date.

Pending Needs Assessment – All cases that are pending (End Date is null AND Refuser Code is null) that have not been authorized. This will only report cases that do not have a new assessment tracking record within 60 days of the current date.

Active Needs Monitoring – All cases that are active (End Date = 12/31/9999) and have a currently authorized Extension of Benefits. This will only report cases that do not have a monitoring visit tracking record with a date after the current EOB authorization period.

Tracking Indicators – Active participants listed by the type of tracking indicators marked on the most recent home visit (new or reassessment).

Cash Utilization – Active participants listed by percentage of funds not utilized for personal care service hours. First participants listed have highest alternative utilization of cash.

Diagnoses Reports – Upon running this report, a prompt will appear, asking for the input of a primary diagnoses. This input is compared to the left-most letters of each diagnosis field in the tracking of all active participants (i.e. ‘Alz’ input will find Alz, Alzheimer’s, Alzheimer, etc.). This will help bring back all matching records, regardless of spelling or abbreviation. Care must be used to not catch other diagnoses into the same report, however. After entering the first diagnoses, the report gives the option to enter a second diagnosis. Press enter to use only one diagnosis, or enter a second. This will sort and identify those with the primary that also have the secondary. MDS-HC Rug categories may be used instead of or in combination with diagnoses.

340.320

Compliance Reports

7-1-09

Counselor Performance – This report will summarize basic statistics on performance for the counselor running the report only. This report will not report statistics to anyone other than the counselor running the report and the program management staff.

EC POC Expiring – Lists each active participant listed as an ElderChoices Waiver participant, who has an EC POC expiration date within 30 days of the current date.

Reassessment Past Due – Active participants whose current authorization has expired. These participants may only continue on the program for 14 days, according to Medicaid policy. Participants that have exceeded this 14 day timeframe are flagged for closure.

Need Signed CEP – Active participants with a Date CEP Sent, but without the

correlating date received. This will only report on the most current CEP sent out, as reported in the tracking table.

No Contact in 90 Days – Active participants without a contact note entered in the database within the last 90 days. All cases listed on this report are out of compliance with the monitoring guidelines, and should be contacted.

340.330 Error Reports

7-1-09

IC Hours Not Equal To EC POC Hours – This report analyzes all active IC participants who are also EC Waiver participants. It will list all participants whose total current hours is not equal to the sum of the PC and ACS hours listed on the EC POC tab in the IC Database.

Invalid Reassessment Date – Active or Pending participants whose reassessment date does not match a valid timeframe from the assessment date (e.g. More than 1 year after original, prior to original, within 60 days of original, etc.)

No Physician Information on File – Active participants without physician information on record.

No Personal Assistant Information on File – Active participants without information on their primary personal assistant on record.

No Backup Assistant for Backup Plan on File – Active participants without information on their backup personal assistant on record.

No PALCO ID on File – Active participants without a PALCO ID assigned.

No Physician Indicated as Active – Active participants with physician information on record, that do not have a physician indicated as active. This will also report on participants with more than one PCP marked as active.

No Personal Assistant Indicated as Active – Active participants with primary personal assistant information on record, that do not have a primary personal assistant indicated as active.

No Backup Assistant for Backup Plan Indicated as Active – Active participants with backup personal assistant information on record, that do not have a backup

personal assistant indicated as active.

340.340**Workflow Reports****7-1-09**

Assessment Sent but Not Received – All assessments that have a sent to DAAS date in tracking, but do not have a valid and corresponding date received by DAAS.

Assessment Completed, Application still Pending – Pending applications with completed personal care assessments, who have not yet been enrolled.

Paperwork Completed, Application still Pending – Pending applications with complete tax forms received from PALCO, who have not yet been enrolled.

Pending Enrollments without Application or Assessment Completed – Pending applications without complete tax forms received from PALCO or a completed assessment.

Workflow Process Timeline Compliance – Report of exceptions to the workflow guidelines. This report can be utilized to identify bottlenecks in the workflow by analyzing the quantity and duration of delays at each procedure step.

Full Assessment Tracking – Report of assessments completed and progress since completion. This report will request a start and end date. This will report on all assessments in the caseload selected for the timeframe specified.

340.350**Decision Support System Reports****7-1-09**

Participant Lost Eligibility – This report is provided from the DSS by the Program Manager. All active participants on this list should be informed of their change in status and closed on the eligibility end date.

Participant Deceased – This report is provided from the DSS by the Program Manager. All active participants on this list should be closed on the date of death.

Open Long Term Care Segment – This report is provided from the DSS by the Program Manager. All active participants on this list should be closed on the date prior to the opening of the long term care segment.

APD/IC Crossover – This report is provided from the DSS by the Program

Manager. List of all IC participants that are also APD participants. Should be reviewed to determine if services should continue

A IC TC Listing – This report is provided from the DSS by the Program Manager. Reports problems with the MMIS segments (multiple entries, incorrect hours, etc.)

Hospitalization – This report is provided from the DSS by the Program Manager. All active participants that have had hospital stays of more than 5 days. This report is coordinated with PALCO to determine if funds must be repaid.

350.000 Change Of Information Status**350.100 Participant****7-1-09****A. Participant Changes Their Last Name**

IndependentChoices Counselors case loads are determined alphabetically by the last name of the participant. Whenever the participant's last name changes, the current Counselor must transfer the case file to the new Counselor, if necessary. In some cases, the participant may request to keep their current Counselor. This is acceptable.

- When a participant changes their last name, PALCO requires a copy of the participant's marriage license or a copy of the divorce decree in order to change the tax ID number over to the correct name for the IRS.
- If the name on the Social Security Number is not correct for the participant, the participant should contact the Social Security office in the county where they live. Social Security will assist the participant in making the correction. Once the corrected Social Security card is received, the participant should send a copy to IC Central Office. IC Central Office will forward a copy to PALCO.

B. Participant Move

If an IC participant moves into the PCDC region from the DAAS region, the Counselor will forward the participant's case file to the PCDC counselor and notify Palco of the address change. The RN segment in MMIS must be updated to reflect the new provider number (135507787), to ensure proper payment of management fees. This change should be coordinated with the Counselor responsible for PCDC billing.

If an IC participant moves into the DAAS region from the PCDC region, the PCDC Counseling staff will forward the participant's case file to the DAAS Counselor. The Counselor will notify Palco of the address change. The RN segment in MMIS must be updated to reflect the new provider number (147999787), to ensure proper payment of management fees. This change should be coordinated with the Counselor responsible for PCDC billing.

If a participant in the DAAS managed region moves to another area within the DAAS designated counties, the participant must notify the Counselor of this change so that PALCO and the RN will be notified of the address change. The participant must submit the change of information form to the Counselor. If the participant does not have this form, the Counselor will mail the form out to the participant. This must be submitted in a timely manner to keep assessment schedules and for the participant to receive their discretionary funds with no interruptions. If IC Central Office does not receive a change of address in writing, the participant's check will be returned to PALCO, and it could take up to two weeks for the participant to receive it.

The same conditions apply for PCDC participants moving within the PCDC region.

C. Hospitalization

If a participant is hospitalized, the participant/decision-making partner/communications manager must immediately notify the IC counselor of the hospitalization. Only the first five days of hospitalization may be claimed for personal assistant services. Anything after the five days cannot be claimed and must be refunded back to Medicaid. Once the counselor is notified of the hospitalization, the counselor will notify PALCO and the IC RN. If IndependentChoices is not notified of participant hospitalization, and the participant turns in the time for personal assistant services beyond the allowed five days, the participant is required to pay Medicaid back. Once out of the hospital, the participant/decision-making partner/communications manager must notify the IC counselor of the hospital discharge date. The participant/decision-making partner/communications manager and Personal Assistant must indicate on the timesheets the days in hospital. Any hospital stays longer than 30 days will result in disenrollment. (See: IndependentChoices Participant Responsibilities and Agreement form)

D. Rehabilitation

If a participant enters into a rehabilitation facility, the participant/decision-making partner/communications manager must immediately notify the IC counselor of the occurrence. Only the first five days of rehabilitation may be claimed for personal assistant services. Anything after the five days cannot be

claimed and must be refunded back to Medicaid. Once the counselor is notified of the rehabilitation, the counselor will notify PALCO and the IC RN. If IndependentChoices is not notified of participant rehabilitation, and the participant turns in the time for personal assistant services beyond the allowed five days, the participant is required to pay Medicaid back. Once out of the rehab facility, the participant/decision-making partner/communications manager must notify the IC counselor of the rehab discharge date. The participant/decision-making partner/communications manager and Personal Assistant must indicate on the timesheets the days in rehab facility. Any rehab stays longer than 30 days will result in disenrollment. (See: IndependentChoices Participant Responsibilities and Agreement form)

E. Out-of-State

If a participant wishes to go out-of-state for a temporary time, the participant must notify the IC counselor and provide physician authorization/prescription to receive prior authorization. This will ensure the IC RN can be notified and arrangements can be made with PALCO. It is also a Medicaid requirement for providing services out-of-state. At this time the participant must tell the counselor who will be providing their personal assistant services, whether it be the primary or backup Personal Assistant. If the participant does not have a Personal Assistant tending to their personal assistant services needs during this time, the participant must be disenrolled, as they would not be meeting program requirements. Failure to notify the IC counselor may result in disenrollment due to no contact or expired authorization. The duration of out-of-state services cannot exceed 20 days. After 20 days out-of-state, the participant will be disenrolled.

F. Temporary Move

If a participant has to temporarily move to a new address due to an emergency such as damaging weather or fire, the participant/decision-making partner/communications manager is responsible for notifying the IC Counselor of the new temporary address and phone number so that PALCO and the IC RN can be notified of the situation. If the participant moves out-of-state temporarily due to the emergency, the participant must follow the guidelines for an out-of-state move in the previous section. If disenrolled, the participant may call again to be referred to the program as long as they have an established Medicaid eligibility in Arkansas. If the counselor is not notified of the

temporary move, this could result in disenrollment due to no contact or past due assessment.

350.200**Personal Assistant****7-1-09****A. Contact Information Changes**

1. If the Personal Assistant plans to change address, he/she must notify the Counselor by completing and submitting form DAAS-IC-19. Submission of this form should allow IC and Palco staff time to input the new address into the system. This will ensure that when the Personal Assistant is at the new address, there will be no interruption in the Personal Assistant receiving their paycheck.
2. IndependentChoices **will not take address-change information over the phone. *IT MUST BE IN WRITING.*** If IC Central Office does not receive a change of address in writing, the Personal Assistant's check will be returned to Palco, and it could take up to two weeks for the personal assistant to receive it.
3. IC Central Office will notify Palco and Palco will notify IC Central Office of proper address changes.
4. Phone number changes may be accepted over the phone, if confirmed as the correct new number.

B. Name Change

1. Palco and the IC Central Office need to know if a Personal Assistant has a name change. The name on the Personal Assistant's Social Security card must be correct. If a name has changed for any reason (such as in marriage or divorce), the Personal Assistant must get a new Social Security card. If the name on payment and Social Security information does not match, the Internal Revenue Service could suspend the money from the Personal Assistant's timesheets.
2. If the name on the Social Security card is not correct, the Personal Assistant should contact the Social Security office in the county where they live. Social Security will assist the Personal Assistant in making the correction.

Once the corrected Social Security card is received, the Personal Assistant should send a copy to IC Central Office. IC Central Office will forward a copy to Palco.

C. Other Personal Assistant Changes

1. The participant/decision-making partner/communications manager must notify the Counselor immediately when a Personal Assistant is no longer providing services. This change should be reported on a change form (DAAS-IC-09). PALCO will mail a new Employee packet to the participant. PALCO will assist the new Personal Assistant in completing the Employment Application, if needed.
2. The Counselor will document in the database when a Personal Assistant is no longer working and the name of the new Personal Assistant. On the Change of Information Form, the participant must write in the date the new Personal Assistant started and the date the old Personal Assistant stopped working for them, along with signing the form for authorization. This will be updated in the IC database and then submitted to PALCO
3. The IndependentChoices Personal Assistant cannot remain a Personal Assistant without an IndependentChoices participant. All services are the participant's, and when their participation ends, the Personal Assistant's position ends also.

350.300 Decision-Making Partner/Communications Manager 7-1-09

- A. **Amount of time a participant who requires a decision-making partner can remain in the IndependentChoices program without a decision-making partner.** If, at any time, it is determined by the RN or Counselor that the participant is not capable of self-directing his/her personal assistant services by him/herself and requires a decision-making partner, one must be established. If a decision-making partner cannot be found within one week of this determination, the participant will be disenrolled from the IndependentChoices program and agency care will be coordinated by the Counselor to provide personal assistant services for the participant.
- B. **Monitoring and tracking of participant's who require a decision-making partner.** Participant's who require a decision-making partner must have a

decision-making partner to continue in the IndependentChoices program.

- The decision-making partner must be able to visit the participant at least once to twice a week to oversee the participants care. If the participant has a decision-making partner who is court appointed, then they must act as their acting decision-making partner. The decision-making partner is responsible for supervising the Personal Assistant's service hours and verifying the personal assistant services hours worked on the timesheets.
- The decision-making partner is responsible for communicating with IndependentChoices when there is a change in the participants care needs, medical conditions, new physician, new address and telephone numbers.

C. Designating a change of Decision-Making Partner/Communications Manager

Changes to the authorized decision-making partner or communications manager must be submitted on the DAAS-IC-24 form. This form must be signed by the existing decision-making partner or the participant.

360.000 Closing IndependentChoices Participation**360.100 Reasons to Close (Disenrollment)****7-1-09**

An IndependentChoices Participant may be disenrolled for the following reasons:

A. Loss of Medicaid Eligibility

1. The IC Program Manager will provide a weekly report of Participants who have lost Medicaid eligibility, or if the Participant is an ElderChoices client, the EC RN may send an AAS-9511 Change of Status. If the Participant's ElderChoices waiver status becomes inactive, but they are Medicaid eligible for IndependentChoices without ElderChoices, the Participant may continue participation in IndependentChoices.
2. When notification of lost Medicaid eligibility is received, the counselor will contact the participant to determine if they are aware of their Medicaid status and notify the Participant of the effective closure date of IndependentChoices.
3. The Participant will be advised to notify the IC Counselor when Medicaid eligibility is reestablished.

B. Loss of Medical Eligibility for Personal Care

1. If at the time of the IC RN reassessment it is determined the Participant no longer requires personal care, the Participant will be disenrolled effective the ending date of the current authorization. A notice of disenrollment will be sent to the Participant by certified mail. (Reference: Medicaid Personal Care Manual Section 214.200 B, *Personal care services may not continue past the six-month anniversary of an initial or revised beginning date of service until the client's physician authorizes a revised service plan or renews the authorization of an existing service plan.*)
2. If the Participants Personal Care Provider (PCP) will not authorize personal care, the Participant will be disenrolled effective the ending date of the current service plan. (Note: Medicaid Personal Care Manual, Section 214.110 B, *The physician must forward the completed authorized service*

plan with original signature and authorization date to the personal care provider no later than 14 working days following the authorized beginning date of personal care service.)

C. Long-term Care Placement (LTC) – Nursing Home/Rehab

1. If a Participant enters a LTC facility for more than thirty (30) days the IndependentChoices case will be closed. No monthly allowance will be provided during the time of institutionalization. Arkansas Medicaid considers an individual an inpatient of a nursing facility beginning with the date of admission. However, personal care services are billable on the date of discharge. (See Section 350.100 D.)
2. All payments for services provided during a LTC stay will be subject to repayment.

D. Moves Out-of-State

Upon notification that the Participant has permanently moved out of the state of Arkansas, the Participant will be removed from IndependentChoices. The effective date of disenrollment will be the date the Participant moved out-of-state. If the date of move is not known, the date notified of the move will be used as the effective date. (See Section 350.100 E. and F.)

E. Hospitalization

If a Participant is hospitalized for more than 30 days in either an acute care hospital or in a rehabilitation setting, the participant will be removed from the IC Program. The Participant may request their case to be reactivated on the date of discharge from the hospital. To be reactivated the Participant must be Medicaid eligible and have an active IC Personal Care Service Plan. If there is not an active IC Personal Care Service Plan see Section 360.400 for the reactivation process.

F. Death

Upon notification of a Participant's death, the case will be closed effective the date of death.

G. Transfer to Alternatives for Adults with Physical Disabilities (AAPD) Waiver

Generally, a Participant who transfers to AAPD will be disenrolled. However, in some instances the IndependentChoices Participant may be enrolled in both AAPD and IndependentChoices. (See Section 400.200 B) Additionally, the IC Program Manager will run a Business Objects query each week to identify persons receiving AAPD and IC without waiver approval for provision of IC services.

H. Voluntary Disenrollment

The Participant may elect to discontinue participation in the IC Program at any time. When a Participant request to be removed from the IC Program, the IC counselor will attempt to identify and resolve issues to allow the Participant to continue in the IC Program.

I. Temporary Absences from the Home

IndependentChoices, like Medicaid personal care, is an in-home service. The services may be provided outside the Participant's home, if the Participant's physician authorizes the service during a trip or vacation. The Participant must provide IC with Physician authorization prior to period of absence from their home. If the temporary absence extends past 30 days, the participant will be disenrolled.

J. Involuntary Disenrollment

1. The goal of the IC Counselor is to work with the Participant/Decision-Making Partner to resolve issues that may affect their continued participation in the IC Program, in a manner respectful of the independence and integrity of the Participant while maintaining the integrity of the IC Program.

Participants may be disenrolled from IndependentChoices for non-compliance with the IC Participant Responsibilities and Agreements. The IC Counselor will work with the Participant/Decision-Making Partner to inform them about their role in the IC Program, explain policy, and communicate with the Participant/Decision-Making Partner about their non-compliant

decisions or actions that might affect continued participation in the IC Program. Each IC Participant/Decision-Making Partner is required to agree to and sign a copy of the DAAS-IC-02.

2. A chart (Disenrollment Guidelines for Non-Compliance of the IndependentChoices Participant Responsibilities and Agreements) listing the subject matter of each responsibility and agreement included in the DAAS-IC-02, issues of non-compliance, and the steps for corrective action and/or disenrollment is in the appendix of this manual.
3. Following are some instances of non-compliance of the IC Participant Responsibilities and Agreements that requires the IC Counselor to implement steps of corrective action or disenrollment. Refer to the Disenrollment Guidelines for Non-Compliance of the IndependentChoices Participant Responsibilities and Agreements for the corrective action/disenrollment process:
 - a) **Health, Safety and Well-being** - If, at any time, the IC RN or Counselor believes the health, safety and well-being of the Participant is compromised by continued participation in the IndependentChoices program.
 - b) **Changes in Condition** - A Decision-Making Partner is required if a Participant's health or cognitive ability declines and they are no longer able to direct their own personal care or manage the responsibilities of the IC Program.
 - c) **Absent from Home** – A Participant is absent from the home for thirty (30) days, for reasons other than institutionalization or an authorized temporary absence, and the personal care assistant can no longer deliver services as prescribed by the PC Service Plan.
 - d) **Unable to Locate** - A Participant cannot be contacted by phone by either the IC staff or the Financial Management Service (FMS) provider, PALCO.
 - e) **Misuse of Allowance** - The Participant or the Decision-Making Partner uses the allowance to purchase items unrelated to personal care needs.

- f) **Failure to Provide Required Documentation** - The Participant/Decision-Making Partner fails to provide required documents or receipts of expenditures upon request.
- g) **Incarceration** - This situation is not directly addressed in the Disenrollment Guidelines for Non-Compliance of the IndependentChoices Participant Responsibilities and Agreements. However, if a Participant is incarcerated participation will be closed upon notification. If the Decision-Making Partner is incarcerated, the participant will be allowed 14 days to provide required documents to name a new Decision-Making Partner or be disenrolled.

360.110**Database Updates****7-1-09**

When a Participant is disenrolled from the IC Program for any reason the IC Counselor is responsible for entering the following information into the IC Database:

- A. **Closed Date** – the effective closure date will be entered in the Closed Date field of the database.
 - 1. **Lost Medicaid Eligibility:** Enter the date Medicaid eligibility ended. This can be verified by checking MMIS RE screen for the end date of the current Medicaid segment.
 - 2. **Loss of Medicaid Eligibility for Personal Care:** Enter the end date of the current PC Service Plan.
 - 3. **Long-Term Care Placement – Nursing Home:** Enter the date of placement in a nursing facility. This can be verified by checking MMIS RA screen for the begin date.
 - 4. **Hospital/Rehab:** Enter a date thirty-one (31) days from the date Participant entered the hospital or rehabilitation facility. The Participant/Decision-Making Partner is responsible for reporting the date they are admitted to the hospital/rehabilitation facility.
 - 5. **Moves Out-of-State:** Enter the date the Participant moved out-of-state.

6. **Death:** Enter the actual date of death. This can be verified by checking MMIS RE screen for the end date of the current Medicaid segment.
 7. **Transfer to Alternatives for Adults with Physical Disabilities (AAPD) Waiver:** Enter the date prior to the effective date of the AAPD Waiver. This date can be verified by checking the eligibility date in the MMIS RW screen. Confirm with AAPD nurse or staff before closing.
 8. **Voluntary:** Enter the date the Participant elects to discontinue participation in IC.
 9. **Authorized Temporary Services Provided Outside of the Home:** Enter the date thirty (30) days after the beginning date of the authorized temporary services.
 10. **Unauthorized Services Provided Outside of the Home:** Enter the date thirty (30) days after the beginning date of the unauthorized period of service, or the date notified of the IC Participant receiving service in a location other than the home.
- B. **Close Code** – The appropriate close code will be entered in the Close Code field of the database. Use the drop-down box to select the appropriate code. The first field is the Close Code field and the second field is for a Refuse Code. A Refuse Code is used **only** for Applicants that refuse the IC Program. This field is not to be populated for a case closure.

360.120**Communication****7-1-09**

- A. Phone contact will be made with the Participant/Decision-Making Partner whenever possible to relate information regarding non-compliance or disenrollment from the IC Program.
- B. Written correspondence will be sent to the Participant/Decision-Making Partner. Letters for most instances of non-compliance or disenrollment can be found in the database letters. All letters in the database letters may be modified to fit the situation. Correspondence notifying the Participant/Decision-Making Partner about an issue of non-compliance will include specific information related to the non-compliance and exact due dates for the Participant/Decision-Making Partner to take corrective action. Correspondence notifying a Participant/Decision-Making Partner of

disenrollment will include the reason for disenrollment, the effective date of disenrollment, and appeal information, if applicable. (See Section 502.000) Certified mail delivery may be required for correspondence, see the chart (Disenrollment Guidelines for Non-Compliance of the IndependentChoices Participant Responsibilities and Agreements) in the Appendix Section for the requirements.

360.130 MMIS Updates

7-1-09

RN Screen Updates

In order to stop generating the Participant's monthly budget, the Medicaid system must be updated to include the end of participation in IndependentChoices. This is done by replacing the 99991231 End Date in the active segment with the effective disenrollment date. To see more detailed instructions for RN Screen Updates go to Section 330.540.

360.200 Permanent Case Closure

7-1-09

A point system, permanent case closure review, and approval process will be developed for non-compliance disenrollments. A permanent close code will be used to identify former Participants who are no longer eligible for participation based on their inability to manage a self-directed program. (This will be included at a later date.)

360.400 Closed Case Re-Activation

7-1-09

- A. An IC Participant removed from the IC Program for reasons other than permanent closure, may be re-activated if the IC Participant is Medicaid eligible (see Section 310.200) and has an active PC Service Agreement.
1. At the time the former Participant requests re-activation, the counselor will update any changes of phone number and/or address in the database. The counselor will also verify the Participant will be using the same primary and backup Personal Assistants as is recorded in the database. If there are no changes participation will be re-activated.
 2. Any changes in phone numbers or address will be updated in the database and reported by email to the IC RN and to the F/EA.
 3. If the participant wants to change their primary Personal Assistant, F/EA will

be notified to send a new hire packet. The new hire packet must be completed and returned before re-activation can be completed.

400.000**Overview**

The information contained in the Nursing Section details information about the IndependentChoices (IC) Program and is intended as a guide to assist the IndependentChoices Registered Nurse (IC RN). The IC RN should use this guide, along with instructions received verbally and/or in other written formats, to properly perform the duties of the IC RN. Each IC staff person is responsible for reviewing and complying with all material contained within the entire IndependentChoices Procedure Manual that relates to his or her job assignments.

400.100**General Duties****7-1-09**

Each IC RN is responsible for the written RN job description in a specifically assigned geographic area. Based on the current caseload, an IC RN from the closest geographical region may be asked to assist another IC RN in another region.

- A. All areas are subject to change based on current participant caseload. These areas may change at any time at the discretion of the Program Administrator, based on factors that are in the best interest of the program and its participants. See Appendix for a map showing the current county assignments.
- B. The IndependentChoices Registered Nurse Supervisor (IC RN Supervisor) directly supervises each IC RN. Areas of supervision may also change at any time at the discretion of the Program Administrator, based on factors that are in the best interest of the program and its participants.
- C. Each IC RN must be available in his or her office on FRIDAY of each week. If one day a week in the office is not sufficient to get job duties accomplished, the IC RN must obtain permission from the IC RN Supervisor for another office day. The decision will be based on the timeliness of visits and the work that is to be completed.
- D. The IC RN's workday is 8 a.m. to 4:30 p.m. This is true whether the IC RN is working in the office or making home visits. The drive to and from the office is outside the 8:00 to 4:30 timeframes. The IC RN must obtain permission from the IC RN Supervisor to change workday hours.
- E. The IC RN is responsible for reporting home visits completed each day to the RN Supervisor either by phone or by email. The report shall include the name of the participant, the type of visit made, and the mileage. The IC RN Supervisor will maintain a daily log.

- F. Travel reimbursement is available according to established DHS policy. Each IC RN is responsible for submitting a TR-1 online to receive the reimbursement. The internal policies and procedures related to travel is located in the Administration section of this manual. A link for the procedures regarding completion of the on-line TR-1 is located on the DHS Share home page. Mileage submitted will be compared to the RN's Outlook calendar, the IC database and/or daily logs at the discretion of the IC RN Supervisor. Each nurse must keep an organized calendar in Outlook that is continually updated to reflect actual visits made. The IC RN is required to plan and schedule home visits efficiently to increase productivity while decreasing travel cost.
- G. If the IC RN learns a participant has moved (or is planning on moving) the IC RN should remind the participant of their responsibility to contact the assigned Counselor. The IC RN will notify the assigned IC Counselor by email; and if appropriate, "new" IC RN. The Counselor will be responsible for following up with the Participant, updating the IndependentChoices database (IC database), and the contracted Fiscal/Employer Agent (PALCO).
- H. Black ink must be used to complete all forms and documentation. "White out" or "dry line" is not allowed. When making changes and/or revisions to DAAS/IC forms, nurse narrative, etc., the IC RN will strike through the error, write "error" and initial and date the error.
- I. All documentation must be legible.
- J. It will be the IC RN's responsibility to determine at the Enrollment Visit if a Decision-Making Partner or a Communications Manager is required in order for a person to enroll in the IC Program.
 - 1. Decision-Making Partner Designation
 - a) A Decision-Making Partner will be required if the individual interested in participating in the IC Program has a court appointed legal guardian or other court appointed representative.
 - b) A Decision-Making Partner will be required for any applicant who is unable to understand his/her own personal care needs; make decisions about his/her own care; organize his/her life style and environment by making these choices; understand how to recruit, hire, train and supervise personal care assistants; understand the impact of his/her decisions and assume responsibility for the results; or when circumstances indicate a change of competency or ability to self-direct demonstrated by non-compliance with the IC Program's

Responsibilities and Agreements. The Applicant, IC staff, and/or PALCO may request a Decision-Making Partner be designated.

c) A Decision-Making Partner must:

- Show knowledge about the participant's preferences
- Be willing and able to meet and uphold all program requirements listed for the participant
- Be willing to sign tax forms and verify timesheets on behalf of the participant, as well as cooperate with the bookkeeper when needed
- Show a strong personal commitment to the IndependentChoices participant
- Agree to visit the participant at least weekly
- Independently uphold these duties without being influenced by the personal assistant or the paid backup personal assistant
- Be at least 18 years of age
- Obtain the approval from the participant and/or a consensus from other family members to serve in this capacity
- Be willing to submit to criminal background checks, if requested
- Be available to discuss the program during business hours

d) All Decision-Making Partners will be required to complete and sign a Decision-Making Partner Screening Questionnaire and Designation of Decision-Making Partner Form. This person cannot be paid for their service and cannot be the paid personal assistant. They can be the unpaid backup personal assistant.

2. Communications Manager Designation

- a) If the Participant is able to make their own decisions, but requires assistance communicating, they may appoint a Communications Manager.

- b) The Communications Manager will be able to sign forms, speak with IndependentChoices, and otherwise assist in communicating at the direction of the Participant. This person cannot be paid for their service, and cannot be the paid personal assistant.

The Enrollment Packet the IC RN receives from the Counselor will consist of the following forms for enrollment:

<u>Enrollment Forms*</u>	<u>Communication Forms*</u>
Participant Responsibilities and Agreements	Disenrollment Form
Backup Worker	Participant Address and/or Phone Number Change
Authorization to Disclose Health Information	Changing or Adding a Worker
<u>Designation Forms</u>	<u>Additional Forms (If Requested)</u>
Communications Manager / Decision-Making Partner Fact Sheet	Media Consent
Designation for Decision-Making Partner	Consent to Use Name, Photograph & Biographical Data
Designation for Communications Manager	Arkansas State Police Individual Record Check

** These forms are required to be sent to all Applicants*

The following is a brief explanation of how to complete the forms:

Designation

First determine whether or not the participant will need a Decision-Making Partner or Communications Manager. If the participant does need assistance, they or their family will need to determine who that will be. Ensure that the prospective partner/manager understands the requirements of the position as outlined in the packet. The designee will then fill out the forms and sign the authorization. If the participant cannot sign to designate the person, a witness signature is required. Be sure to get a good **daytime** phone number for the designee.

Enrollment

- A. Responsibilities and Agreements: Needs to be signed by participant or by decision-making partner. The Communications Manager can sign the form at the direction of the participant. When signed by the decision-making partner

or communications manager, it must be signed: Decision-Making Partner/Communications Manager Name for Participant's Name.

- B. Backup Personal Assistant: Make sure the participant has a backup personal assistant (not the primary personal assistant). Make sure the mailing **and** physical address is entered. Be sure they indicate whether or not that person will be paid, and if they can discuss the case with us. If they indicate that they can discuss the case, make sure they are listed on the DHS-4000.
- C. DHS-4000: The participant will need to designate everyone who we can speak with about the case and sign. Make them aware the Personal Assistant or paid backup Personal Assistant is limited to health issues only.

If you need additional assistance, contact one of the Counselors.

400.200

Working Relationships

7-1-09

The IC RN has regular contact with Participants, family members, departmental staff, physicians, and occasional contact with other state, federal, and/or private hospital or clinical personnel and the general public.

A. Adult Protective Services

If an IC Participant has an Adult Protective Services (APS) incident reported, the IC RN will talk with APS to determine the nature of the report. If the incident is not related to the functions of IC, the IC RN will document the incident in the Participant's contact notes. If the incident is related to the functions of IC then the IC RN must report to the IC RN Supervisor for further action.

All DHS employees are mandated reporters of adult abuse; therefore, any cases of suspected abuse should be reported immediately to APS field staff or to the APS abuse hotline at 1-800-482-8049.

B. Alternatives for Adults with Physical Disabilities (AAPD) Waiver

An Alternatives participant is not automatically precluded from receiving IndependentChoices services. Medically necessary IndependentChoices services may be provided, but only if it is included in the AAPD evaluation and plan of care and it is not a duplication of services. The Alternatives (AAPD) participant must first be receiving the maximum care benefit limit of eight hours per day. The IC RN must assess the participant after the referral is

made and create a plan of care of no more hours than is provided by the AAPD plan of care. If the AAPD plan of care exceeds more than 14.75 hours per week, an extension of benefits will be required.

C. Developmental Disabilities Services (DDS) Waiver

The DDS waiver is a home and community based waiver program offered through the Division of Developmental Disabilities Services. Under the IC state plan guidelines, DDS waiver participants may receive their personal care through IndependentChoices. The IC RN must assess the participant. Note: IndependentChoices Participants cannot live in a property owned or operated by a provider.

D. ElderChoices (EC) Waiver

ElderChoices waiver participants are eligible for IndependentChoices. These participants will receive the level of care designated on the EC Plan of Care. Each county has at least one specific nurse assigned for EC. Some counties have several nurses that divide the caseload. The ElderChoices waiver offers the Participant other services on the plan of care such as:

1. Homemaker services. The homemaker services may be provided up to a maximum of 43 hours per month. One hour equals one unit of service. The homemaker aid must perform whatever homemaker tasks are required in order to meet the Participant's needs such as cleaning an area utilized by the Participant, laundry or cleaning.
2. Personal Emergency Response System (PERS). This service is for those high-risk individuals who have a high medical vulnerability and social isolation and is capable, mentally and physically, of operating the PERS unit.
3. Home-Delivered Meals. Home-Delivered Meals provide one meal per day.
4. Respite Care. Respite Care provides temporary relief to caregivers providing long-term care for elderly individuals. During the period of Respite Care, specific tasks will be carried out according to a written plan developed by the provider in accordance with the individual's plan of care.
5. Adult Day Care (ADC) and Adult Day Health Care (ADHC). These services should only be included in the individual's plan of care when it is necessary to prevent the permanent institutionalization of the individual.

6. Adult Family Homes (AFC). Care is provided in a home setting and the provider must include the individual in the life of the family as much as possible.
7. Chore Services. Chore service provides heavy cleaning and/or yard and walk maintenance only in extreme, specific individual circumstances.
8. Adult Companion Service. These services are for non-medical care, supervision and socialization. The maximum amount of Adult Companion Services activities is 23 hours per week/100 hours per month.
9. Personal Care. The maximum amount of hours for Personal Care activities without an extension of benefits is 14.75.
10. Targeted Case Management. The Targeted Case Manager is responsible for monitoring the client's status on a regular basis for changes in their service need.
11. Home Health. The types of service, amount and frequency must be included on the plan.
12. Medical Transportation. Non-emergency medical transportation is a covered service by the Medicaid program.
13. Diapers and/or Underpads. These items, if utilized by the client, must be included on the plan of care.

E. Hospice Care

The receipt of Hospice Care automatically excludes an individual from receiving IndependentChoices personal care services. However, an EC participant assessed to receive Adult Companion Services (ACS) may still self direct through IndependentChoices for those hours assessed. This is the only situation where adult companion services can be provided by IC without personal care services being provided.

410.000 Time Management and Visit Scheduling**410.100 Scheduling Visits / Outlook Calendar****7-1-09**

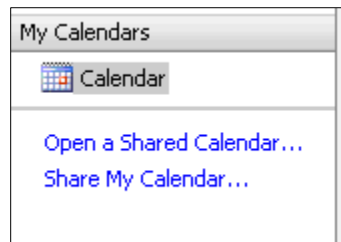
- A. The IndependentChoices Registered Nurse (IC RN) is required to generate and print the Enrollment/Re-assessment information from Reports Section of the IndependentChoices database (IC database).
- B. The IC RN is to prioritize scheduling by county and by assessment date.
 - 1. The IC RN is to plan and schedule home visits with participants who live near one another to minimize travel costs and for efficient use of assigned work hours. The first step in completing this task is to tentatively schedule each county on specific dates in a given month.
 - 2. Prioritize the scheduling of the home visits by reviewing the information from the Enrollment/Re-assessment reports you have generated.
 - a) Reassessments cannot be completed more than 60 days prior to the end of the personal care service plan. The completed reassessment must be received in IC central office no later than 3 weeks prior to the end of the personal care service plan to insure continuation of service for the participant. Medicaid policy requires that a participant be disenrolled when a plan of care expires unless a new one has been authorized.
 - b) Initial Assessment/Enrollment should be scheduled within 20 days of notification of a referral.
- C. Ideally, the IC RN's will tentatively schedule home visits by phone at the end of the month for the following month and confirm the appointment with the Applicant and Decision-Making partner or Communications Manager (if applicable) a minimum of 2-3 weeks in advance.
- D. The IC RN's Outlook Calendar must be electronically shared with all counselors, the IC RN Supervisor, the Administrative Specialist III, and all other IC RNs.
- E. IC EC re-assessments must be completed every 6 months. (See 2(a) above for time frames.)

- F. Appointments are to be entered in the Outlook calendar with any necessary revisions updated on the IC RN's office day each Friday. Update the calendar with the visits that were added or did not occur during the work week.
- G. All appointments are to be confirmed the day preceding the appointment to insure a situation has not occurred which would necessitate the cancelling of the appointment to comply with travel reimbursement procedures.
- H. To add an appointment, double-click on the day you wish to schedule.

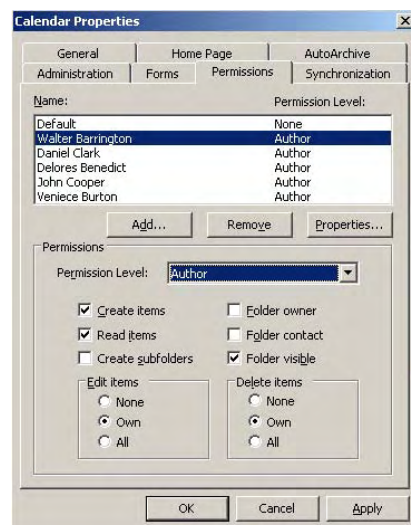
Enter Subject (participant's name), Location (city), and Type of visit (R: Re-assessment, EOB: Extension of Benefit, or E: Enrollment). There may be times when an unannounced visit is required (e.g. APS), when this happens code M: Monitor.

- I. To share the Outlook Calendar with other IC staff members:

1. Select Calendar option
2. Select Share My Calendar



3. Select Permission



4. Select Add—The Global Address book will open. Type the First name then Last name of contact you want to add.
5. For the contact you add, Select Permission level and grant it for the Author.

410.200 Contacting IC Participants

7-1-09

The Participant or Decision-Making Partner is the employer and accepts the responsibility in directing the work of their employee (the personal assistant) to the degree necessary to meet their individual needs for assistance with activities of daily living and instrumental activities of daily living. A Communications Manager is responsible for completing any and all paperwork at the direction of the Participant and/or communicating for the Participant.

The IC RN is responsible for contacting a Participant/Decision-Making Partner/Communications Manager to set up an appointment for assessments, monitoring visits, and enrollments:

- A. The IC RN is to call at least 3 or 4 times. If there is no answer and the Participant/Decision-Making Partner/Communications Manager cannot be reached by phone, enter a contact note in the IC database and email the Counselor requesting a no contact letter be sent to the Participant.
- B. If the phone is disconnected, enter a contact note in the IC database and email the Counselor to send a no contact letter.
- C. Many times updated contact information can be obtained from the IC Counselor, PALCO (toll free number is 866-710-0456 or office number is 501-604-9936), or the DHS county office.

410.300 Content of Visits (Types)

7-1-09

A home visit may be of multiple types identified as follows:

- A. Enrollment (Initial) (E)
- B. Reassessments (R)
- C. Extension of Benefits (EOB)

D. Phone Monitoring Visits (PM)

E. QSource (QS)

410.400 Reports**7-1-09**

IC RN's are responsible for regularly generating reports through the IC database to review the status of participation to assure home visits are completed within required time frame. Procedures for preparing reports can be found in the Administrative Section of this manual. (See Section 204.270 screenshots.)

410.500 Nurse Productivity Chart**7-1-09**

Nursing Activity	Allocated Time in Minutes	Max Minutes per Week If Driving Miles = 3.5 Hours per Day	Maximum Events in Week Per Activity	Maximum Events Per Day
Reassessment Less than 14.75 Hours per Week	45	1,320	29	7
EOB (Includes sync MDS-HC)	75	1,320	18	4
New Enrollment W/O EOB	90	1,320	18	4
New Enrollment With EOB	120	1,320	13	3
Monitoring Visit + Form (Any Recipient including EC)	15	1,320	88	22
EC Initial Visit + Assistance with Enrollment Forms + Monitoring Form	45	1,320	29	7
Phone Monitoring + Form	15	1,320	88	22

***Max Hours per Week - If Drive Time per Day is Less than 3.5 Hours then Maximum Events Should Increase. Productivity and mileage per day can be cross-compared to submitted TR-1.**

420.000 Assessments**420.100 Enrollment (Initial Visit)****7-1-09**

IC Central Office staff responds to inquiries, completes the Referral-Screening Questionnaire, verifies Medicaid eligibility to enroll, and, if eligible, enters the Applicant's information into the IC database.

Once an initial referral is entered in the IC database, the Counselor has **5** days to mail the enrollment package to the appropriate IC RN. The Counselor will notify the IC RN via email when the enrollment paperwork is mailed from IC Central Office.

The IC RN will notify the Counselor via email when they receive the Applicant's enrollment package is received. The IC RN will review all information in the IC database and communicate with the Counselor any concerns or discrepancies prior to the Enrollment Visit.

The IC RN then has **20** days to contact and schedule the Enrollment Visit with the Applicant. If the Applicant has designated someone as a Decision-Making Partner or as a Communication Manager, then the IC RN will also contact that person to inform them they must be present for the Enrollment Visit. The Communication Manager will only be required to be present if they are needed by the Applicant.

The IC RN will document all attempts to contact the Applicant for enrollment in the IC database. If the IC RN is unsuccessful in scheduling or contacting the Applicant, a contact note will be entered in the IC database with detailed information and sent to the Counselor requesting a "No Contact Letter". The Counselor will send a letter, and enter a contact note in the IC database. If there is no response within 14 days, the Counselor will enter the appropriate refuser code.

Once the Applicant provides correct contact information and telephone numbers, the refuser code will be removed and the IC RN will be notified to schedule an Enrollment Visit.

It is the IC RN's responsibility to determine if the Applicant qualifies for personal care services by observation and communicating with the Applicant and Decision-Making Partner/Communications Manager (if applicable). During the Enrollment Visit, the IC RN will complete the enrollment paperwork and the initial assessment, with or without an Extension of Benefits, as required.

During the home visit the RN will:

- A. Meet with the Applicant and Decision-Making Partner/Communication Manager (if applicable);
- B. Determine if services are appropriate for the Applicant by assessing the applicant's functional ability through observation and demonstration as needed;
- C. Determine personal care needs;
- D. Determine if an agency or other service providers are in the home;
- E. Determine if an EOB is necessary (See Section 424.000);
- F. Complete the DMS-618, the DAAS-IC-20, and the MDS-HC, if applicable (See Sections 420.300 and 420.500)

NOTE: If the IC RN's assessment of an EC client differs from the EC POC, the IC RN must contact the EC RN to discuss the change. If both agree the change is justifiable, the IC RN will proceed with what was agreed to by both programs.

- G. Complete the enrollment paperwork, including the designation of decision-making partner if one is determined needed by the IC RN and one has not already been designated;
- H. Complete the Enrollment Checklist. (See Section 430.800)

Within **5** working days after the Enrollment Visit, the IC RN will enter all tracking information in the IC database, including assessment information and the **actual date** the paperwork is mailed to IC Central Office. The documentation to be mailed to IC Central Office must be stapled together in the following order:

- A. Completed Enrollment Checklist
- B. Enrollment Paperwork
- C. DMS-618, DAAS-IC-20, and MDS-HC (if applicable)

(See Section 230.403 for tracking procedures.)

It is the goal of the IC Program to complete the entire enrollment process within **45** days of the initial referral date.

420.200**Revision****7-1-09**

If a request for an increase in personal care hours is received due to a significant change in the Participant's personal care needs or change in environment, the IC RN is required to make a home visit to determine if an increase in hours is warranted. Note: Medicare could be providing personal care temporarily if there is an acute condition.

When the IC RN deems an increase of personal care hours is applicable for the participant, (e.g., new EOB or personal care hours increased up to 14.75 hours), the IC RN will:

- A. check the Revision box in the Service Plan Status section of the DMS-618
- B. complete the DMS-618, the DAAS-IC-20, and the MDS-HC for an EOB if applicable

(See Section 424.000 for EOB procedures.)

NOTE: If the IC RN assessed personal care hours for an EC client differ from the EC POC on file, the IC RN must contact the EC RN to discuss the difference. If both agree a change in hours is justifiable, the IC RN will proceed with what was agreed to by both parties.

Within **5** working days after the Reassessment Visit, the IC RN will enter all assessment tracking information in the IC database and staple the completed paperwork together and mail it to IC Central Office. The **actual date** the paperwork is mailed to IC Central Office must be entered into tracking. (See Section 230.40 through 230.406 for tracking procedures.)

The IC RN will document all attempts to contact the Participant for an assessment in the IC database. If the IC RN is unsuccessful in scheduling or contacting the Participant, they will enter a contact note in the IC database with detailed information and forward the contact note to the Counselor requesting a "No Contact Letter" be sent. The Counselor will send a letter, enter a contact note in the IC database, and proceed according to their procedures.

420.300**Renewal****7-1-09**

If an IC Participant is receiving ≤ 14.75 hours per week, the reassessment is to be conducted at 6-month intervals. (This includes participants also enrolled in ElderChoices.) (See 410.200 for time frames)

NOTE: If the IC RN's assessment of an EC client differs from the EC POC on file, the IC RN must contact the EC RN to discuss the difference. If both agree a change in personal care hours is justifiable, the IC RN will proceed with what was agreed to by both parties.

During the Reassessment Visit, the IC RN will determine if an EOB is necessary by evaluating the Participant for significant changes in personal care needs. If the IC RN determines changes warrant an EOB, he/she will begin the EOB process. (See Section 424.000 for procedures)

Within **5** working days after the Reassessment Visit, the IC RN will enter all assessment tracking information in the IC database and staple the completed paperwork together and mail it to IC Central Office. The **actual date** the paperwork is mailed to IC Central Office must be entered into tracking. (See Section 230.405 for tracking procedures.)

If the IC RN has been unsuccessful in contacting the Participant to schedule a re-assessment visit, the IC RN will enter a contact note in the IC database with detailed information and forward that note to the Counselor requesting a "No Contact Letter" be sent. The Counselor will send a letter, enter a contact note in the IC database, and proceed according to their procedures.

If the IC RN becomes aware of a Participant being hospitalized or entering a rehab facility, a contact note should be entered in the IC database and sent to the Counselor. The Counselor will proceed according to their procedures.

420.400 **Extension of Benefit (EOB)**

7-1-09

Personal Care assessments for Participants age 21 years or older and authorized by the Participant's physician in excess of 14.75 hours per week require approval of Utilization Review (UR).

A determination will be made if it is an initial EOB, a routine continuation, or an increase (due to a significant change in the Participant's status).

Schedule a home visit with the Participant and the Decision-Making Partner or Communication Manager, if applicable.

Completion of the DMS-618 (Re-assessment form) for an EOB will include:

- A. PCP information and date of last exam.

- B. Medical Diagnoses with ICD-9 codes. The IC RN will list diagnoses in descending order, if possible, by the most medically complex or functional impairment. These are only the diagnoses that pertain to physical dependency.
- C. In the Physical Dependency Status category, be sure to indicate if the Participant is Total Help. NOTE: If the Participant is NOT total help an EOB is not appropriate.
- D. The Assessment Narrative is to be completed (on a separate form) and submitted with the entire packet of paperwork. The narrative incorporates current results from the MDS-HC Client Assessment Protocols (CAP) reports. Each narrative represents the current functional ability of the client and can never be a copy of the previous narrative assessment. If the IC RN copies previous narratives they should expect disciplinary action. The separate form must include the name and signature of the IC RN. (See Example in Form Appendix)

The IC RN will complete the MDS-HC form at the home visit.

For an initial EOB, it is necessary to complete all of the questions on the MDS-HC.

When a Participant is also receiving ElderChoices services, the IC RN and the ElderChoices (EC) RN must agree that an EOB is necessary. The IC RN will write the EOB. Within **5** business days after the EOB Visit, the IC RN will enter all tracking information in the IC database and staple the completed paperwork together and mail it to IC Central Office. The **actual date** the paperwork is mailed to IC Central Office must be entered into tracking. (See Section 230.406 for tracking procedures.)

Paperwork to be submitted: DMS-618, DAAS-IC-20, RUG III report, Caps and Triggers, the Assessment, the Medications report, and the IC RN's narrative.

If the EOB is a continuation of a previously approved EOB, Section CC does not need to be completed; it is for intake only.

NOTE: Each IC RN has the RAI manual for reference, if needed.

The IC RN must complete the DAAS-IC-20 (Work Agreement/Plan of Care) making sure the number of hours requested for the Participant is completed.

NOTE: Times are to be entered in 5-minute increments.

The following must be completed after the home visit:

- A. MDS-HC data entry via PICK (Portable Information Collection Kit),
- B. connect to the VPN,
- C. synchronize the PICK system,
- D. generate reports (using the AR Reports Portal),
- E. print the reports (RUG III, Caps and Triggers, Assessment, Medications),
- F. enter the RUG III category in the IC database (using the drop down box in IC RN Tracking), and
- G. write the IC RN's narrative

(See Section 442.000 for further information)

If the physician authorizes the personal care hours on the assessment, the assessment is faxed to the EC RN (using an EC POC Revision Fax Form) requesting their revision of the EC POC if the EC RN has not submitted a revised EC POC based upon prior communications with the IC RN. Personal care hours on the DMS-618 and the EC POC must agree prior to requesting UR approval. The Counselor will proceed according to their procedures.

The timeline for UR varies with their workload.

Approvals may be Total, Partial, or Denied.

The Service Plan is for 1 year unless UR stipulates a specified timeframe. The IC RN can also request a shorter timeframe to meet a need not expected to exist for 1 year. The Counselor will be responsible for updating the IC database with the authorized plan of care dates upon receipt of the approval from UR.

420.410 Extension of Benefit Phone Monitoring

7-1-09

A phone monitoring visit is required every 6 months for with an EOB approval.

The phone monitoring form must be completed, submitted to IC Central Office within **5** working days, and Nurse Tracking information entered in the IC database.

Enter the following:

- A. IC RN Name

- B. Select the type of visit using the drop down box.
- C. Enter the date of the phone monitoring visit
- D. Enter the date to IC Central Office (date actually mailed, not the date tracking information entered)
- E. Check appropriate box (Person well cared, etc.)
- F. If EC Participant, check the EC box
- G. Make notation of any concerns or relevant references (e.g. Phone monitoring, etc.)

420.500**QSource****7-1-09**

All Personal Care Services for Medicaid recipients under age 21 are subject to prior authorization. To request prior authorization of personal care services, the IC RN must submit a completed MDS-HC and accompanying forms and narrative for any Participant requiring approval by QSource. Once the Counselor receives the required documents and receives physician authorization, the Counselor will then fax the appropriate forms to QSource according to the procedures outlined in the Counselor Section.

Source of Arkansas
124 West Capitol, Suite 900
Little Rock, AR, 72201

When enrolling or doing an assessment on a QSource Participant, make the Counselor aware that the Participant is a QSource Participant.

At a minimum, the IC RN must document the following:

- A. Complete patient demographic information
- B. Detailed physical assessment of the QSource Participant, including medical diagnoses that have resulted in the child's increased physical dependency needs.
- C. Detailed personal care service plan. This must specify the individual tasks the personal care aide/worker is to perform, including the duration and frequency of each task.

- D. Section X - Alternative Resources for Assistance. When filling out this section please note, if the family member is the IC paid caregiver, no other member of the family or community provides the care. In other words, no other family member or person in the community is available to provide the care informally. If there are other family members or persons in the community (e.g., church members, friends) providing care for free (informal support), QSource wants you to detail the amount of informal care that is provided to the Participant by other members of the family, friends, church members, etc.
- E. The IC RN is required to note in the narrative that this is an IndependentChoices Participant.
- F. The Participant or the Participant's Decision-Making Partner, the Personal Assistant, the IC RN and the Participant's PCP must sign and date the appropriate forms (e.g., MDS-HC; DAAS-DAAS-IC-20 and DAAS-IC-618). Failure to have all of these signatures will result in a denial.
- G. IC RNs are required to sign and date all MDS-HC's and Assessment Narratives. This is not a type written name, but the RN's signature and date.
- H. On the DMS-618, page 2 of 7, the Special Administrative Section must be completed. The procedure "Codes Requested" is, T1019. Also, include the number of hours a day, minutes a day, and frequency being 7 days a week.

Providers must submit request for the prior authorization of personal care services within thirty calendar days of the start of care date. Approvals may be retroactive to the beginning date of services if the request is received within thirty days of the start of care date.

420.600**Missed Visits****7-1-09**

The day prior to traveling to a scheduled home visit, the IC RN is required to contact the Participant or Decision-Making Partner/Communications Manager, if applicable, to verify the appointment. This is necessary to avoid waste of work hours and travel expense. If the IC RN appears for the home visit and the Participant or any other required party is not available, the IC RN must complete the Missed Visit document and complete the Nurse Tracking record as follows:

- A. IC RN Name
- B. Date of visit

- C. Enter the type of visit using the drop down box.
- D. Date, time and name of person contacted to confirm the appointment should be entered in the Nurse's Concerns section.
- E. Date to DAAS - Enter the date **mailed** to IC Central Office.
- F. If prior contact was not made the day preceding the scheduled appointment, a contact note must be entered in the IC database and emailed to the RN Supervisor with an explanation.

A contact note must be entered in the IC database and emailed to the Counselor so a "No Contact Letter" can be mailed.

430.000 Documentation**430.100 Time Frame and Directions for Submission****7-1-09**

- A. The IC RN will complete all Assessments, Re-assessments, Extension of Benefits, Phone Monitoring visits (not completed during the week) documentation and mail them to IC Central Office by interoffice mail or parcel on Friday. All documentation must be completed and submitted to IC Central Office within **5** working days of home visit. The TR-1, whether submitted on-line or on paper, will be completed and submitted on Fridays for travel completed during the current week.
- B. The DMS-618 must be completed within 60 days prior to the end of the current service plan and must be received in IC Central Office no later than 3 weeks prior to the end of the current personal care service plan to insure continuation of service for the participant. Medicaid policy requires that a participant be disenrolled when a service plan expires unless a new one has been authorized. This includes cases where the Participant is also receiving ElderChoices (EC) waiver services.
- C. The DMS-618 must be signed by the physician within the last 60 days of the current authorization (See Section 320.300).
- D. New Applicants, including EC clients, will be assessed within 20 days of receiving the enrollment forms from the Counselor.
- E. Extensions of benefits assessments are completed one time a year (except QSource) unless they are authorized for a shorter duration. Phone monitoring visits will be conducted six months after each extension of benefits assessment.
- F. QSource assessment will be conducted every six months, regardless of the level of care.
- G. Tentative Scheduling of appointments is to be completed on the IC RN's Outlook Calendar the last week of the month for the next month. The updating of the Outlook Calendar will occur on the IC RN's office day on Friday.
- H. The IC RN must make a daily report of home visits/activity to the IC RN Supervisor. The report is due at the end of each work day and may be delivered by phone or e-mail.

430.200

Completing DMS-618

7-1-09

A. Participant and Provider Information

1. The participant's information

- a) Medicaid ID: Enter the participant's 10 digit Medicaid number (e.g. 0000000000).

Note: The Medicaid ID must be entered at the top of each page of the DMS-618.

- b) Service Plan Status: Check Initial (First Nursing Assessment visit), Revision (A visit for Change in Condition/increased hours), or Renewal (Regular scheduled 6month/1year visit).

- c) Name: Enter the participant's last, first and middle name (e.g. Sunshine, Little Miss).

Note: The participant's name must be entered at the top of each page of the DMS-618.

- d) County of Residence: Enter the county where participant lives (e.g. Pulaski).

- e) Telephone Number(s): Enter the participant's phone numbers (e.g. 501-222-2222).

- f) Parent(s)/Guardian(s) Name(s): If the participant has a legal guardian or decision-making partner, enter the name(s) (e.g. Jane Doe, Decision-Making Partner).

- g) Complete Mailing Address: Enter the participant's complete mailing address (avoid abbreviating) (e.g. 1234 Happy Lane, Sunshine, Arkansas 72919).

- h) Participant Resides: Check the box where the participant lives. If the participant does not live alone, with relatives, Boarding Home, Group Home, Community-Based Residential Home or in a Residential Care Facility (RCF); then mark the other box and describe.

2. Primary Care Physician (PCP) Information

- a) Name: Enter the physician's name (e.g. Dr. John Lee).
- b) Provider Number: Leave Blank.
- c) Date of Last Exam: Leave Blank. (Enter the date **outside the box**. The physician will provide the exact date later.)
- d) MD Phone #: Enter physician's phone number under the PCP name (e.g. 999-999-9999).
- e) MD Fax #: Enter PCP fax number next to the physician's phone number (e.g. 999-999-9999).

3. Personal Care Provider

- a) Name: Always enter IndependentChoices here.
- b) Provider Number: Always enter 147999787.
- c) Mailing Address: Always enter P.O. Box 1437, Slot S 530, Little Rock, Arkansas, 72203-1437.

B. Service Locations

- 1. Personal Care Service Location(s): Check the place where the care will be provided. If the care will not be provided at a Private Residence, Residential Care Facility, School or DDS Facility select other and describe. Individuals residing in facilities or other properties owned or operated by providers will not be eligible for IC.
- 2. Service Location(s) Address (es): Usually this is the same address as the participant's residence. It is okay to enter "same as above."

C. Dates of Service

- 1. Start of Care Date(s):
 - a) Original (Required): Enter date of first home visit. If initial assessment, enter the current assessment date (e.g. MM/DD/YYYY).
 - b) Per this service plan:

- i. Initial 14.75 or less: Enter the assessment date and the date 6 months from the assessment (e.g. 09/09/2008-03/09/2009).
 - ii. Initial EOB >14.75: Enter the assessment date and the date 1 year from the assessment (e.g. 09/09/2008-09/09/2009).
 - iii. Reassessment 14.75 less: Enter the reassessment due date from the previous assessment as the current assessment date on the new assessment. The new reassessment due date should be 6 months from the new current assessment date (e.g. 09/09/2008-03/09/2009).
 - iv. Reassessment EOB >14.75: Enter the reassessment due date from the previous assessment as the current assessment date on the new assessment. The new reassessment due date should be 1 year from the new current assessment date (e.g. 09/09/2008-03/09/2009).
2. Projected End Date of Service: Enter N/A.
 3. Current Assessment Date: Enter the date the participant was assessed (e.g. 09/09/9999).
 4. Assessing RN: Enter the assessing RN's name and title (e.g. Dedicated Nurse, RN).

Note: This does not have to be a signature; the name can be printed or typed.

5. Attending Physician: Enter N/A.
6. Attending Physician's Medicaid Provider Number: Enter N/A.
7. Date of the Order or Referral for Assessment: Enter N/A.
8. Referral Source: Enter N/A.

D. Participant Freedom of Choice

1. Signature: The Participant, Decision-Making Partner, or Communication Manager must sign here.
2. Date: Enter the Assessment date (e.g. 09/09/9999).
3. Witness: If participant signs with an "X" two witnesses are required.

E. Medical Diagnoses

1. ICD-9 Code: Enter the ICD-9 diagnosis code in the order of significance here (e.g. V15.88).
2. Description: Enter each description next to its number (e.g. falls).

Note: Use the ICD-9 coding book; include as many ICD-9 and descriptions as needed.

F. Mental Status

1. Check the box clear, somewhat confused, moderately confused, hyperactive, withdrawn, needs restraint, or needs supervision for personal safety.
2. Comments: This section is to add more information on the participant's mental status if needed.

Note: The participant that is diagnosed with a mental disorder may not make decisions; but if their mental state is clear, note this on the Comment line.

3. Special Administrative Section: This section should be completed only if the participant is less than 21 years of age (QSource).
 - a) Procedure Codes Requested (should always be T1019)
 - b) Hours
 - c) Minutes
 - d) Frequency

G. Physical Dependency Status

1. Bedridden: Check the box (es) that best describe the participant's mobility in bed.
 - a) Bedfast: Check if participant does not get out of the bed.
 - b) Requires turning in bed: Check if participant is immobile in the bed.
 - c) Bed to chair with help: Check if participant needs assistance with transferring.

- d) Bed to chair without help: If participant can transfer without assistance
 - e) Must be lifted into Chair: If participant cannot stand and pivot.
2. Ambulation: Check the box that best describes the participant's ability to ambulate.
- a) Walks alone: Check if participant ambulates without human assistance or a device.
 - b) Walks with device: Check if the participant uses a cane, walker, etc. to ambulate.
 - c) Walks with help: Check if participant needs human assistance to ambulate.
 - d) Wheelchair (self): Check if the participant can propel self.
 - e) Wheelchair (push): Check if participant cannot propel self.
 - f) Motorized chair: Check if participant has a motorized chair.
3. Continence Status: Check the box (es) that best describe the participant's continence status.
- Catheter: Check if participant has a catheter.
- Colostomy: Check if participant has a colostomy.
- Incontinent: Check if the participant is incontinent of bowel or bladder.
- Bladder: Check if the participant is incontinent of bladder.
- Bowel: check if the participant is incontinent of bowel.
- Training: Check the box that best describes the participant's ability to be trained, cannot train, trained or needs training.
4. Grooming: Complete this section to describe how much assistance the participant needs with the following ADL's.

- a) Bathing: Check no, partial, or total assistance according to the participant's ability.
 - b) Dressing: Check no, partial, or total assistance according to the participant's ability
 - c) Shaving: Check no, partial, or total assistance according to the participant's ability
 - d) Care of hair: Check no, partial, or total assistance according to the participant's ability
5. Eating: Check the box (es) that best describes the participant's ability to eat.
- a) Has physical ability to eat without assistance: check if the participant can feed self.
 - b) Needs partial help to eat: Check if the participant needs set-up only.
 - c) Needs help with eating: Check if the participant must be fed.
 - i. Special diet: Check if participant is on a specific diet.
 - ii. Cannot cut food into bite-sized pieces: Check if someone must cut food for participant.
 - iii. Cannot bring food from plate to mouth: Check if participant must be fed.
6. Preparing Meals: Check the box that best describes the participant's ability to prepare meals.
- a) Check "has physical ability to cook or prepare food without help"; if participant can prepare meals independently.
 - b) Check "needs partial help" if participant can perform some of the task.
 - c) Check "physically incapable of cooking or preparing meals". If the participant is totally dependent on personal assistance to complete this task.

H. Activities of Daily Living

1. Laundry: Check the box that describes the participant's ability to do the laundry.
 - a) Check "needs no help" if the participant is totally independent.
 - b) Check "needs partial help" if participant can perform some of the task.
 - c) Check "physically incapable of performing this task" if participant is totally dependent on personal assistants to complete this task.
2. Incidental Housekeeping: Check the box that describes the participant's ability to do the housekeeping.
 - a) Check "needs no help" if the participant is totally independent.
 - b) Check "needs partial help" if participant can perform some of the task.
 - c) Check "physically incapable of performing this task" if participant is totally dependent on personal assistants to complete this task.
3. Shopping: Check the box that describes the participant's ability to do the shopping.
 - a) Check "needs no help" if the participant is totally independent.
 - b) Check "needs partial help" if participant can perform some of the task.
 - c) Check "physically incapable of performing this task" if participant is totally dependent on personal assistants to complete this task.

Note: Additional pages to describe the participant's dependency needs may be attached. The assessing IC RN must sign and date all attachments.

I. Assessment Narrative

The assessment narrative may be written in the space provided or typed if the participant has 14.75 personal care hours or less. If the participant needs > 14.75 personal care hours an EOB is needed. In this case, the narrative must be typed and submitted with the DMS-618. There are examples of EOB narratives available if needed.

J. Alternate Resources for Assistance

List the participant's resources (e.g. family, IC and EC, no other resources are available).

K. Certification of Service Need and Duration

1. I certify that personal care services are required to: The IC RN must list the personal care needs that are required (e.g. maintain adequate personal hygiene, a safe and clean environment and prevent nursing home placement).
2. Service Time/Daily totals: Copy the number of personal care hours from the DAAS-IC-20 and enter the number in this section. (See Section 430.700)
3. Weekly Totals: Total the hours from the DAAS-IC-20 and enter the maximum and the minimum hours in this section.
4. Additional Comments: Enter Personal Care hours for 12 months and the comment "Will continue to need personal care services indefinitely due to condition."
5. Registered Nurses Signature and Date: The assessing IC RN must sign and date on the line.

L. Personal Care Service Plan

1. The IC RN can write the participant's needs on this line or enter "See DAAS-IC-20".
2. Medications go here. Enter the medication name, dosage, route and frequency of each medication.
3. Physician Authorization: Leave this area blank. This is where the doctor will sign and date.
4. Participant Acceptance of Authorization Service Plan
 - a) The participant or decision-making partner must sign on this line, to accept the DMS-618. Enter the date.

- b) Additional Service increment is to be completed if the participant is age 21 or older and an EOB.
 - i. If the participant needs 21 hours you must subtract 14.75 and enter the additional number of hours. (e.g. 6.25 hours are the additional time requested.)
 - ii. If the participant needs 14.75 hours or less enter N/A
- c) Begin date of services must be entered for EOB.
 - i. If this is the initial assessment, write the current assessment date.
 - ii. If this is a continuation, enter the Reassessment Due date from the Participant's IC database main record.
- d) End Date of Service must be entered for an EOB.
 - i. If this is an Initial Assessment, enter the date that reflects one year from the Begin Date of Service.
 - ii. If this is a Renewal, enter the date that reflects a year from the Reassessment due date.

M. Provider Notification

This section must be left blank. UR will use this section for notification of an approval or denial.

430.300

ICD-9 Codes

7-1-09

ICD-9 Codes are the official guidelines for coding and reporting. Adherence to these guidelines when assigning ICD-9-CM diagnosis codes are required under the Health Insurance Portability and Accountability Act (HIPPA). The diagnosis codes are to be inserted by the IC RN on the DMS-618, page 2 and the MDS-HC.

430.400

Medications Sheets

7-1-09

Medication(s) Sheets are to be completed by the IC RN each time the IC RN performs an assessment. The medications are to be written on page 6 of the DMS-618 under the heading of XIII. Personal Care Service Plan. When completing an

MDS-HC the medications are to be entered under the heading of medications. The name of medication, route, amount and frequency are to be documented.

430.500 Assessments

7-1-09

Assessments are completed on DMS-618 forms. If a participant requires approval from QSource or an Extension of Benefits, a DMS-618 form and a MDS-HC must be completed.

The assessment must support the service plan.

430.600 Narrative

7-1-09

The narrative must include a written description of each physical dependency need. The identification of each physical dependency need must include:

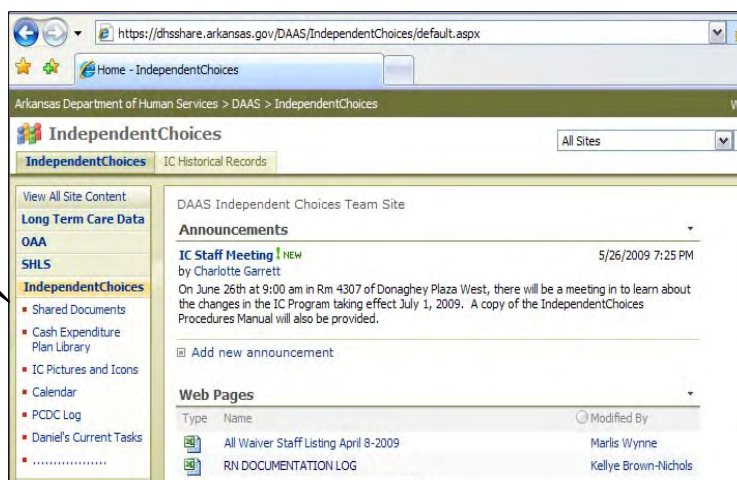
- A. The extent to which the participant can personally perform individual task components of routines and activities of daily living;
- B. The extent beyond which the participant cannot personally perform individual task components of routines and activities of daily living;
- C. The type and amount of assistance the participant may need with each task identified.

430.700 Developing Hours – DAAS-IC-20

7-1-09

To locate a copy of the document to automatically calculate the number of personal care hours for the DAAS-IC-20, open the “Shared Document Link” on the IC Share Home Page and search for “AutoPCHours.xls”.

Open
Shared
Documents



Activities of Daily Living X		Functional Abilities	Value	Minutes to Ability Level	Minutes per Day
05/26/2009					
Eating	Limited assistance	1	5	0	
	Extensive assistance	2	10	0	
	Maximal Assistance	3	15	0	
	Total dependence/ Tube feeding	4	30	0	
Mouth Care	Set-Up	1	5	0	
	Extensive assistance	2	10	0	
	Total dependence	3	15	0	
Hair Care*	Set-Up	1	5	0	
	Extensive assistance	2	10	0	
	Total dependence	3	15	0	
Shaving*	Set-Up	1	5	0	
	Extensive assistance	2	10	0	
	Total dependence	3	15	0	
Skin Care*	Limited / minimal assistance	1	5	0	
	Extensive assistance	2	10	0	
	Total dependence	3	15	0	
Nail Care*	Extensive assistance	1	5	0	
	Total dependence	2	10	0	
Range of Motion*	Limited / minimal assistance	1	5	0	
	Extensive assistance	2	10	0	
	Totally dependent	3	15	0	
Foot Care*	Partial assistance	1	5	0	
	Total dependence	2	10	0	
Dressing- Upper	Partial assistance	1	5	0	
	Extensive assistance	2	10	0	
	Total dependence	3	15	0	
Dressing- Lower	Partial assistance	1	5	0	
	Extensive assistance	2	10	0	
	Total dependence	3	15	0	
Turning and	Partial assistance	1	5	0	
	Extensive assistance	2	10	0	
	Total dependence	3	20	0	
Incidental Housekeeping*	Partial assistance	1	10	0	
	Extensive assistance	2	20	0	
05/26/2009					
Ostomy Management	Total management of ostomy &/or colostomy	4	25		
	Total management of tracheostomy	4	25		
OR					
Toileting	Incontinent <1X/Week	1	5		
	Occasional incontinent up to 3X/Week	2	10		
	Daily incontinence	3	20		
	Incontinent , no control	4	30		
Bowel	Occasional incontinence <1X/Week	1	5		
	Frequently incontinent 2 - 3X/Week	2	10		
	Incontinent > 5X/Week	3	20		
	Incontinent , no control	4	30		
Cleaning Assistance	Requires help by a person to clean	3	15		
	Not able to assist with cleaning self	4	25		
				0	05/26/2009
Activities of Daily Living X	Functional Abilities	Value	Minutes to Ability Level	Minutes per Day	
Ambulation	Walks with assistive device	1	5		
	Walks with help of person	2	15		
	Unable to ambulate / Pushed in wheelchair	4	30		
Transfers	Transfers with minimal help	1	5		
	Transfers with extensive assistance	1	10		
	Transfers with maximal assistance	2	15		
	Must be lifted / Total dependence	3	15		
Bathing	Partial assistance	2	10		
	Extensive assistance	3	15		
	Complete bed bath / Total dependence	4	30		
Grooming	Limited assistance	2	10		
	Extensive assistance	3	20		
	Total dependence	4	30		
Shampoo	Partial assistance	2	10		
	Total dependence	3	15		
Vision	Impaired	1	5		
	Blind	3	15		
Memory	Limited impairment	2	10		
	Little to no STM	3	15		
Fall Risk	Needs supervision to prevent	3	10		
	Requires velcro belt or lap/strap for wk	4	15		
Communications	Unable to make needs known	1	5		

7-1-09

The IC RN is to complete the “Initial Enrollment Checklist” form and submit the original with the completed enrollment forms and the initial assessment. A copy should be maintained in the IC RN participant file.

IndependentChoices RN Initial Enrollment Checklist									
PARTICIPANT NAME:									
ADDRESS & PHONE NO:									
SSN:						Medicaid ID			
ENROLLMENT FORMS									
DAAS-IC-02		Responsibilities & Agreement				<input type="checkbox"/>			
DAAS-IC-08		Backup Worker				<input type="checkbox"/>			
DHHS-4000		Auth. to Disclose Health Information				<input type="checkbox"/>			
DECISION MAKING PARTNER									
DAAS-IC-05		Designation of Decision Making Partner				<input type="checkbox"/>			
COMMUNICATIONS MANAGER									
DAAS-IC-05		Designation of Communications Mgr				<input type="checkbox"/>			
FORMS LEFT WITH PARTICIPANT									
Communication Packet		YES		NO					
Media Consent		YES		NO					
Consent to Use Name, Photograph & Biological Data		YES		NO					
ASP Individual Record Check		YES		NO					
ENROLLMENT PROCESSES & COMMUNICATIONS						Hours Authorized			
PLAN OF CARE (618)		YES		NO					
DAAS-IC 20		YES		NO					
MDS-HC (if applicable)		YES		NO					
Q SOURCE		YES		NO					
NOTES									

430.900**Participant Files****7-1-09**

Each IC RN is required to maintain a participant file for each assessment. A copy of each document completed and sent to IC Central Office shall be maintained in the participant file in chronological order.

If a participant relocates to another region, the IC RN will mail the participant file to the new IC RN within 10 days.

When a case is closed due to the death of the Participant, the case file will be brought to the Administrative Specialist II in the IC Central Office for storage.

When a Participant is disenrolled for any other reason, the IC RN will maintain the closed participant file for two years from the date of disenrollment in the event the participant should re-enroll.

IC RNs can deliver closed participant files ready for storage to the IC Administrative Specialist II when attending a meeting scheduled at IC Central Office.

All procedures related to protection of Personal Information or Protected Health Information shall be followed. (See Section 270.000)

440.000 Computer Work**440.100 Protected Information and Security Issues****7-1-09**

Refer to Section 270.000 and DHS Share for complete information on policies and procedures relating to protection of personal and protected health information and access to DHS Information Systems.

All DHS employees are responsible for safeguarding sensitive information. Such materials include data received and/or recorded in case files, on computer hard drives, and computer peripherals. Employees are also responsible for complying with any policy and associated standards associated with DHS Information Systems. Any non-compliance can result in restriction or suspension of all network access to DHS information which would affect your ability to perform your job assignments. DHS employees are subject to disciplinary action, as provided in DHS Policy 1084 and 1085, for violations of this policy.

You are reminded to maintain a “clean desk” in your workspace. In addition to protecting PI and PHI, the clean desk requires an organized work environment free from clutter.

You are reminded that case files and mobile computing devices must be kept in a secure location at all times to ensure access by authorized users only. This means that you are not to leave your laptop or any case files in your vehicle. There have been situations reported where a DHS employee had done so and their car was stolen. In addition to protecting PI and PHI, your notebook computer is sensitive to weather conditions. Extreme heat and cold can permanently harm the notebook.

You are reminded to destroy any and all discarded documents containing PI or PHI in accordance with DHS policies as soon as possible or at a minimum at the end of each day.

440.200 MDS-HC**7-1-09**

You must complete the MDS-HC for any participant who requires more than 14.75 hours of care or is under the age of 21. To complete the process:

- A. Click on the VPN Client icon on your desktop.
- B. Connect to the VPN.
- C. Click on the PICK AR icon.

- D. Select the participant's name.
- E. Click on "Open Case File"
- F. If there is not a prior record, click on "Create New Case"
- G. The following screen shots show the personal information which is to be completed **EACH** time you enter information in the computer.

Section AA	
Name and Identification Numbers	
Name of Client	
a. Last/Family Name	<input type="text"/>
b. First Name	<input type="text"/>
c. Middle Initial	<input type="text"/>
Social Security Number	<input type="text" value="- -"/>
Health insurance number (or other comparable insurance number)	<input type="text"/>
Original Medicaid ID	<input type="text"/>
Active Medicaid ID	<input type="text"/>
Medicare ID	<input type="text"/>
Enrollment Date	<input type="text" value="05/08/2009"/>
Universal ID	<input type="text" value="DFA2D20E-16E3-A4B8-9E5B-6CC34974538B"/>
Location Code	<input type="text" value="WA"/>

Section BB	
Personal Items	
Client	
Address 1	<input type="text"/>
Address 2	<input type="text"/>
County	No Selection <input type="button" value="v"/>
City	<input type="text"/>
State	Arkansas <input type="button" value="v"/>
Zip Code	<input type="text"/>
Zip + 4	<input type="text"/>
Mail in care of	<input type="text"/>
Area Code	<input type="text"/>
Phone	- <input type="text"/>
Directions to Home	<input type="text"/>

Gender	<input checked="" type="radio"/> No Selection <input type="radio"/> Male <input type="radio"/> Female
Birthdate	<input type="text" value="//"/>
Race (Check all that apply)	<input type="checkbox"/> a. American Indian/Alaskan Native <input type="checkbox"/> b. Asian <input type="checkbox"/> c. Black or African American <input type="checkbox"/> d. Native Hawaiian or other Pacific Islander <input type="checkbox"/> e. White
Ethnicity	<input type="checkbox"/> f. Hispanic or Latino
Marital Status	<input checked="" type="radio"/> No Selection <input type="radio"/> Never Married <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Other

Primary Language	<input checked="" type="radio"/> No Selection <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> French <input type="radio"/> Other
Education (Highest Level Completed)	<input checked="" type="radio"/> No Selection <input type="radio"/> No schooling <input type="radio"/> 8th Grade/Less <input type="radio"/> 9-11 Grade <input type="radio"/> High School <input type="radio"/> Tech or Trade School <input type="radio"/> Some College <input type="radio"/> Bachelor's degree <input type="radio"/> Graduate degree
Responsibility/Advance Directives	
a. Client has a legal guardian	<input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes

Responsibility/Advance Directives	
a. Client has a legal guardian	<input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes
b. Client has advance medical directives in place (for example, a do not hospitalize order)	<input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes
Surrogate or Representative	<input checked="" type="radio"/> No Selection <input type="radio"/> Surrogate decision maker <input type="radio"/> Representative
Surrogate or Representative:	
Last Name	<input type="text"/>
First Name	<input type="text"/>
Middle Initial	<input type="text"/>
Address 1	<input type="text"/>
Address 2	<input type="text"/>

Surrogate or Representative	
	<input checked="" type="radio"/> No Selection
	<input type="radio"/> Surrogate decision maker
	<input type="radio"/> Representative
Surrogate or Representative:	
Last Name	<input type="text"/>
First Name	<input type="text"/>
Middle Initial	<input type="text"/>
Address 1	<input type="text"/>
Address 2	<input type="text"/>
City	<input type="text"/>
State	Arkansas <input type="button" value="v"/>
Zip Code	<input type="text"/>
Zip + 4	<input type="text"/>
Area Code	<input type="text"/>
Phone	- <input type="text"/>

Section CC	
Referral Items (complete at intake only)	
Date of First Contact	<input type="text" value=" / /"/>
Reason for Referral	
	<input checked="" type="radio"/> No Selection
	<input type="radio"/> Post hospital care
	<input type="radio"/> Community chronic care
	<input type="radio"/> Home placement screen
	<input type="radio"/> Eligibility for home care
	<input type="radio"/> Day care
	<input type="radio"/> Other
Goals of Care (client/family understanding of goals of care)	
a. Skilled nursing treatments	<input checked="" type="radio"/> No Selection
	<input type="radio"/> No
	<input type="radio"/> Yes
b. Monitoring to avoid clinical complications	<input checked="" type="radio"/> No Selection
	<input type="radio"/> No
	<input type="radio"/> Yes

c. Rehabilitation	<input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes
d. Client/family education	<input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes
e. Family respite	<input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes
f. Palliative care	<input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes
Time Since Last Hospital Stay Time since discharge from last in-patient setting (Code for most recent instance in LAST 180 DAYS) <input checked="" type="radio"/> No Selection <input type="radio"/> No hospitalization within 180 days <input type="radio"/> Within last week <input type="radio"/> Within 8 to 14 days <input type="radio"/> Within 15 to 30 days <input type="radio"/> More than 30 days ago	

Where lived at time of referral <input checked="" type="radio"/> No Selection <input type="radio"/> Private home/apt with no home care services <input type="radio"/> Private home/apt with home care services <input type="radio"/> Board and care/assisted living/group home <input type="radio"/> Nursing home <input type="radio"/> Other	
Who lived with at referral <input checked="" type="radio"/> No Selection <input type="radio"/> Lived alone <input type="radio"/> Lived w/spouse only <input type="radio"/> Lived w/spouse and other(s) <input type="radio"/> Lived w/child (not spouse) <input type="radio"/> Lived w/other(s) (not spouse or children) <input type="radio"/> Lived in group setting w/non-relatives	
Prior NH Placement Resided in a nursing home at anytime during 5 YEARS prior to case opening <input checked="" type="radio"/> No Selection <input type="radio"/> No <input type="radio"/> Yes	

- H. After all entries are completed, synchronize the PICK system
- I. Generate the reports (using the AR Reports Portal)
- J. Print the reports (RUG III, Client Assessment Protocols, Assessment, Medications)
- K. When completing the tracking in the IC database, don't forget to enter the RUG III category.

440.300**Nurse Tracking****7-1-09**

Each IC RN is responsible for tracking information in the IndependentChoices database (IC database) regarding visits with the Participants. (See Section 230.403 through 230.408 for more detailed information) The following are the basic steps for entering information. As there are modifications, the procedures manual will be revised and the changes will be forward to everyone.

- A. Open the IC database.
- B. Find Participant's name.
- C. Verify the name with other identifiers such as date of birth and social security number.
- D. Select the tab marked "Tracking", and then use the tab for Nurse Tracking.
- E. Select Nurse by using the drop-down box.
- F. Select the type of visit by using the drop-down box.
- G. Enter the MDS Rug Category (if applicable), use drop-down box and select category listed from the MDS generated report, for EOBs.

MDS Rug Category:	Clinically Complex
Principal Diagnosis:	CVA--LATE EFFECTS
Secondary Diagnoses:	L WEAKNESS
	DIET CONTROL
	INCONTINENT--URINE
	OBESITY
	HTN/CAD
	ARTHRITIS
<input checked="" type="checkbox"/> EC Client	<input type="checkbox"/> Checked EC POC Tab on Database
	<input type="checkbox"/> Hours Requested Matches EC POC

- H. Principal Diagnosis—enters the principal diagnosis (e.g. CHF—stage IV, RA, CVA, etc., see MDS generated report).
- I. CAP Triggers are OPTIONAL.
- J. If the Participant is currently on ElderChoices, check the EC participant boxes.
- K. Locate the EC POC tab and verify the hours and the date of last re-assessment.
- L. Enter the appropriate date in the Authorization End Date field.
- M. Enter number of hours assessed (e.g. 10, 14, and 14.75).
- N. Enter Date to DAAS—the date the paperwork is actually placed in the County Office interoffice mail system.
- O. Discrepancies in hours are to be addressed with the EC RN.
- P. Additional check boxes are available for other details: Client is well-cared, Strong Informal Support, No Concerns Noted.
- Q. Needs Frequent Counselor Contact is checked if the RN determines a routine telephone call will be beneficial to the participant or if other concerns are noted.
- R. The “Comment” section has an area to write free text (e.g. O2 via NC, recent fall, etc.).

440.400**E-mails****7-1-09**

Refer to Section 270.100 and DHS Share for procedures and policies applicable to the acceptable use of e-mails.

IC RNs are required to enter relevant information about participants in the IC database and email the contact note to the appropriate IC or EC staff.

When a contact note email is received by an IC RN, any response must be documented in the contact note section of the IC database. This can be achieved by entering a contact note in the IC database and e-mailing the appropriate person, or copying and pasting your reply into the IC database. Do **NOT** just reply through Outlook without a contact note.

440.500

Travel Reimbursement

7-1-09

IC RNs seeking reimbursement for work related travel expenses shall comply with the procedures outlined below, those outlined in Section 280.300, and with the procedures outlined in DHS Administrative Procedures Manual, Chapter 304, Travel Reimbursement. Regular review and compliance of travel regulations is required.

- A. TR-1s should be completed and submitted **each Friday (office day)**, as it reflects the updates made to your calendar on the same day. The requirement increases the efficiency in submitting travel as well as approving travel. Failure to follow this guideline will impact performance ratings during the year;
- B. Travel must be verified before it can be approved and submitted for payment;
- C. Travel expenses reported on the IC RN's TR-1 must correspond to the RN Tracking in the IC database and to home visit appointments as scheduled on the RN's Outlook Calendar. Any incorrectly completed TR-1, discrepancies between the TR-1, RN Tracking, and the entries in the RN's Outlook Calendar, or non-submission of required documentation to IC Central Office, may cause a significant delay in the approval of the TR-1.
- D. TR-1's with identified discrepancies cannot be processed for payment and may be returned to the RN to be corrected. If the TR-1 is returned to the IC RN, a new TR-1 must be completed with the correct information. The date of the corrected TR-1 is the date of the correction, not the date the TR-1 was originally submitted.
- E. Travel mileage is to be calculated from the IC RN's office location or home location, whichever is the shorter as your starting point;
- F. Travel reimbursement including expenses in addition to mileage (for example: motel expenses, etc.) must be completed on the paper form TR-1 and mailed to IC Central Office with the receipts attached. Receipts must be signed by the IC RN;
- G. Make sure you sign and include "IndependentChoices RN" on the title line;
- H. To have TR-1 payments directly deposited, write "Direct Deposit Please" in the top right hand corner of the form;

- I. The IC Cost Center is 417012 and our Internal Order Number is currently HCEX0108 (Medicaid-Independent Choices Nurses). Always recheck to make information is entered correctly;
- J. The description field must include information supporting the trip and the participants. Examples: “Home Visit - B. Jones” on the line with your “From” town and “To” town indicated where you don’t have any vicinity miles;
- K. Just “Home Visits” on the line with your “From” town and “To” town where you will also have vicinity miles;
- L. Client information as description (e.g. B. Jones; J Smith) on the next lines. With Vicinity in the From and To Columns;
- M. “Return Trip” or “Return to the Office” is the description for the return from a home visit;
- N. For incidentals and/or meals when staying with family or friends, make sure you attach a clear explanation and justification for reimbursement;
- O. For reimbursement of **mileage only** expenses for travel on or after April 1, 2009, all IC staff must complete the “TR-1 Online”; and
- P. Description of the travel will be the same as described above.

Instructions for completing and submitting the TR-1 Online can be found on the listing of links on the DHS Share home page or by entering the following site in your internet browser:

Website – <https://dhsshare.arkansas.gov/dhstr1>

450.000 PEER AUDITING COMMITTEE

The purpose of the Peer Group Auditing Committee is to perform auditing of the responsibilities of the IC RNs to ensure program quality and compliance.

- A. Two Committees have been established.
- B. Each group will meet once per quarter.
- C. Each peer group will elect their Chairperson every year.
- D. The Chairperson will select the charts to be reviewed. The charts will be pulled at random.
- E. All results are submitted to the Registered Nurse Supervisor.
- F. A copy of the findings will be provided to the IndependentChoices Registered Nurse for his/her information.

The following shows a screen shot of the scoring use.

CHART REVIEW SCORING			
RN REVIEWED:		DATE:	
CHART REVIEWER:		TITLE:	
CLIENT NAME		COUNTY	
COUNSELOR REVIEWED:			
INITIAL ASSESSMENT	REASSESSMENT	EXTENSION OF BENEFITS	
DATE OF ASSESSMENT:		DATE RECEIVED:	
DUTY AREA 1- MANAGES PATIENT CARE			
PERFORMS COMPREHENSIVE FUNCTIONAL ASSESSMENTS			
		YES	NO
1. Was the POC completed and submitted to agency within 5 working days of completion?			
2. Was the POC stamped as received by agency within 5 working days of submission?			
3. Primary care physician's name, telephone number, and fax number present			
4. Date of last exam performed within past 60 days identified?			
5. Other dates of service information complete?			
6. Current assessment date and signature of nurse present			
7. Thorough, accurate assessments completed, including a brief medical History related to physical functioning disabilities			
8. Does the DMS-618 have all of the information completed and legible?			
DEVELOPS APPROPRIATE INDIVIDUALIZED PLANS OF CARE			
		YES	NO
1. Was the POC completed within 60 days of the assessment due date?			
2. The client's assessment and service plan justifies the medical necessity for personal care			
3. The narrative assessment includes the client's need for personal care services and a written description of each physical dependency need.			
4. The identification of each physical dependency includes: a) The extent to which the client can personally perform individual task components of routines and activities of daily living. b) The extent beyond which the client cannot personally perform individual task components of routines and activities of daily living. c. The type and amount of assistance the client may need			
PROCESSES REQUIRED FORMS ACCORDING TO ESTABLISHED GUIDELINES AND TIMEFRAMES			
		YES	NO
1. Does the POC terminate 6 months after original, or 1 year if it is an EOB?			
2. Was the POC signed by the physician within 60 days of the assessment (within timeframe)			
3. Is there a representative if mental status is unclear?			
4. Is Personal Care Assistant Agreement signed and dated by both participant and employee?			
5. Was form received, if applicable, from utilization and review within 60 days of assessment?			
Total:			
COMMENTS			
1. DOES THE POC HAVE CERTIFICATION PERIOD PRESENT			
2. DATE SENT TO MD:			
3. DATE RECEIVED FROM MD:			
4. IS THE INDEPENDENTCHOICES COUNSELORS ENROLLMENT CHECKLIST ON CHART?			

460.000 IC RN Responsibilities and Expectations

The following must be consistently met and will justify your annual performance rating:

- A. Each IC RN's calendar will be completed prior to the end of each current month. The calendar indicates the work plan with anticipated visits each month. On Friday of each week the IC RN will adjust the calendar to reflect the actual work accomplished.
- B. Each IC RN will run reports to identify pending enrollment and assessments. Reports will be run and enrollments and assessments completed within the time frame established according to policy.
- C. Home visits will be efficiently planned to increase productivity while decreasing travel cost.
- D. The IC RN will communicate effectively and on an on-going basis (verbal and contact notes in database with emails).
- E. The IC RN will assume accountability and demonstrates ability to self-manage job assignments.
- F. The IC RN will be issued a State cell phone that will only be used for State business. Phone bills will be audited on a monthly basis. Any use of the cell phones for personal reasons will result in disciplinary action.
- G. The IC RN will keep the phone on during the work day to receive and respond to calls from the IC RN Supervisor, Program Manager and Counselors.
- H. All tracking will be completed and all required home visit documentation will be submitted to IC Central Office within **5** working days of home visit.
- I. A minimum on average of 3-5 visits per day will be conducted Monday through Thursday. This is based on the amount of time to perform the specific type of home visit, as each assessment requires a certain amount of time to complete. Travel and assessment time must equal eight hours per day. Any remaining time must be spent contacting the participants scheduled for the next day to verify the appointments and/or completing documentation of the home visits.

- J. The IC RN will have reviewed the database and contacted the participants immediately prior to traveling to an area, to avoid “missed visits”.
- K. The IC RN will complete and submit their TR-1 for that week’s home visits **each Friday** (scheduled office day).
- L. The IC RN will actively participate in a professional manner in the function of the committee you are assigned to, monitoring meetings and trainings, and informing other agencies of the IndependentChoices Program.
- M. The IC RN will complete and submit leave slips to the IC RN Supervisor according to DHS policy 1007. This means annual leave must be submitted and approved before taken.

Performance standards are based on a thorough and conscientious observation of the IC RN’s adherence to the following:

- A. on-site home visits;
- B. observations through peer group committee meetings;
- C. scheduled telephone contact with the RN Supervisor;
- D. keeping coworkers updated on visits;
- E. reporting in at the end of each day giving persons enrolled, persons reassessed, persons monitored and number of miles driven;
- F. written communication skills;
- G. performing work activities within required timeframes;
- H. keep monthly Outlook calendar current to the weeks activities;
- I. keep the IC database updated to accurately reflect completed work activities
- J. keeping participants informed in the event the scheduled visit cannot be made or if the time of the appointment is delayed or could be scheduled earlier; and by
- K. seeking assistance when needed.

500.000 Appeals and Hearings Process**501.000 Appeal Rights****7-1-09**

The IndependentChoices (IC) participant has the right to appeal certain decisions or actions with which they disagree. The method used to make the appeal and the time frames within which an appeal is made depend on the basis of the appeal. The Division within the Department of Human Services that will hear the appeal is also based on the reason for the appeal.

Appeals for hearing from IC participants will also be handled in several ways based on the reason the appeal has been made.

The determination that an individual is not eligible or is no longer eligible for personal care services cannot be appealed.

502.000 Reason for Appeal**7-1-09**

An appeal may be filed by a participant/decision-making partner based on actions/circumstances as listed below.

- A. Dissatisfaction with an action taken by an IC Counselor or Fiscal Agent.
- B. Dissatisfaction with number of personal care hours
- C. Involuntary case terminations including, but not limited to:
 - 1. Loss of Medicaid eligibility
 - 2. Health, safety or well being of participant is compromised
 - 3. Duplication of services
 - 4. IC case closure based on non-compliance with IC program requirements
- D. Loss of Medicaid eligibility will result in the closure of the IC case. The Division of County Operations (DCO) will send the closure notice and right to appeal information to the client. IC will not send a letter of disenrollment. Any appeal the participant may wish to file based on this closure would be filed with the Office of Appeals and Hearings in the Office of Chief Counsel.

If the individual files an appeal within the ten-day notice period, the individual has the option of continuing Medicaid services until a decision is made on the appeal. If the individual chooses to have Medicaid continue during the appeal process and loses the appeal, any services that Medicaid paid during the appeal period would have to be repaid to Medicaid.

It's important that the IC participant understands the repayment obligation if IC continues to pay the caregiver during the appeal period. Some participants who have family personal assistants may opt to not have IC pay during the appeal period and then if the appeal decision is in the participant's favor, IC can retroactively pay the personal assistant through a POG.

- E. Denial letters for Extension of Benefits (personal care hours more than 14.75) will be mailed by Utilization Review (UR) in the Division of Medical Services with appeal rights information directly to the participant. Any appeal on this action will be filed with the Office of Appeals and Hearings in the Office of Chief Counsel.

502.100 Counselor/Fiscal Agent

7-1-09

Appeals based on dissatisfaction of any service or level of service with the IC Counselor or Fiscal Agent may be made in writing to the Division of Aging and Adult Services (DAAS), IndependentChoices Program, P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437 or by telephone to DAAS IC toll free number (1-800-682-0044).

The counselor will first work with the participant to resolve the issue. If the issue cannot be resolved at the counselor level, the IC Program Manager will work with the participant. If the issue is still not resolved, the issue will go to the appeals committee chair and an appeal hearing will be scheduled.

502.200 Involuntary Closure of IC Case

7-1-09

The involuntary closure of an IC case will be appealed in writing to the Division of Aging and Adult Services (DAAS), IndependentChoices Program, P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437 or may be received via fax (1-501-683-4180). The IC appeals committee will schedule and conduct the hearing.

502.300 Change in Number of Personal Care Hours

7-1-09

If the participant/decision-making partner feels that the number of personal care hours recommended by the IC Nurse after completion of the assessment or

reassessment are not sufficient to meet his/her medical needs, a request for re-evaluation can be made.

These appeals should be made to DAAS, IndependentChoices Program by telephone or in writing as indicated in 502.200.

If the participant continues to be dissatisfied with the decision after an informal review, a fair hearing may be requested in writing.

503.000 Format for Hearing of Appeals 7-1-09

Appeals made to IC will be conducted in several different formats depending on the reason for the appeal. All appeals will be heard telephonically.

503.100 Mediation Process 7-1-09

The mediation process will be utilized when a difference of opinion has occurred between the participant or the decision-making partner and the IC Counselor or Fiscal Agent.

If the mediation process is not satisfactory the participant or participant's decision-making partner may request an Administrative Review.

503.200 Informal Review 7-1-09

The informal review process will be a review of documents such as the Plan(s) of Care completed by the IC Nurse.

The procedure may include telephone contact with the participant/decision-making partner and/or the IC Nurse who completed the Plan of Care. Resolution may include requesting another IC Nurse to conduct another assessment of the participant.

503.300 Administrative Review 7-1-09

During the Administrative Review (fair hearing) the participant or the participant's decision-making partner will have the opportunity to present any and all pertinent evidence. Documents that are presented as evidence for the Administrative Review shall be mailed or faxed to DAAS, IndependentChoices Program to be received prior to the time of the Administrative Review. Information from the IC case file may be utilized and this information will be available for the participant or the participant's decision-making partner to view and question.

The Administrative Review will be scheduled so that the participant/decision-making partner will be notified in writing at least 14 days in advance of the review.

504.000 Timeframes for Appeals 7-1-09

Time frames for the receipt of an appeal vary based on the reason for the appeal. Appeals received outside the time frame given will not be heard. If an appeal is received outside the time frame, the participant or decision-making partner who filed the appeal will be notified in writing why the appeal is not being heard.

504.100 Problem with Counselor or Fiscal Agent 7-1-09

No time frame exists for appeals based on dissatisfaction with the IC Counselor or Fiscal Agent.

504.200 Involuntary Closure of IC Case 7-1-09

Appeals based on the involuntary closure of the IC case must be received within 30 days of the date the notice to the participant/decision-making partner advising that the IC case had been closed was postmarked or received (if notice issued by certified mail).

504.300 Change in Number of Personal Care Hours 7-1-09

There is no time frame for the first stage of an appeal regarding the number of hours of personal care authorized by the Plan of Care. However, once the decision of the informal review is received, if the participant/decision-making partner continues to be dissatisfied with the number of hours, any further appeal must be received in writing within 10 days of the date of notification of the result of the informal review.

505.000 Decision Format 7-1-09

Decisions made in the mediation and informal review processes will be documented in the case record with telephonic communication of the decision given to the participant/decision-making partner, which will be followed up in a letter format.

All decisions made as a result of an Administrative Review will be in writing. The decision shall include at a minimum the name and Medicaid number of the IC participant who filed the appeal or on whose behalf the appeal was filed, the reason for the appeal, the pertinent facts which were presented during the hearing or in

documentary evidence provided for the hearing, the guidelines or rules on which the decision is based and the outcome of the hearing. A cover letter shall accompany the decision giving the participant/decision-making partner further appeal rights (if any) that they may have and the time frame and place for making this appeal. The original of the decision will be mailed to the client and a copy kept in the IC case record. The decision is binding on the IC Program.

506.000**Further Appeal Rights****7-1-09**

In some instances if the decision is not favorable to the participant/decision-making partner, further appeal rights are provided. However, further appeals rights do not exist when both processes have been exhausted when the participant/decision-making partner disagrees with the number of hours of personal care provided in the Plan of Care.

507.000**Allegations of Discrimination****7-1-09**

If an appeal is filed in any format and an allegation of discrimination is made by the participant or his/her decision-making partner, the individual against whom the allegation is made must be available to answer the allegation. The findings on the allegation will be addressed in the hearing decision.

