



Welcome to Part A of Module 4 in the series of training modules for Services Facilitators in Virginia. Completion of all four modules and successful completion of the corresponding learning assessments will satisfy the DMAS training requirements to provide consumer-directed Services Facilitation in Virginia.

Again, please note that this training is meant to serve as a supplement to information that you are responsible to obtain and understand through regular review of the applicable regulations and provider manuals.

Other Responsibilities of Services Facilitators



Required Visits and Plan Modifications

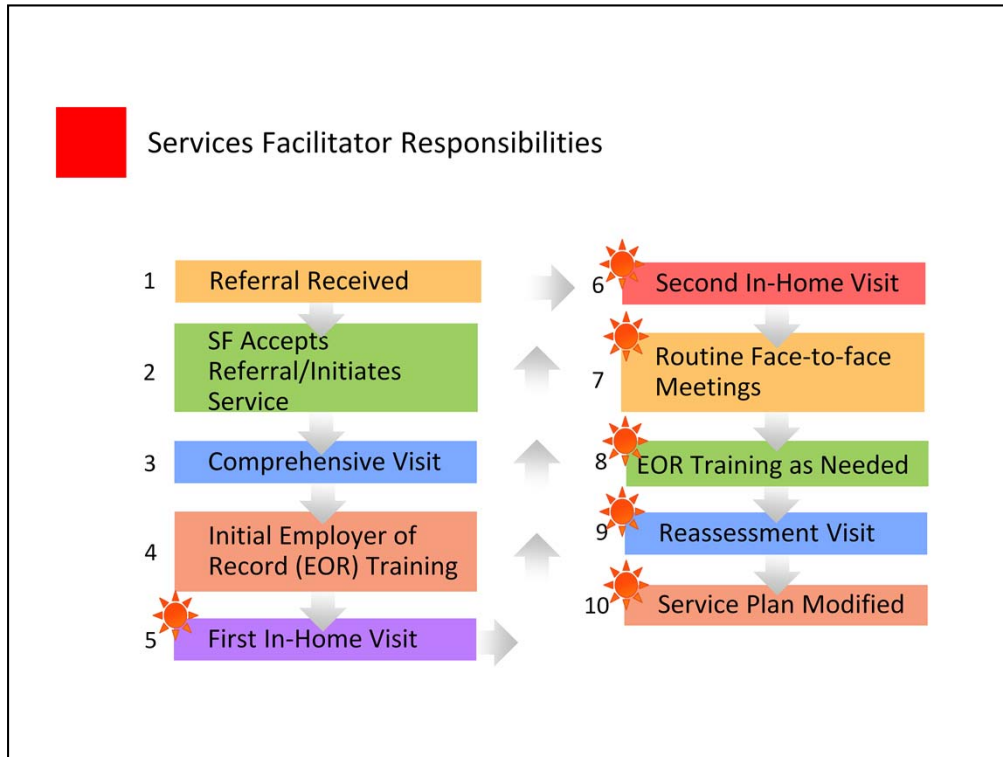


Service-Specific Requirements

In Module 4, Part A, we will cover responsibilities of Services Facilitators following the initial visit, including follow-up visits and plan modifications.

Additionally, we will provide information on several service-specific responsibilities, including:

- Monitoring, with attention to certain service limitations and requirements;
- Family members and people who live under the same roof as attendants; and
- Services to more than one person in the home.



First, we will look at steps 5 through 10 in this flow chart: These include:

- A first and second home visit that are required following the initial EOR Training;
- Face to face meetings and trainings as needed;
- Reassessment visits which are performed periodically; and
- Any modifications that need to be made to the CD service plan.



Required Visits and Other Contacts



Following the initial EOR Training, a Services Facilitator must meet face to face with individuals at certain times. Additionally, a Services Facilitator must be available to the individual, and EOR if not the individual, at other times. The next few slides take a close look at these required visits and contacts.



Required Visits and Other Contacts



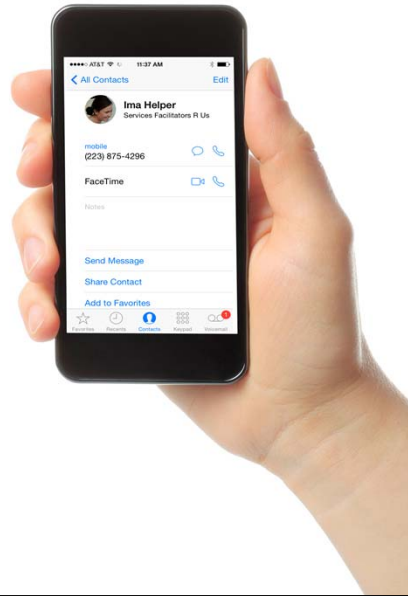
Be available to the EOR/individual for ongoing support
between visits

Part of every Services Facilitator's responsibility is to provide ongoing monitoring of CD services. Ongoing monitoring does not require a visit, and not all monitoring activities are billable services. (If, however, a visit is required, it can be billed as a Routine Visit as we will explain in a minute.) We will cover monitoring responsibilities in more detail now.

Importantly, the individual and EOR should be able to count on ongoing support from the Services Facilitator in the event that questions or problems arise between required visits.



Required Visits and Other Contacts



Be sure to leave your contact information in case your assistance is needed. The Services Facilitator is responsible for counseling an EOR regarding his or her responsibilities as an employer and for consulting with the individual, EOR or family member or caregiver as needed. Specifically, you should:



Required Visits and Other Contacts



- Be available by telephone to individuals and EORs during normal business hours;
- Have voice mail capability; and

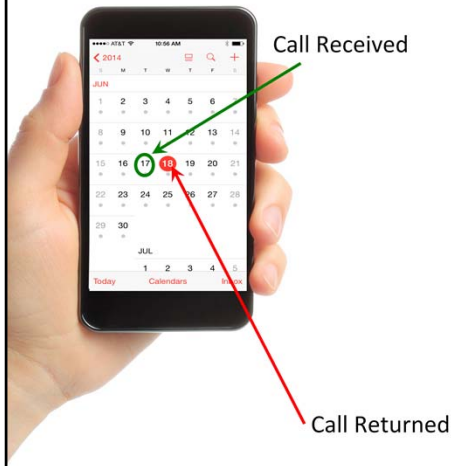


Required Visits and Other Contacts

Requirements for Ongoing Monitoring

CL, FIS, CCC Plus Waivers
And
EPSDT Consumer Directed
Model of Service Delivery:

12VAC30-120-770



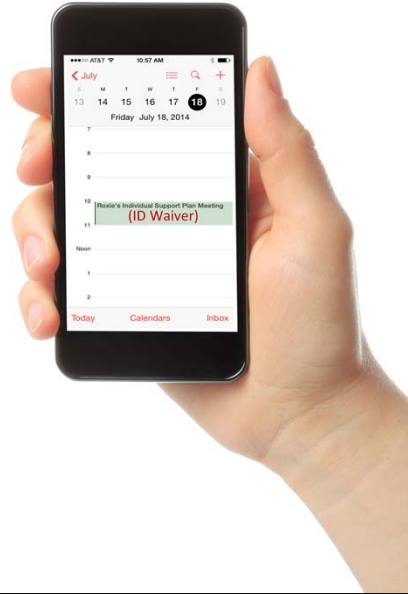
Return phone calls within one (1) business day.

You can find exact requirements for all waivers and the EPSDT Program by referencing the regulation sections shown on the slide.



Required Visits and Other Contacts

Attend Individual Support Plan Meetings



In the CL and FIS Waivers, if the individual, family, or caregiver requests, it is also preferred that you be available to attend the Individual Support Plan meetings. If you cannot attend, it is recommended that an attendant be present to support the individual during the meeting and participate in development of outcomes.



Required Visits and Other Contacts

Overview: 1st & 2nd In-Home Visits

AKA:

Routine Follow-up Visits

Services Facilitators are required to conduct two in-home visits, often called “Routine Follow-Up Visits” on a 30 day frequency within 60 days following the initial visit.



Required Visits and Other Contacts

Overview: 1st & 2nd In-Home Visits

PURPOSE:

to visit individual at home to
provide ongoing support

The purpose of in-home visits is to provide ongoing support to the individual and EOR. In all waivers and the EPSDT Program, these visits are necessary in order to monitor the individual's service plan and assess both the quality and appropriateness of the services being provided.



Required Visits and Other Contacts

Overview: 1st & 2nd In-Home Visits

Timing:

CL Waiver & FIS Waiver*: both visits within 60 days of services initiation

CCC Plus Waiver* & EPSDT**: both visits within 60 calendar days of initial comprehensive visit

*once per month

**one every 30 days

Although there are slight differences in timing requirements, generally the first of these two visits should be conducted within 30 days following the services authorization or the initial comprehensive visit, and the second visit within 30 days of the first visit. It is important to note that both visits must be conducted at the individual's home, because an evaluation of the individual's environment and support system is essential in evaluating needs. Also, the individual using services must be present at these visits.

If the Services Facilitator is unable to make a required visit on the time schedule set due to inclement weather or because the individual is not available, the Services Facilitator must document in a progress note the reason for the delay in the visit and record when the next visit will occur.



Required Visits and Other Contacts

Tasks & Documentation

Observe and evaluate

Discuss satisfaction

Review and discuss attendant's time sheets

Identify and report suspected abuse, neglect or exploitation

During these visits, the Services Facilitator must observe and evaluate, in consultation with the individual and EOR, family member or caregiver, the adequacy and appropriateness of the CD services with regard to the individual's current functioning and cognitive status, medical and social needs, and, in the CCC Plus Waiver and the EPSDT Program, the established Plan of Care.

The individual's and EOR's satisfaction with the type and amount of service must also be discussed.

It is required for all waivers and the EPSDT program for Services Facilitators to review the attendant's time sheets and discuss any discrepancies with the EOR and F/EA. Services Facilitators should never confuse the task of reviewing an attendant's time sheets with approving time sheets. Approving attendant time sheets is never the responsibility of the Services Facilitator. If a pattern of discrepancies is noted, the Services Facilitator should meet with the EOR, family member or caregiver (and in the CL and FIS Waivers, the Support Coordinator or Case Manager, respectively) to determine if the EOR can properly manage CD services.

Home visits also allow the Services Facilitator to identify any indicators of—and report—any suspected abuse, neglect or exploitation to the local department of social services for investigation. The Services Facilitator's mandated reporting status will be covered in more detail in a few minutes.

Completion of all of these tasks must be documented in each waiver and the EPSDT Program.



Required Visits and Other Contacts

1st and 2nd Home Visits

Waivers and EPSDT Program



Also required to be documented is the presence or absence of the attendant in the home during the visit.



Required Visits and Other Contacts

1st and 2nd Home Visits

Waivers and EPSDT Program



The Services Facilitator must also document any change in who is employed as the attendant. The F/EA cannot pay for any services until a completed packet is received for each employee.



Required Visits and Other Contacts

1st and 2nd Home Visits

Waivers and EPSDT Program



If certain programs are part of an individual's Plan of Care due to physician's orders, they require monitoring by the individual's primary health care professional or an RN and special documentation by the Services Facilitator of their ongoing completion and the attendant's qualifications to perform these tasks. These include bowel and bladder programs, ROM exercises, catheter and wound care.



The Services Facilitator must also document the individual's bowel and bladder program, if applicable.

A written physician's order in the individual's file must specify the method and type of digital stimulation and frequency of administration. The Services Facilitator must document that the attendant has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to the RN, and that the RN has observed the attendant performing this function. The attendant's continuing understanding and ability to perform bowel and bladder programs must also be documented in the routine visit note.



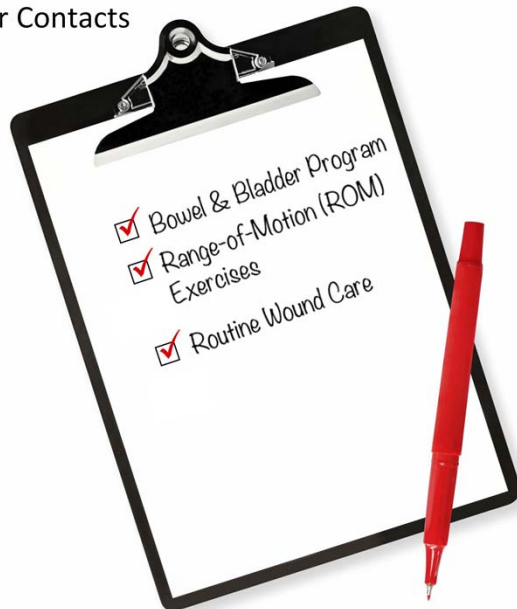
The Services Facilitator must also document range of motion (ROM) exercises. The written physician's order, which indicates the need and extent of ROM exercises to be performed, must be in the individual's file. The Services Facilitator must document in the individual's record that the attendant has been instructed by the RN in the administration and maintenance of ROM exercises and that the attendant's correct performance of these exercises has been witnessed and documented by the RN. The continued need for ROM exercises and the monitoring of the attendant's performance of these exercises must be noted in the routine visit note.



Required Visits and Other Contacts

1st and 2nd Home Visits

Waivers and EPSDT



The Services Facilitator must also document routine wound care. During each visit, the Services Facilitator must document the status of the wound and the monitoring of the individual's care.



Required Visits and Other Contacts

1st and 2nd Home Visits

Waivers and EPSDT



The Services Facilitator must also document catheter care. When routine care of an external condom catheter is to be provided by the attendant, the Services Facilitator must indicate in the initial comprehensive visit note that the attendant is providing condom care and what instructions the attendant has received regarding this care. Documentation must indicate the attendant's ability to perform this procedure.

Required Visits and Other Contacts

1st and 2nd Home Visits

**Waivers
and
EPSDT Program**

Hospitalization/
change of status

The graphic features a red square at the top left, followed by the text 'Required Visits and Other Contacts'. Below this is '1st and 2nd Home Visits'. To the right is an illustration of a black clipboard with a silver clip at the top and a red pen resting on it. On the clipboard, there is a checked box next to the text 'Hospitalization/ change of status'. Below the clipboard, the text 'Waivers and EPSDT Program' is written in a green font.

In the Waivers and the EPSDT program, the Services Facilitator must also document any hospitalization or change in medical condition, functioning, cognitive status, and/or social support.



Required Visits and Other Contacts

1st and 2nd Home Visits

Waivers and EPSDT Program



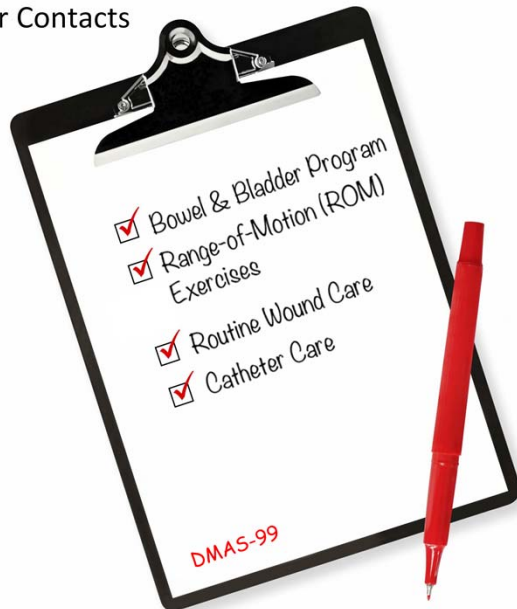
Next, the Services Facilitator must document dates of and reasons for any service lapses (hospitalization admission, attendant not available, and so forth).



Required Visits and Other Contacts

1st and 2nd Home Visits

**Waivers
and EPSDT**



All of this information should be documented on the standardized DMAS-99 form.



Required Visits and Other Contacts

1st and 2nd Home Visits

Waivers and EPSDT Program



The DMAS-99 must be completed. Additionally, if the Plan of Care does not meet the individual's needs, then a new DMAS-97A/B must be developed for those enrolled in the CCC Plus Waiver and EPSDT Program. For enrollees of the CL and FIS Waivers, the Part III and V of the ISP needs to be modified and submitted to the support coordinator/case manager. If a change in the amount of hours is needed, the Services Facilitator must submit the request to the service authorization contractor for review. Remember that for modifications of plans for the CL and FIS Waivers require coordination with the support coordinator or case manager. For hours over the Level of Care maximum, supporting documentation must be submitted with the service authorization request. Hours are not retroactive.



Required Visits and Other Contacts

1st & 2nd Home Visit Billing

Confirm current rates

Check out latest rates on the DMAS website:

http://www.dmas.virginia.gov/Content_pgs/ltc-wvr.aspx

Use Code # 99509

Submit CMS-1500 Form electronically

The image shows a CMS-1500 Health Insurance Claim Form. The form is titled "CMS-1500 HEALTH INSURANCE CLAIM FORM" and includes a QR code in the top left corner. The form is partially obscured by a large, semi-transparent watermark that reads "MCO". A mouse cursor is pointing to the right side of the form.



Click document to
locate and download.

We will cover general billing procedures later in Module 4. As for now, just remember that you can bill for each in-home visit you conduct. It is extremely important to confirm DMAS rates at the website provided on the slide prior to billing. Currently, the In-Home (Routine) Visit is Code # 99509, using the CMS-1500 form or billing through an enrollee's MCO.



Required Visits and Other Contacts



Additional Meetings & Trainings

CL Waiver:

Home visits: every 30-90 days

CCC Plus Waiver:

Personal care: every 90 days

Respite: every 6 months or 240 hours

EPSDT Program:

Every 90 days

FIS Waiver:

Face-to-face meeting at least every 6 months after 2nd of initial 2 routine on-site visits

After the first two routine in-home visits, the Services Facilitator and the EOR can decide how frequently the routine on-site visits will occur. However, please note that some future visits are required within a certain time frame:

In the CL Waiver, the Services Facilitator is responsible for conducting routine on-site visits at the individual's home every 30 to 90 days to ensure the appropriateness of services. These meetings must include times when services are scheduled to be delivered. The Services Facilitator must record all significant contacts in the individual's file.

In the CCC Plus Waiver and EPSDT Program, the Services Facilitator must conduct a face-to-face meeting with the individual every 90 days for personal care, to ensure the appropriateness of services. During these visits, the Services Facilitator must review the individual's status, make any needed adjustments to the Plan of Care, provide any necessary information to the individual and EOR, and record all significant contacts in the individual's file. Additionally, when respite is provided as a sole service in the CCC Plus Waiver, a similar face-to-face meeting must be conducted every six months (or upon the usage of 240 hours, whichever comes first).

In the FIS Waiver, the Services Facilitator must conduct a face-to-face meeting with the individual at least every six months after the second of the initial two routine on-site visits to ensure appropriateness of services. These meetings should also include times when services are scheduled to be delivered, and all significant contacts must be recorded in the individual's file. During the visits with the individual, the Services Facilitator must observe, evaluate and consult with the individual and family member or caregiver and document the adequacy and appropriateness of the CD services with regard to the individual's current functioning and cognitive status, medical and social needs. If a health or safety issue is noted by the Services Facilitator during a visit, he or she must report this to the Support Coordinator and immediately to CPS or APS, as appropriate.

If any adjustments are made to an individual's service plan during these meetings, the revised plan must be submitted to the service authorization contractor.



Required Visits and Other Contacts

Additional Meetings & Trainings

In all services:

- Counseling or training for EOR
- Making changes to the CD Services Plan
- Submitting service authorizations
- Offering support in the hiring process of new employees as needed

NOTE: additional face-to-face meetings can be billed as a routine visit



In all services, the Services Facilitator should also take any other actions needed, including:

- Counseling or providing additional training to the EOR about his or her responsibilities as an employer;
- Completing any needed changes to the CD service plan and authorizations and forwarding them to the appropriate service authorization contractor; and
- Offering support in the hiring process of new employees as needed.

Additional face-to-face meetings in the individual's home can be billed as a routine visit.



Required Visits and Other Contacts

Additional Reviews (CL and FIS Waiver)

Personal Assistance: Every 30-90 days

Companion: Every 6 months or more as needed

Respite: Every 6 months or 240 hours



It should be noted that the CL and FIS Waivers require completion of reviews every 30 to 90 days for personal assistance, companion and respite services which must be forwarded to the Support Coordinator. The due date for reviews is determined by the start date of the Person-Centered Individual Support Plan and communicated to the Services Facilitator by the Support Coordinator. A copy of all reviews must be maintained in the individual's record.

All of these reviews should be accompanied by the following documentation:

- Any plan for CD supports revisions;
- The individual's general status (including any medical issues and any medication changes);
- Any significant events; and
- The individual's and family's or caregiver's satisfaction with the services.

Billing, for written work and documentation, is not allowed for these reviews; however, if a visit is required, billing for a routine visit is appropriate.



Required Visits and Other Contacts



Reassessment Visits

Full assessment: individual's current status & summary of services

Update/summary of activities

Update of CD Services Plan

Timing:

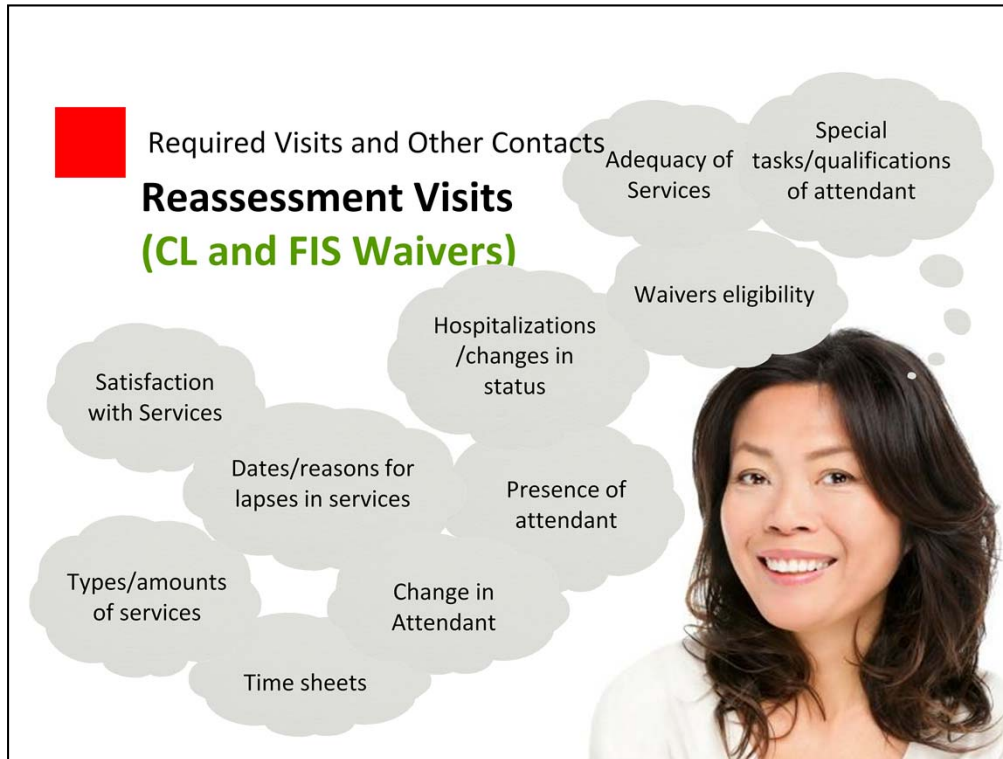
Every 6 months (Waivers & EPSDT)

When Services Facilitator changes (every time)

Services Facilitators are required to conduct a reassessment visit every 6 months. The purpose is to reassess the individual's current medical, functional, and social support status and complete a summary of all services received. In the visit, updates and summaries of activities since the last assessment are recorded, and the individual's CD service plan is updated as needed.

If an individual chooses to work with a new Services Facilitator, a reassessment must always be conducted by the new Services Facilitator. Note that this is considered a reassessment, and not an initial (comprehensive), visit.

We will explore unique reassessment requirements in the next few slides.



In the CL and FIS Waivers, the 6-month reassessment may coincide with the DMAS request for the DMAS-99 but it must be completed once every six months regardless of whether the DMAS-99 is due. Documentation of the reassessment must include a complete review of the individual’s needs and available supports, and a review of the Plan of Care. Specifically, it must include:

Any change in the previously-documented individual’s medical condition, functional status, and social support. The Services Facilitator is expected to know the Waiver criteria and apply them when assessing whether the individual continues to meet the criteria to receive services. If the Services Facilitator determines that the individual does not meet the criteria, the Services Facilitator must notify the Support Coordinator or Case Manager;

Whether CD services are adequate to meet the individual’s needs and whether changes need to be made;

Any special tasks performed by the attendant and their qualifications to perform these tasks;

Any change in who is employed as the attendant. The Services Facilitator must note this in the individual’s file and ensure that the criminal history record check, CPS Registry check if applicable, and the TB testing are performed on the new attendant;

The individual’s, EOR’s and/or family member’s or caregiver’s satisfaction with services;

Any hospitalization or change in the individual’s medical condition, functioning, or cognitive status;

Other services the individual receives and their amount;

Dates of and reasons for any service lapses (for example, hospital admission and discharge dates, attendant not available, and so on);

The presence or absence of the attendant in the home during the visit; and finally

A review of the attendant time sheets to determine whether the approved number of hours is being recorded. If a discrepancy occurs, the Services Facilitator should notify the F/EA.

Required Visits and Other Contacts
Reassessment Visits
(CL and FIS Waivers)

Review current status with EOR/Individual/Family

Complete CD Plan; Jointly Develop Annual Support Plan

Confirm annual TB screening

Complete & forward ISAR(s) to Support Coordinator

Additionally, in the CL and FIS Waivers, the Services Facilitator must:

- Meet with the EOR, the individual, or family member or caregiver prior to the end date of the current Individual Support Plan to review the individual's current medical, functional, and social support statuses as they relate to CD services;
- Complete the CD Services Plan for Supports and provide it to the Support Coordinator. The Services Facilitator and the Support Coordinator then work together with the individual to develop the annual Plan for Supports;
- Complete new ISAR(s) and submit them to the Support Coordinator if any changes in current authorized hours are needed; and
- Confirm with the EOR the completion of annual TB screening for attendants.

All of this information should be documented and filed in the individual's record.



In the CCC Plus Waiver and the EPSDT Program, the Services Facilitator must conduct a reassessment visit at least every six months for personal care, and in the CCC Plus Waiver, when respite is the sole service. Reassessment visits require a meeting with the EOR, the individual and family member or caregiver in order that the individual’s current functional and social support status and a complete summary of all services can be reviewed.

Documentation of the reassessment visit must include a complete review of the individual’s needs and available supports and a review of the Plan of Care. The reassessment visit must be documented on the DMAS-99 and include the following elements:

- A review of the CD service plan with the individual and EOR, and family member or caregiver, to determine if it is adequate to meet the individual’s needs or if changes need to be made;
- Any change in the individual’s previously-documented medical condition, functional status and social support, which may require modifications to the Plan of Care. The Services Facilitator is expected to know the CCC Plus Waiver (or EPSDT) criteria and apply the criteria when assessing whether the individual continues to meet the criteria to receive services. If it is determined that the individual does not meet the criteria, the Services Facilitator must contact DMAS for a level of care review and to discuss discontinuation;
- Dates of any lapse of services and the reason why (for example, hospitalization, nursing facility or inpatient rehabilitation admission, attendant not available, and so forth);
- The presence or absence of the attendant in the home during the visit;
- Documentation of the attendant’s annual TB screening;
- The individual’s, EOR’s and family member’s or caregiver’s satisfaction with the services; and
- Any other services received by the individual.

All criteria and documentation requirements must be met for the entire time the service is provided. Remember that the Services Facilitator will not be reimbursed for services unless the individual is authorized for services by the service authorization contractor.



Required Visits and Other Contacts

Plan Modifications

Needed when:

- Services are being added or discontinued
- Hours for a particular service change

Service authorization must be submitted when:

- Individual requires supervision to be added
- Increase in plan is needed for more than the amount allowed
- Increase or decrease in plan is needed within the level of care

Must be available to all attendants

Throughout the past few slides, we have referenced changes or modifications to the individual's plan. Basically, the Services Facilitator is responsible for making modifications to the CD service plan as needed to ensure that the attendant and the individual, the EOR, family member or caregiver are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual. Modifications are required when services are added or discontinued, and when the number of hours for a particular service change. If no changes are needed, the Services Facilitator must document on the current plan annually that it was reviewed, then date and sign that no changes are necessary. In that case, there is no need to send it to the service authorization contractor.

However, the Services Facilitator must follow the procedures to request a revised service authorization whenever a change in the individual's condition (physical, mental, or social) indicates that:

- The individual requires supervision to be added to the plan even if the individual's hours will be within the established guidelines for each service;
- An increase in the plan is needed for more than the amount allowed according to the established guidelines for each service; or
- An increase or decrease in the plan is needed within the established guidelines for each service, in order to assure appropriate reimbursement for services.

The service authorization contractor may request plans or any supporting documentation at any time. Changes in hours are required to be submitted when they occur.

Copies of all plans must be maintained in the individual's file. These plans document service delivery and must be consistent with the written information submitted to the service authorization contractor or communicated to the service authorization contractor by telephone when contacted for an authorization.

The most recent plan must always be in the individual's home and available for the attendant to review prior to delivery of services.



Required Visits and Other Contacts

Plan Modifications: Multiple Providers

Each provider must have a plan

All providers must coordinate plans

Plan modifications require consultation among all providers

Each provider must document plan modifications

When multiple providers and a Services Facilitator are working with the individual, each provider must have a separate plan and coordinate with the other providers to ensure continuity of services and no duplication of service or hours.

When a change to the overall service plan is required, all providers must consult to coordinate the changes. This applies to changes upon admission of a new individual or after services have been initiated.

This communication must be documented in each provider's plan and in the Services Facilitator's individual record.



Required Visits and Other Contacts

Annual Reassessment Visit Billing

Confirm current rates

Check out latest rates on the DMAS website:

http://www.dmas.virginia.gov/Content_pgs/lrc-wvr.aspx

Use Code # T1028

Submit CMS-1500 Form electronically

The image shows a CMS-1500 Health Insurance Claim Form. The form is titled "HEALTH INSURANCE CLAIM FORM" and "CMS-1500". It features a QR code in the top left corner and a mouse cursor pointing to the form. The form is partially obscured by a large, semi-transparent watermark that reads "REASSESSMENT VISIT".



Click document to
locate and download.

As always, be sure to confirm the current DMAS rates at the website on the slide prior to billing. Currently, DMAS can be billed for a “Reassessment Visit” using Code #T1028, submitted electronically via the CMS-1500 form.



Service-Specific Responsibilities



Now that we have examined all of the required visits, reviews and other contacts that a Services Facilitator must have with an individual and the EOR and others, let's take a look at other ongoing responsibilities that every Services Facilitator has at all times. We will start with reviewing some requirements that relate specifically to the CD services being provided.



Service-Specific Responsibilities

Monitoring Services

Quality of care received
Satisfaction with services
Individual needs and plan modification
Additional support needed
Assessment of safety and welfare
Hours of services used



As we have discussed previously, the Services Facilitator is responsible for monitoring the ongoing provision of CD services to each individual. This monitoring includes:

- The quality of care received by the individual;
- The individual's overall satisfaction with services;
- The functional and medical needs of the individual and any modification necessary to the CD service plan due to a change in these needs;
- The individual's need for support in addition to the care provided by personal care attendants. This includes an overall assessment of the individual's safety and welfare in the home with personal care services; and
- The hours of each service being used. This is especially important for respite.



Service-Specific Responsibilities

Personal Care (EDCD (now CCC Plus) Waiver Only)

56 hours per week unless exception granted

Exception Requires:

Minimum of B or C level of care

AND

Documentation of risk of institutionalization by 1 or more of the following:

- Dependencies in activities of daily living
- Dependencies in behavior and orientation
- Local DSS documentation of open APS or CPS case and need for more than 56 hours of care per week



In 2011, the General Assembly decided to limit personal care in the EDCD Waiver, now CCC Plus, to 56 hours per week unless an exception is requested and approved. This cap was contained in the 2011 Appropriation Act.

The Services Facilitator will need to apply to the service authorization contractor for an exception if the individual meets the medical necessity. The following criteria apply when seeking an exception to the 56-hour-per-week limit. The individual must have a minimum level of care of B or C as defined in Chapter 4 of the EDCD Waiver manual; AND have one or more of the following which documents the increased risk of institutionalization:

Dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and eating/feeding, as defined by the current pre-admission screening criteria. This is submitted to the service authorization contractor using the DMAS-99; OR

Dependencies in both behavior and orientation as defined by the current pre-admission screening criteria. This is also submitted to the service authorization contractor via the DMAS-99; OR

Documentation from the local Department of Social Services that the individual currently has an open case with either Adult Protective Services or Child Protective Services and is in need of additional services above the 56-hour-per-week cap. Documentation can be in the form of a phone log contact or any other documentation supplied to the service authorization contractor electronically. An open case with APS means a substantiated APS case with a disposition of needs protective services and the adult accepts the needed services. An open case with CPS means open to CPS investigation if it is either founded OR a completed family assessment documents the case with moderate or high risk. When submitting documentation, be sure it is also in the clinical record; otherwise, reimbursement may be subject to retraction and/or a referral to the Medicaid Fraud Control Unit.

A copy of the Medicaid Memo explaining the EDCD Waiver 56-hour personal care cap and the process for applying for an exception is included in the Module 4 training materials.



Service-Specific Responsibilities

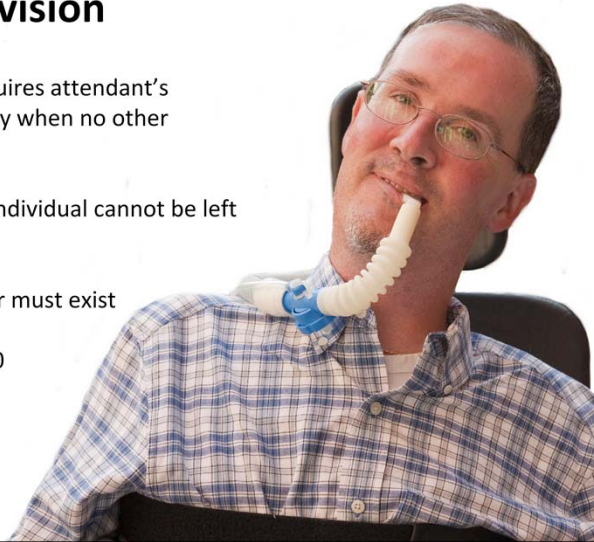
General Supervision

Allowed if individual requires attendant's presence to ensure safety when no other support is available

Appropriate only when individual cannot be left alone at any time

Clear and present danger must exist

Request using DMAS-100



General Supervision is a covered service in the Waivers and EPSDT Program within the personal care Plan of Care when the purpose is to supervise or monitor those who require the physical presence of the attendant to ensure their safety during times when no other support system is available. The inclusion of supervision in the Plan of Care is appropriate only when the individual cannot be left alone at any time due to mental or severe physical incapacitation. There must be a clear and present danger to the individual as a result of being left unsupervised. This includes individuals who cannot use a telephone to call for help. The clear and present danger must be clearly detailed in documentation when submitted to the service authorization contractor.

The DMAS-100 is used to request supervision. Please note the DMAS-100A can also be used to request Personal Emergency Response Systems (PERS) under the Waivers. Forms for use should always be accessed through the Virginia Medicaid web portal.



Service-Specific Responsibilities

General Supervision

Supervision **NOT** authorized

- ✗ For family members to sleep (unless individual cannot be left alone at any time)
- ✗ For general concerns about leaving individual alone
- ✗ When the only need is for assistance exiting the home in the event of an emergency

Supervision *may* be authorized if there is no one to call for help in the case of an emergency

Supervision will not be authorized for family members to sleep either during the day or during the night unless the individual cannot be left alone at any time.

Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual alone or would prefer to have someone with the individual.

Supervision cannot be authorized for persons whose only need for supervision is for assistance exiting the home in the event of an emergency.

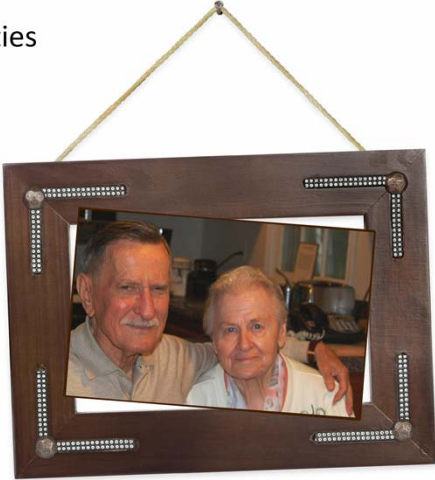
Supervision may be authorized if there is no one else in the home competent to call for help in an emergency.

Service-Specific Responsibilities

Respite Services

No respite for paid caregivers

Max of 480 hours per year



Individuals who receive CD respite services or agency-directed respite services, or both, may not receive more than 480 hours per fiscal year combined, regardless of service delivery method. Fiscal year is defined as July 1 through the following June 30.

If respite hours are being shared between two different providers, the providers must coordinate hours (for example, AD and CD respite providers cannot exceed 480 hours between both providers combined).

Respite is not available to paid caregivers.



Service-Specific Responsibilities

Companion Services

Individuals 18 years or older

Not to exceed 8 hours in a 24-hour period

RESTRICTED

In the CL and FIS Waivers, companion services are restricted to individuals over the age of 18 and may not exceed 8 hours in any 24-hour period.



Service-Specific Responsibilities

Family Members* as Attendants



Allowed in extenuating circumstances, if:

--Objective, written documentation there is no one else available to provide support

--Attendant qualifications are met

Attendant may not be the parent of a minor or the individual's spouse

* And people living under the same roof

Payment may not be made for personal care, respite, or companion services rendered by family members or people who live under the same roof as the individual using services unless there is objective written documentation as to why there are no other providers available to provide the supports. Documentation can include newspaper or other advertisements indicating that an attempt to hire an attendant was made and copies of interview notes if applicable.

Examples of situations meeting the criteria of no other providers available might include when:

- Individuals are living in a remote area un-served or underserved by other providers; or
- Other providers have been unsuccessful at appropriately supporting the individual.

Family members or people who live under the same roof who are reimbursed to provide these services must meet the same qualifications standards and policies as all other attendants.

The attendant may never be the parent of a minor child or the spouse of the individual.



Service-Specific Responsibilities

Services to More Than One Person

ADLs

Separate ADL plans
Services for each individual according to plan

IADLs

Time combined
Hours split between plans

Supervision and Companion hours split between plans

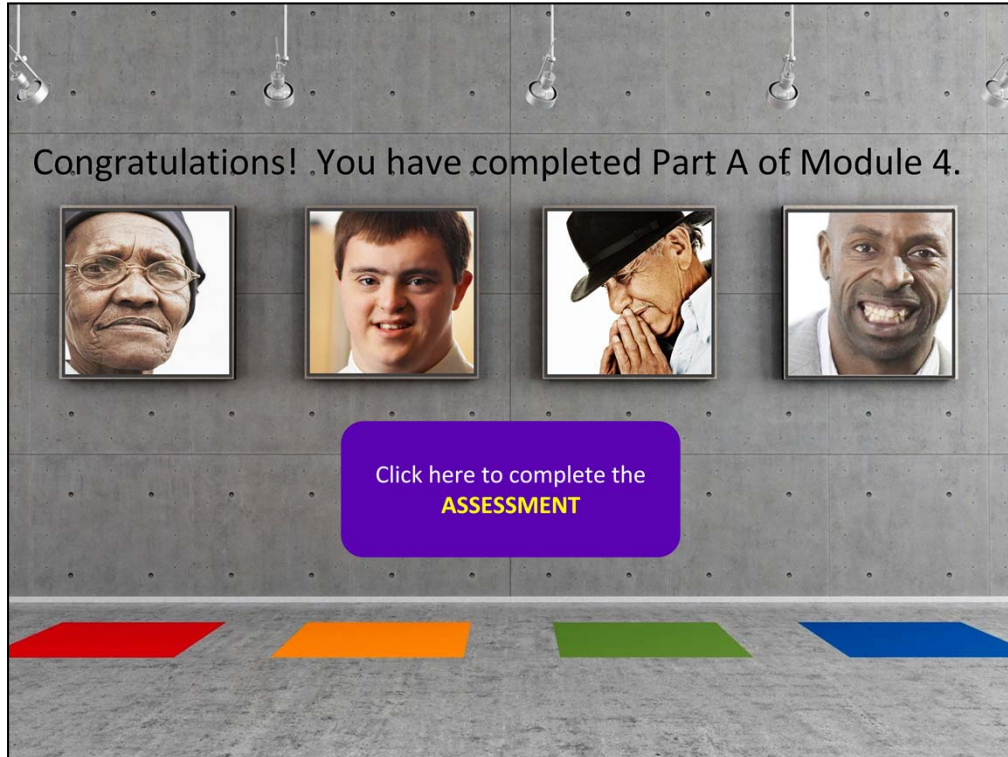


When two individuals who live in the same home request services, the following rules apply:

- Plans are to be developed separately for the individuals' unique Activities of Daily Living, and each individual will receive the number of hours required for his or her plan.
- Time for Instrumental Activities of Daily Living (such as cooking, housekeeping or grocery shopping) are to be combined and the hours split between the plans. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each plan.
- Supervision and Companion hours are also to be split between the plans unless there is justification otherwise.

In the CL Waiver, no more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the attendant.

For the EPSDT Program, two individuals living in the same home must share one attendant unless one person has high needs. The high needs of the one person must be documented in order for that individual to get his or her own attendant.



You have now completed Part A of Module 4 in the four-part online series for meeting the requirements for training as a Services Facilitator.

Please note that all of the web links provided in this Module are contained in the accompanying training materials.

Please complete the Module 4, Part A learning assessment at this time. You are then ready to proceed to Module 4, Part B.

Thank you for your participation!