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DIVISION: (Required Field)	Program and Policy
DOCUMENT TYPE: (Required Field)	Manual
MEDIA:	**Select Media**
TOPIC: (Required Field)	Manual Revision
DOCUMENT TITLE:	Manual G Chapter: 52
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06/06/2017

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-250
ISSUED: 07/10/86

FROM: Thelma Struck, Assistant Secretary
Community Services OB-44J

SECTIONS REVISED:
52.15 E.

EFFECTIVE: 07/25/86
FOR INFORMATION CALL:
Bureau of Aging and
Adult Services
SCAN 234-2502 or
Non-SCAN (206) 753-2502

IF NOT DELIVERABLE, RETURN TO: DSHS STOCKROOM MS FB-11

SUBJECT: CHANGE IN THE TREATMENT OF MARRIED COPES APPLICANT'S AND RECIPIENT'S INCOME

Place this notice in front of Manual G, Chapter 52, and note on the Green Notice Control Sheet the date Notice No. G-250 was entered.

Effective July 1, 1986 financial regulations which affect the treatment of community income and the transfer of income between spouses will be revised.

I. Background

Prior to January 1, 1985 a married COPES applicant/recipient's income was considered available for participation in the cost of his or her care based on his or her "name on the check."

During the period January 1, 1985 through June 30, 1986, married COPES applicant/recipient's income was considered differently as a result of the Purser vs. Rahm Class Action Lawsuit on Community Income. Ownership of community income was divided equally between the spouses. The amount available for COPES participation was established accordingly.

On April 4, 1986 the Engrossed Substitute Senate Bill (ESSB) 4659 was signed into law. The law changed two major factors in the consideration of married COPES applicant/recipient's income as follows:

1. Agreements between spouses transferring or assigning rights to future income from one spouse to the other shall be invalid for determining eligibility for medical assistance.

2. Community income rules will be used only when it is a benefit to the non-COPES spouse.

ESSB 4659 will eliminate the negative effects of Purser vs. Rahm. It provides that the community income rule will be applied only when it will benefit the COPES applicant/recipient's spouse.

The Division of Medical Assistance will change WAC 388-95-335 and 388-95-340 by emergency rule adoption effective July 1, 1986 as follows:

WAC 388-95-335
Ownership of Income

(1) Community property law, shall be used in determining ownership of income for purposes of Medicaid eligibility.

(2) All income received after marriage by either husband or wife or both is presumed to be community income.

(3) The total of the community income received by the husband and the wife shall be divided by two with one-half of the total assigned to each individual, as their income.

(4) An agreement between spouses transferring or assigning rights to future income from one spouse to the other shall be invalid for determining eligibility for medical assistance or the limited casualty program for the medically needy.

(5) Income produced by transferred or assigned resources shall be recognized as the separate income of the transferee.

WAC 388-95-340 (2) (b) (i)

(A) Remains the same

(B) If the community income received in the name of the nonapplicant spouse exceeds the community income received in the name of the applicant spouse, the applicant spouse's interest in that excess is unavailable to the applicant.

(C) Old (B) without change

II. Definitions

A. Income

Income means any appreciable gain in real or personal property (cash or kind) received by an applicant/recipient on or after the first of the month in which eligibility is determined, and which can be applied toward meeting the requirement of the applicant and his or her dependents, either directly or by conversion into money or its equivalent.

1. Individual Income Definition

Income received by or for an individual is presumed to be that individual's income. This is sometimes referred to as the "name on the check" rule. This income may be: 1) "Community Income," i.e., available to the marital unit or 2) "Separate Income," i.e., not available to the marital unit.

2. Community Income Definition

All income in either the name of the husband or wife or both names is presumed to be the income of both, i.e., wages, pensions, etc. The income of a husband and wife is community income, unless it is separate income.

An agreement between spouses transferring or assigning rights to future income from one spouse to the other shall be invalid for purposes of determining eligibility. Example: Retired state employees have been married for fifty years. When the husband enters a nursing home, he signs an agreement to give his wife the right to payments from his retirement. The department does not recognize this as a legal transfer for the purpose of determining his eligibility; the husband's retirement income shall be considered his individual income.

3. Separate Income Definition

Separate income is income that is not available to the marital unit. Legal evidence is required to designate part or all of the husband's or wife's income as separate income. The verified separate income will not be considered as community income.

Separate income will remain the sole and separate property of the spouse receiving it. Example: Retired state employees marry; all their benefits were earned prior to their marriage and they maintain it as their separate income.

Income received by the spouse from his/her separate resource is separate income. Example: The spouse at home has a separate savings account that was transferred to her by her spouse in the nursing home. The interest income from that account is held separately and is her separate income.

B. Income Rules

The income rules defined below are used solely to determine income ownership.

1. Community Income Rule

The community income rule dictates that once total community income of the marital unit has been determined it is divided equally and the husband and the wife each own one half of the total.

Application of rule: The sum of the applicant/recipient's share of the community income added to his/her separate income is used to determine eligibility.

2. One Way Community Income Rule

The one way community income rule dictates that the community income rule is used only when it will benefit the spouse of the COPES applicant/recipient.

Application of rule: When the COPES applicant/recipient has more than one half of the community income it will be a benefit to the spouse to share in the division of the marital unit's community income and the community income rule will be used to determine income ownership.

3. Separate Income Rule

The separate income rule dictates that the COPES applicant/recipient's separate income is used only when it will benefit the spouse of the COPES applicant/recipient.

Application of rule: When the COPES applicant/recipient has less than one half of the community income it will be a disadvantage to the spouse to share in the division of the marital unit's community income and the community income rule will not be used to determine income ownership. The COPES applicant/recipient's separate income will be used to determine eligibility.

C. Ownership of Income

The "ownership of income" is the amount of income determined to be owned by the applicant/recipient. The owned income amount is used in the COPES eligibility determination and to establish the income amount available for participation in the cost of care.

III. Action Required

A. Financial Services will:

1. Review all active COPES cases

a. with income code 82 on the DSHS 7-01 (M form) as of the May 1, 1986 warrant roll.

b. opened after the April warrant role deadline.

2. Complete the computation sheet and use the applicable income rule to determine:

a. community income and

b. participation.

3. Change the income codes on the DSHS 7-01 to track community income and state allocation amounts.

4. Send an award letter to:

a. the applicant/recipient (the participation amount may be unchanged or it may be reduced) and

b. the authorizing service worker.

NOTE: Advance notice is not required since there is not adverse action affecting the client; adequate notice is required.

B. Social Services upon receipt of the new award letter from financial services, will review the DSHS 14-159, Service Authorization and

1. Code changes in the participation amount on the DSHS 14-159 and

a. write in the comments section, "Your participation is reduced starting July 1, 1986." and

b. distribute copies of the DSHS 14-159; or

2. Take no action since financial services is notifying the applicant/recipient that there is no change in participation.

3. File the financial award letter copy in the service case record.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-245
ISSUED: 04/02/86

FROM: Thelma Struck, Assistant Secretary
Community Services OB-44J

SECTIONS REVISED:
52.15 C., 52.38

EFFECTIVE: 04/18/86
FOR INFORMATION CALL:
Bureau of Aging and
Adult Services
SCAN 234-2502 or
Non-SCAN (206) 753-2502

IF NOT DELIVERABLE, RETURN TO: MANUAL PRODUCTION UNIT, MS OB-16

SUBJECT:
A. Criteria for Nursing Home Level of Care Determinations
B. Institutionalization Predictors: Additional Eligibility Requirements for COPES Individuals Diverted from Institutionalization
C. Minimum Standards for Individual Care Providers
D. Standards for Evaluation of Care Providers' Performance

Place this notice in front of Manual G, Chapter 52, and note on the Green Notice Control Sheet the date Notice No. G-245 was entered.

I. BACKGROUND

The publication of the Final Rule for Section 2176 Waivers for Home and Community-Based Services in the Federal Register of March 15, 1985, codified new and more stringent federal requirements to waiver programs.

Included among the revisions to the interim final regulations were requirements that the states provide satisfactory assurances to the Health Care Financing Administration (HCFA) that:

A. Evaluation [assessment] and periodic re-evaluations [reassessments] of the need for the level of care provided in an ICF or SNF will be made in accordance with federal regulations.
(CFR 441.302(c))

B. Waiver services will be limited to persons who would otherwise receive institutional care in the absence of the waiver.
(CFR 441.302(d))

C. There are adequate standards for all types of providers of waiver services.

(CFR 441.302(a))

Additionally, the state must furnish HCFA with sufficient information to support the assurances provided.

(CFR 441.303)

II. ACTION REQUIRED

A. Criteria for Nursing Home Level of Care Determinations

"Criteria for Nursing Home Level of Care Determinations," Memorandum No. 85-65, was issued August 9, 1985, by the Division of Medical Assistance. The criteria in Attachment 1 to this notice shall be used:

1. To determine nursing home eligibility and level of care for each applicant or recipient considered for COPES. This determination is made by the participants in the initial case staffing.

2. To redetermine nursing home eligibility and level of care for each recipient of continuing COPES services at the 30-day, 90-day, and the annual review(s).

B. Institutionalization Predictors: Additional Requirements for COPES Individuals Diverted from Institutionalization

In addition to the determination that he or she is eligible for nursing home care at the ICF or SNF level according to the criteria above, the client who is not being discharged from an institution shall also be evaluated for the likelihood that he or she will require institutionalization in the near future.

There is reasonable indication that the client might need nursing home placement services, in the absence of the waiver, when the comprehensive adult assessment documents that he or she has three (3) or more predictors of institutionalization.

Besides ICF or SNF nursing care eligibility, at least three of the following predictors must be present as a condition of COPES program eligibility. The eligible client must:

1. Be 75 years of age or older;

2. Live alone;

3. Need assistance with multiple, prescribed medications not for sale over the counter;

4. Have moderate or total self-care deficits (personal ADLs);

5. Be incontinent of bowel and/or bladder;

6. Be without adequate family or other social supports which might make formal assistance or placement unnecessary.

C. Minimum Standards for COPES Individual Care Providers

Personal care may be provided by the informal support network (neighbors, friends, or family) or by other persons. The care provider is employed, trained, and supervised by the client.

To ensure that necessary safeguards have been taken to protect the health and welfare of COPES recipients:

1. The minimum provider standards in Attachment 2 will be

   a. used by the case manager in establishing a service plan; and

   b. given to clients to use in evaluating a potential care provider.

2. Individuals who do not meet those standards will not be authorized for payment as COPES care providers.

D. Minimum Performance Standards for Evaluation of COPES Service Plan

The case manager monitors the effectiveness of the service plan. Regular client contact is maintained in addition to the mandatory reviews. The minimum standards for the case manager's evaluation of the care provider's performance include each of the following:

1. The client's satisfaction with the care received.

2. The observable evidence of the client's

   a. cleanliness,

   b. adequate nutrition,

   c. physical health, necessary nursing services, and welfare.

3. The sanitation of the recipient's environs.

4. The adequacy of necessary supplies.

Service plans which do not meet these minimum standards shall be revised or terminated in accordance with Chapter 52.39.

Attachment 1

CRITERIA FOR NURSING HOME PATIENTS LEVEL OF CARE DETERMINATIONS

Nursing home patients are classified as requiring Skilled Nursing Care (SNC), Intermediate Nursing Care (INC), or Not in Need of Nursing Home Care (NNNC). The criteria for these determinations have been formalized and are attached.

Review criteria for level of care determinations and appropriateness of nursing home care is based on an individual's functional ability, medical need, and the intensity of the care and services required. Diagnosis and discharge potential are considered, but they do not determine the level or appropriateness of nursing home care.

These criteria are consistent with the definitions of care and services identified in the 42 Code of Federal Regulations 405.1124, 440.40, 440.150, 442.338, and 442.343 (see Nursing Home Law and Regulations Manual). They are intended for use by professional staff and provide a useful tool for implementing consistent level of care determinations.

If you have any questions, please address them to the Nursing Care Consultant, her immediate supervisor, or Garlien Are'valo, Manager, Patient Review Program, 753-3486 or SCAN 234-3486.

Summary of Criteria

Skilled Nursing Care patients are those whose functional level and intensity of service require:

- prescribed services that must be provided by or under the supervision of licensed nursing personnel available 24 hours per day.

- special therapeutic services directed toward rehabilitation.

- therapeutic services necessary to establish an effective, safe maintenance program regardless of rehabilitation potential.

These patients have multiple, complex care and service needs. Their condition is unstable and/or at risk of complications.

Intermediate Nursing Care residents are those whose condition is stable and whose functional level and intensity of service require:

- prescribed services that must be provided by or under the supervision of licensed nursing personnel at least daily. Such services must involve more than supervision, protection, and assistance with personal care.

CRITERIA

Patient Problems/Needs	Nursing Interventions (Planning, Implementation and Management) SNC	INC
Self-care Deficit Bathing Dressing Grooming Eating Toileting Mobility (C.P. Sections V and VI)	- assistance for patients dependent in all ADL or with a combination of deficits; - medically prescribed physical therapy under the direction of a licensed therapist; - medically prescribed occupational therapy by a qualified therapist; - see Restorative Nursing, SNC.	- moderate assistance with personal ADLs; - assistance in positioning, transfer and ambulation; - assistance in applying braces or prosthetic devices; - see Restorative Nursing, INC.
Skin Integrity, Impairment of: Incisions Decubiti Irritations Fragile skin Infections (C.P. Sections III, IV and V)	- dressing changes requiring aseptic technique and application of medication; - medically ordered decubiti treatments; - whirlpool for peripheral vascular lesions; - post-operative wound care requiring nursing observation and monitoring; - isolation techniques.	- prophylactic skin care including positioning, cleansing and lubricants; - nursing direction to maintain treatment programs.
Nutrition, Alterations in: Ideal/Usual Body Weight Less than More than Dehydration Therapeutic Diet (C.P. Sections III, IV and VI)	- nursing identification and management of nutrition and hydration alterations; - I.V. fluids; - parental hyperalimentation; - nasogastric tube feeding; - implementation of ostomy feedings; - see Restorative Nursing, SNC.	- assistance with eating; - routine maintenance of an ostomy; - monitoring and ongoing provision of special nutritional needs; - see Restorative Nursing, INC.

CRITERIA

Patient Problems/Needs	Nursing Interventions (Planning, Implementation and Management) SNC	INC
Bladder/Bowel Elimination, Alterations in: Incontinence Indwelling catheter Anuria Diarrhea Constipation Colostomy Ileostomy (C.P. Sections III, IV, and VI)	- nursing assessment and management of unstable conditions related to elimination; - dialysis; - see Restorative nursing, SNC; - Intermittent Catheterization Program; - nursing implementation of ostomy procedures.	- sterile insertion/irrigation of urethral catheter; - enema/suppository; - incontinent care; - timed toileting; - see Restorative Nursing, INC - routine ostomy care
Sensory Perception Alterations Speech Visual Auditory Tactile Olfactory Kinesthetic (C.P. Section III, V and VI)	- medically prescribed speech therapy including evaluation and treatment by a qualified therapist; - teaching the use of communication with a system board/electronic communicating; - medically prescribed service of qualified occupational therapist to improve functional level.	- nursing direction of established maintenance programs.
Thought Process Alterations in: Disorientation Anxiety Depression Short-Term Memory (C.P. Sections V and VI)	- nursing assessment of alterations in thought processes; - active management of severe agitation or depression (safety at risk).	- nursing direction of an established maintenance program; - care to assure patient safety; - sensory stimulation; - nursing development and management of behavior modification program.

July 1985

CRITERIA

Patient Problems/Needs	Nursing Interventions (Planning, Implementation and Management) SNC	INC
Airway Clearance, Ineffective (C.P. Sections III, IV and VI)	- intensive respiratory programs; - respirator care; - nursing assessment linking ineffective airway clearance with systemic disorder, i.e., cardiac output;	- nursing direction of maintenance respiratory programs.
Medication Management Administration Teaching Monitoring Alternatives to Pain Management (C.P. Section IV)	- frequent nursing intervention for titration of medications; - I.V. medications; - I.M. medications more than once daily; - ultrasound, diathermy or microthermy.	- application of heat and/or cold; - administration and monitoring of a stabilized medication regime; - implementation and evaluation of a self-medication program.
Restorative Nursing Programs ROM/Strengthening Ambulation Skills Transfer Skills Positioning Progressive Restraint Release Self-Function/Swallowing Communication Skills ADLs Bladder Program Therapeutic Program Teaching	- nursing implementation and management of a restorative care program.	- nursing direction of an established restorative care program.

Attachment 2

MINIMUM STANDARDS FOR INDIVIDUAL CARE PROVIDERS

To protect the health and welfare of the recipients receiving waiver services, the providers of personal care must be 18 years of age or older and must meet the following minimum standards of knowledge and experience, skills, and ability.

A. Knowledge and Experience

1. General knowledge of nonmedical personal care tasks gained from experience in providing care to aged or disabled individuals.

2. General knowledge of acceptable standards of performance, including the necessity to perform dependably, report punctually, maintain flexibility, and to demonstrate kindliness and caring to the recipient.

3. Knowledge of when and how to contact the recipient's representative and/or the recipient's case manager.

B. Skills

1. Adequate reading skills to read plans of care with understanding.

2. Adequate communication skills to convey and understand information required to implement written plans of care and verbal instructions.

3. Adequate skills to maintain provider records of services performed, payments received, etc.

C. Ability

1. Ability to understand specific directions for providing care which the individual recipient requires.

2. Ability to observe the recipient for change in health status, e.g., weakness, confusion, loss of appetite, etc.

3. Ability to identify problem situations and take appropriate action.

4. Ability to respond to emergencies without direct supervision.

5. Ability to perform housekeeping functions such as meal preparation, laundry, cleaning, etc.

6. Ability to perform personal care functions such as bathing, dressing, toileting, and other personal hygiene care tasks.

7. Ability to accept the recipient's individual differences and preferences when performing routine tasks.

8. Ability to work independently.

9. Ability to perform responsibly within the boundaries of the non-medical personal care task limits.

OB-31H OFFICE OF EVALUATION
& PROGRAM REVIEW
3=4,5=4,8=18,9=3,13=19

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-254
ISSUED: 01/29/87

FROM: Charles E. Reed, Assistant Secretary
Aging and Adult Services
Administration, OB-43G

SECTIONS REVISED:
52.15, 52.41

EFFECTIVE: 01/01/87
FOR INFORMATION CALL:
Bureau of Aging and
Adult Services
SCAN 234-2502 OR
Non-SCAN (206) 753-2502

FOR MANUAL DISTRIBUTION CHANGES, PLEASE NOTIFY: MANUAL PRODUCTION UNIT AT MS OB-16
IF NOT DELIVERABLE, RETURN TO: DSHS STOCKROOM MS FB-11

SUBJECT: JANUARY 1, 1987 CHANGES FOR ALL COPES CLIENTS

Place this notice in front of Manual G, Chapter 52, and note on the Green Notice Control Sheet the date Notice No. 254 was entered.

Remove Green Notice No. G-241 from the front of Chapter 52 and note on the Green Notice Control Sheet the date removed.

A. BACKGROUND

1. Effective January 1, 1987, federal SSA, SSI, certain veterans' pensions and aid-and-attendance allowances will increase 1.3 percent.

2. Effective January 1, 1987, persons who have gross monthly income less than $1,020.00 (300% of the federal SSI benefit) will be eligible for COPES.

3. Effective January 1, 1987, the Medically Needy Income Level (MNIL) is:

a.	One person	$368
b.	Two persons	$532
c.	Three persons	$555

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FEB 18 1987
Division of Income Assistance
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4. The maximum plan of care costs, including the at-home living standard ($368.00), will be $1,105.00 per month. The net amount available for payment of COPES waiver services will continue to be $737.00.

B. ACTION REQUIRED

1. COPES Personal Care, CCF, and AFH Participation

a. Notify recipients of changes in service eligibility and/or participation in the cost of care.

The state office will send the CSO two copies of the financial award letter which is being sent to COPES clients who have SSA and/or SSI. The award letter shows the recomputed COPES participation amount for those clients with SSA income codes 30 and 32 and with SSI income code 55 together with the COPES additional requirements code (M1) on the M-form.

(1) The financial service technician will file one copy in the case record.

(2) The authorizing service worker will review the DSHS 14-159 and the award letter for any inconsistency in the client's name, Social Security Number, case number and program. When the inconsistency is resolved, correct entries; and:

(a) File one copy in the service record,

(b) Code changes in client program service eligibility and participation (as shown on the award letter) on the current DSHS 14-159.

(c) Route copies of the DSHS 14-159 per established procedures.

b. The state office will send the CSO two copies of the following lists of COPES clients:

(1) Recertified COPES cases with income codes 55 (SSI), 30 and 32 (SSA). These clients will have financial award letters sent directly to them by state office.

(2) COPES cases not recertified with income codes 31, 41, 42, 47, 48, or 49. These clients will NOT have financial award letters sent directly to them by state office.

(a) Financial service technicians will:

(i) Redetermine Medicaid eligibility for COPES; and

(ii) Issue a new award letter; and

(iii) Notify the authorizing service worker.

(b) The authorizing service worker will:

(i) File the financial eligibility redetermination/new award letter in the service record; and

(ii) Code changes in client eligibility and/or participation on the current DSHS 14-159; and

(iii) Route copies of the DSHS 14-159 per established procedures.

c. Clients are responsible for reporting any changes in circumstances, such as income, which might affect eligibility. If Social Services learns of a change in client income and has not received notice from Financial Services that this income change has occurred, Social Services will notify Financial Services. The procedures in b. above will follow such notification.

d. The effect of the 1987 COLA may result in increased participation for individuals who have increases in income. Since the increase in income may not be offset by the increase in the maintenance standard, the total paid by the department for cost of care may be decreased.

<u>Example</u>:

1986:	$689.00	(1986 income)
	-364.00	(1986 MNIL)
	$325.00	1985 participation

($3.97 per hour x 6 hours per day x 5 days per week x 4.3 weeks per month = $512.13 personal care cost)

$512.13 (personal care cost)
-325.00 (1986 participation)
$187.13 paid by the department in 1986

1987: $689.00 + ($689.00 x 1.3 COLA increase)
= $697.96

$697.00 (1987 SSA income)
-368.00 (1987 MNIL)
$329.00 1987 participation

$512.13 (1987 personal care cost per month)
-329.00 (1987 participation)
$183.13 paid by the department in 1987

2. Revise Manual G, Chapter 52 as follows:

a. 52.15 B. 4., page 5

Change - To be eligible for COPES, a person must have costs of care in excess of available income, gross income that is less than $1,020.00 per month, and resources at or below the Medicaid standard.

b. 52.41 Program Comparison Chart

Void the present Chapter 52 chart. Cross reference to the updated chart attached to this notice.

Attachment

52.41 PROGRAM COMPARISON CHART (Effective July 1, 1986)

COPES PERSONAL CARE (Code 5256) or (Code 5257)
Maximum $737 Per Client

1) Client must participate countable income over $368 directly to provider
2) FICA - provider's responsibility
3) No room/board allowance available for live-in care provider
4) Eligible for medical coupons
5) Additional eligible client in same home can qualify for COPES benefit
6) Consider Home Health/Day Health in cost of care (not to exceed maximum)
7) Provides 52.52% federal matching funds for cost of care

CHORE ATTENDANT CARE (Code 4205)

Service Payment	Up to $18.50 per day. Increased $75 max for additional client in same home (for maximum 31 days per month)
Room & Board (Code 4207)	2.75 per day (if client needs assistance with cost)
Mileage (60 x .20) (Code 4234)	12.00

1) FICA deducted/paid by department
2) Possible Chore Service Waiver for additional hours, rates
3) Medical coverage not automatic with CHORE
4) State and SSBG mix

COPES ADULT FAMILY HOME (Code 5210)

$20.98/day

1) Exempt $36.62 CPI; apply remainder to cost of shelter and food (up to $368.00) and personal care (amount in excess of $368.00)
2) Eligible for medical coupons
3) Provides 50% federal matching funds for cost of care

REGULAR ADULT FAMILY HOME (Code 4611)

$377.11/month

1) Exempt $36.62 CPI and $20; apply remainder to cost
2) Medical coupons only if SSI, GA-U, or if separate application for medical assistance is submitted and approved
3) All state funds for AFH care

COPES CCF (CODE 5226)

$22.66/day

1) Exempt $36.62 CPI; apply remainder to cost of shelter and food (up to $368.00) and personal care (amount in excess of $368.00)
2) Eligible for medical coupons
3) Provides 50% federal matching funds for cost of care

REGULAR CCF (Code 4623)

$17.30/day

1) Exempt $36.62 CPI and $20; apply remainder to cost
2) Medical coupons only if SSI, GA-U, or if separate application for medical assistance is submitted and approved
3) All state funds for CCF care

CHAPTER 52

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES)

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CHAPTER 52

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES)

52.00 PROGRAM AUTHORITY

Federal: 42 CFR Part 435.217
42 CFR Part 440.180
42 CFR Part 441.301-310

State: RCW 74-08-530
RCW 74.09.530
RCW 74.38.010
RCW 74.42.610
WAC 388-15-600 through 630

52.10 POLICY

52.11 Purpose of Service

On January 1, 1983, the department was granted a home and community-based care Medicaid waiver from the federal Department of Health and Human Services. Such waivers were made possible through enactment of Public Law 97-35, the Omnibus Reconciliation Act of 1981. In Section 2176 of the Act, Congress authorized the Secretary of the Department of Health and Human Services to offer an array of services under Medicaid to persons who would otherwise require care in a skilled nursing facility or in an intermediate nursing care facility. The department's home and community-based care program is called the Community Options Program Entry System, or COPES. The purpose of the COPES program is to avoid unnecessary institutionalization. The waivered services, i.e., case management and paid COPES services are to augment the presently available informal support system to maintain the recipient's health and safety. Participation in COPES is the choice of the otherwise eligible recipient.

52.12 Service Description

A. The waiver services offered under COPES are:

1. Congregate Care

2. Adult Family Home Care

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3. Personal Care

One waiver service may be provided to an eligible recipient at a time.

B. Case management is provided in conjunction with the waiver services. Case management is not provided as a singular and independent service under the COPES program.

C. Adult day health and home health are Medicaid reimbursed services which enhance the care provided to the client. Adult day health and home health are not authorized as singular and independent services under the COPES program.

D. COPES eligible recipients are eligible for covered medical services reimbursed by Medicaid, just as if these categorically needy recipients were residing in a nursing home.

52.13 General Policies Related to this Service

A. Congregate Care Facility Services (CCF)

1. Congregate care services in a licensed and contracted boarding home provide supervision and assistance with activities of daily living, community living skills, medication, money matters, transportation, and an activity program supportive of an individual service plan. CCF services are more specifically described in Chapter 46. (WAC 248-16-215 defines boarding home services.)

2. COPES CCF recipients may also receive hands-on help with activities of daily living and health-related services, provided that:

   a. The recipients are assessed by the service worker as requiring these additional services; and

   b. The CCFs providing these additional services are deemed qualified by the service worker; and

   c. The CCFs have specifically contracted to provide hands-on help with activities of daily living and health-related services; and

   d. There is a current CCF contract for COPES congregate care.

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3. Recipients of COPES CCF services are not simultaneously eligible for the DDD Community Alternatives Program (CAP).

B. Adult Family Homes Services (AFH)

1. Licensed and contracted adult family home services provide supervised day-to-day activities and assistance with activities of daily living and health-related services for adults who require a protected family like environment. Chapter 46 more specifically describes AFH services.

2. Recipients of COPES AFH services are not simultaneously eligible for the DDD Community Alternatives Program (CAP).

C. Personal Care Services

1. Personal care services are provided in the recipient's home and may include:

a. Skin, hair, and nail care, oral hygiene, and denture care required to maintain good health and psychological and social well-being.

b. Assistance with ambulation, dressing, eating, and bathing. This assistance may require lifting, turning, and steadying the recipient.

c. Transfers to and from bed, wheelchair, and bathtub.

d. Preparation of food, to include meal planning and food selection, buying, and cooking.

e. Transportation and escort to medical services, including medical laboratories (for tests) and specialized treatment, physicians' appointments, and adult day health.

f. Assistance with toileting, such as using a bedpan, diapering, and changing a colostomy or catheter bag. Sterile procedures are allowed only when the provider is a licensed health practitioner or immediate family member.

g. Application of prescribed, and ordinarily self-administered, ointments or lotions, changing of prescribed bandages or dressings, assistance with prescribed exercises and specialized skin care. Sterile procedures are allowed only when the provider is a licensed health practitioner or immediate family member.

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h. Assistance with medications which are ordinarily self-administered. This may include reminding to take a prescribed medicine and delivering the proper dosage into the client's hands if the client is unable to do so. Administration of medications is allowed only when the provider is a licensed health practitioner or immediate family member.

i. Housekeeping and laundry tasks necessary to provide a clean environment in which the recipient lives and to maintain his or her social well-being.

j. Accompaniment while client uses respiratory (iron lung) or dialysis equipment. (Allowable only with special training and RN supervision.)

k. Protective supervision when the recipient has diminished mental capacity or judgment.

l. Assistance with community living skills such as telephoning, writing, and shopping.

m. Full-time care for recipients who require protective supervision or need assistance with unscheduled tasks, such as toileting, wheelchair transfer, and ambulation. Recipients of full-time care require someone in attendance for twenty-four hours, although some of this care may be provided by unpaid care givers, such as family or friends.

2. Recipients of full-time personal care services, such as live-in or full-time care or protective supervision, may require more than one provider. A plan of care may be developed that utilizes two or more providers. For example, a recipient may have a primary care giver and a relief worker. However, a contract for each provider must be in place prior to the provision of services and the cost of all services must not exceed 90% of the median state nursing home rate. (See 52.15 D. 2. a.)

3. Personal care services may be provided by private or public social/health agencies or by independent/individual providers. Individual providers may be friends, neighbors, or relatives with the following restrictions:

   a. A spouse may not be approved and authorized as a paid COPES personal care provider for his or her wife/husband.

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b. A father, mother, son, or daughter may be approved and authorized as a paid COPES personal care provider for an immediate family member. This may be done when the relative will not provide the care unpaid and his or her gross income, including spousal income, is less than the Medically Needy Income Level (MNIL) adjusted for household size. That shall be substantiated in the case record by the provider's written declaration.

The welfare of relatives and increased household income are not the object of the case manager's consideration. When paying relatives for personal care services, the case record must clearly document the reason(s) the relative will not/cannot provide the service without remuneration.

c. A landlord renting space in the landlord's home to the recipient may not be approved and authorized as a paid COPES individual personal care provider. This person may apply for an AFH license to receive payment under the COPES/AFH program.

4. Recipients of COPES personal care cannot also be authorized chore services nor simultaneously receive services under the DDD Community Alternatives Program (CAP).

5. Personal care services are provided to a recipient residing in his or her established residence. This residence may be wholly or partially owned by the recipient, rented by the recipient, or it may be the home of a relative. When the plan of care establishes the need for relief help for the primary care giver, whether or not this care giver is a paid or unpaid provider, personal care services may be delivered outside of the recipient's established residence, provided that:

a. The duration of the relief assistance outside of the home does not exceed five days per calendar month; and

b. Payment for the services does not exceed the payment rate authorized for the primary care giver, unless the primary care giver is unpaid, in which case payment may not exceed the rate established for individual providers; and

c. The relief provider has a current personal care contract in place.

Relief personal care services under these circumstances may be provided in a variety of settings including the home of a neighbor or friend or an adult day care center.

Continuous or ongoing personal care service is provided outside the recipient's home by nonrelatives only as a part of the services provided by a licensed and contracted adult family home sponsor or by the staff in a licensed and contracted congregate care facility.

D. Home Health Services

1. Home health services are provided under the State Plan in a recipient's own home, adult family home, or congregate care facility. Home health services are an array of health services which may be brought into the home singly or in combination to achieve and sustain the optimum state of health, activity, and independence for the recipient.

2. Home health services are appropriate for recipients requiring those services in conjunction with personal care services to maintain their health and safety.

3. Applicants requiring only home health services are not eligible for COPES. COPES waiver services must be a requirement of the plan of care for the client to receive COPES home health services.

4. All home health service expenses paid by medical coupon must be included in the plan of care estimated monthly cost computation. Home health expenses paid by Medicare or some other payor shall not be included in the plan of care estimated monthly cost computation. When completing the plan of care, the maximum amount allowed each month for home health is $400. The service worker and/or case manager should inform the recipient and home health provider of the program's limitations and the necessity to report changes in the cost or frequency of home health services. Medical coupons are not imprinted with "COPES"; notification of the home health provider will allow them to monitor their costs for COPES clients and provide information on the recipient's progress. Substantial home health costs may indicate a review of the service plan is needed to determine whether the recipient's health and safety can be maintained in the community.

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5. A waiver request memo may be submitted to the Bureau of Aging and Adult Services requesting individual exceptions to the limits above for clients in their own home. This is appropriate for clients requiring more home health services for a brief and limited time which will enable them to remain in their own home.

E. Adult Day Health Services

1. The objective of adult day health services is to provide medically necessary services which will maintain or improve the level of functioning of the recipient to prevent or delay institutionalization. Health, rehabilitative, and counseling services are provided by the adult day health centers, as well as supervision, support, and therapeutic activities. (Adult day care, providing companionship and socialization, is not an authorized COPES service.)

2. Applicants requiring only adult day health services are not eligible for COPES. Waivered services must be a part of the plan of care for the client to receive COPES adult day health services.

3. The payment for adult day health made by medical coupon is a cost included as a part of the total plan of care. When completing the plan of care, the maximum amount allowed each month for adult day health is $250. The service worker should inform the recipient and adult day health provider of the program's limitation.

4. Not all adult day health centers are eligible for Medicaid reimbursement. Only those centers which accept medical coupons can be reimbursed by Medicaid.

F. Case Management Services

1. As the first priority in the case management target population, case management services shall be provided to COPES clients in accordance with the department's policies and procedures explicated in Manual G, Chapter 30. The services shall continue for the duration of the client's eligibility for COPES.

2. Implementation of the case management policy requires a sharing and coordination of COPES case management responsibilities among the CSO, the Aging Network, Division of Developmental Disabilities (DDD) case services staff, mental health professionals employed by mental health centers, etc.

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3. The Comprehensive Adult Assessment is performed by the CSO/DDD or the Aging Network, depending on which agency was initially contacted by the referral source. Exceptions may be made when the CSO and Aging Network concur.

4. If the client is age sixty or older, the COPES service plan is jointly developed by CSO staff or DDD staff, Aging Network staff, and other attendees at a face-to-face case staffing.

5. The determination of the agency responsible for ongoing case management will be made at the case staffing's joint service plan development.

   In the absence of exceptional circumstances, COPES clients:

   a. Age sixty or over residing in the community receive case management from the Aging Network;

   b. Under age sixty residing in the community receive case management from the CSO or DDD;

   c. Age eighteen and over residing in a congregate care facility or an adult family home receive case management from the CSO or DDD.

6. The assigned case manager must review the plans of care after 30 days, 90 days, and one year; and at least once each year thereafter. These reviews must be face-to-face, preferably in the recipient's home, CCF, or AFH. The period of review begins as of the day the client agrees to and approves the service plan.

7. The case manager will record the results of the case review on the DSHS 14-192B, Comprehensive Adult Reassessment Form. A copy of this form must be on file at the CSO. Therefore, when the designated case manager is not the authorizing service worker, the case manager must forward a copy of the DSHS 14-192B to the CSO service worker.

8. Changes to the service authorization can be made only by the service worker. Case managers should advise the authorizing service worker when changes are appropriate. A case staffing may be necessary when changes in services are advised; service workers and/or case managers should act promptly when a change in the plan of care is required.

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52.14 Priorities Related to this Service

Priority elements of COPES services are:

A. To ensure necessary safeguards have been taken to protect the health and safety of the recipients of the service.

B. To ensure financial accountability for funds expended for home and community-based services.

C. To ensure an objective evaluation and re-evaluation of the applicant/recipient to determine eligibility for the level of care provided in an SNF or ICF.

D. To ensure the eligible beneficiary or a family member acting as his or her representative or his or her legal guardian will be informed of the feasible alternatives under COPES and given the choice of either institutional or home and community-based services.

E. To ensure the maintenance of written documentation of all program/service eligibility factors and the elements above.

52.15 Eligibility

COPES eligibility rules closely parallel those for Medicaid nursing home eligibility. The services offered under COPES are essentially the same as regular department residential care or in-home services, although some variations in payments and specific services do exist. Since COPES is a Medicaid program, financial eligibility determinations are the responsibility of the Community Services Office's (CSO) Financial Service Technician (FST). The CSO/DDD or the Aging Network is responsible for assessing the client's eligibility for COPES services and for evaluating program effectiveness. The CSO/DDD service worker is solely responsible for authorization of services.

A. Screening

1. Applicants requesting nursing home care or other community services, such as chore services, congregate care, or adult family home care should be informed about COPES by the financial and/or CSO/DDD service staff.

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2. Applicants identified by financial staff, other service staff, or other agencies as potentially eligible for COPES should be initially referred to a service worker for COPES screening. This screening may be done face-to-face, over the telephone or through a third party. The service worker must establish, generally, through this screening the applicant's age, income, financial resources, and disability. The client will not be required to verify these factors at the time of the screening.

3. After screening an applicant and determining the applicant may be appropriate for COPES, he or she shall be referred for a financial eligibility determination. Financial services is alerted of the COPES request on the DSHS 14-84, Financial/Social Services Communication form. If the service worker assists the applicant in completing the Application for Assistance, DSHS 14-01, the service worker may attach the DSHS 14-84 to the application. On page one of the application, in section one ("Why Are You Applying"), the service worker or client must check the box labeled "Other" and enter "COPES" in red on the same line. This will identify the application as a priority for eligibility determination by financial services.

B. Financial Eligibility

1. Financial eligibility must be established by the Financial Service Technician (FST) using COPES eligibility rules in Manual F and WAC. COPES financial eligibility criteria are similar to the rules for assistance in the cost of nursing home care.

2. The FST will determine the amount of income available to the applicant or recipient for his or her participation in the cost of COPES care. This is done at the time of application, eligibility reviews and reported changes in circumstances. The determination will be based on regulations currently in effect. The FST will notify the authorizing service worker of eligibility decisions, participation amounts, and changes in eligibility and/or participation on the DSHS 14-84, Financial/Social Service Communication form.

3. The CSO/DDD service worker and the Aging Network case manager must promptly notify the FST, in writing, of any known changes in the applicant's or recipient's circumstances (living arrangement, income amount or source, resources, etc.).

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4. To be eligible for COPES, a person must have costs of care in excess of available income, gross income that is less than $975 per month and resources at or below the Medicaid standard.

5. Only the resources of the applicant are used in determining financial eligibility. Resources of a spouse, parent, or child are not counted. The voluntary transfer of resources between spouses is allowable but must meet Medicaid resource regulations.

6. The FST will notify eligible COPES clients on the DSHS 14-248(X), COPES/CAP Program Notification form.

C. Program Eligibility

The COPES program service eligibility process includes, but is not limited to, the following:

1. The CSO/DDD service worker, Aging Network case manager, or community nurse completes the DSHS 14-192(X), Comprehensive Adult Assessment. The community nurse may be consulted, when available, if level of care determination is in question. The Comprehensive Adult Assessment must clearly support eligibility for nursing home care and specify the level of required care. (See Chapter 41.32 and 46.99.)

2. An in-person case staffing is required for service plan development for all COPES applicants who are determined eligible for nursing home care and who meet the financial eligibility requirements. (See Chapter 41.33.) The purpose of the case staffing is to share information about the applicant necessary to develop an appropriate plan of care which will maintain his or her health and safety, keeping in mind the applicant's preferences.

3. Upon completion of the case staffing, the ongoing case manager prepares the DSHS 14-225, Community Options Program Entry System Eligibility and Benefit Computation Summary, with the client or the client's representative.

   The acceptance of COPES services, like all Medicaid services, is voluntary. The beneficiary or his or her representative or his or her legal guardian shall be informed about COPES services and given the choice of institutional or home and community-based care.

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D. Eligibility Summary

1. Persons eligible for COPES are categorically related Medicaid recipients over 18 years of age who:

   a. Are aged or blind or disabled as determined by the Social Security Administration; and

   b. Have gross monthly income which is less than 300% of the federal SSI standard; and

   c. Have resources at or below the Medicaid standard; and

   d. Are found to be eligible through assessment with the Comprehensive Adult Assessment, DSHS 14-192(X), for skilled nursing care, intermediate nursing care or intermediate nursing care; and

   e. Choose to remain in their own homes or in licensed congregate care facilities or adult family homes.

2. The cost of COPES services (excluding the at-home living expense, medical costs, and case management costs) does not exceed:

   a. $737 per month for in-home care. This at-home amount is determined by subtracting the allowance for at-home living expenses, which is $364, from 90 percent of the average statewide nursing home rate, which was $1,101 on January 1, 1985.

   b. The established rate for COPES/CCF and for COPES/AFH (excluding the clothing and personal incidentals (CPI) allowance).

E. Effective Date of COPES Eligibility

COPES program eligibility is effective on the date that all of the following program criteria have been satisfied:

1. Financial eligibility has been determined; and

2. The Comprehensive Adult Assessment clearly demonstrates eligibility for nursing home care; and

3. There has been a case staffing; and

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4. An individual service plan has been developed and approved by the department and the client to meet the client's health and safety needs; and

5. The client has agreed to pay participation (all countable income in excess of the at-home living standard) directly to the provider of care; and

6. Contract requirements have been met.

F. Reasons for Denial/Termination of Services

An applicant/recipient may be denied COPES services when:

1. The assessment process determines that he or she is not eligible for nursing home care; or

2. He or she has income which exceeds 300 percent of the federal SSI amount; or

3. He or she has resources that exceed the Medicaid standard.

4. His or her cost of services on the plan of care exceeds $737.00 per month; or

5. The service worker or case manager determines that the services offered by COPES do not adequately meet the applicant's needs and places the applicant's health or safety in jeopardy (this includes circumstances when there is no prospective COPES provider of care who demonstrates actual or potential ability to provide reliable, dependable, capable care and hold the client's welfare as foremost in the provider/client relationship); or

6. He or she refuses to participate in COPES or prefers nursing home care; or

7. He or she requires only home health and/or adult day health care; or

8. His or her income is equal to or exceeds the total cost of his or her care in a CCF or AFH; or

9. His or her participation exceeds the cost of personal care in his or her home.

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52.20 PROGRAM STANDARDS

52.21 Program Expectations/Response Time

A. Respond to emergency referrals within one working day after receipt of referral.

B. Respond within the following time to nonemergent referrals:

1. Initial screening completed by phone or in person within three working days after receipt of request.

2. Financial eligibility determination completed within sixty days for medical assistance applications based on disability and forty-five days for all other medical applications.

3. Program eligibility determination:

   a. Comprehensive adult assessment initiated within five working days following the screening.

   b. Service plan development - Case staffing within twenty days following the comprehensive adult assessment.

   c. Service plan implementation - Upon satisfaction of all program eligibility requirements (see 52.15 E).

   d. Service plan reviews - Within thirty days, ninety days, and at the first and subsequent anniversaries of the recipient's approval of initial service plan.

C. The case records of COPES clients shall document the following:

1. A comprehensive adult assessment has been completed; and

2. He or she is eligible for skilled or intermediate level nursing care and COPES services are necessary to avoid institutionalization; and

3. He or she is a categorically related Medicaid recipient (aged, blind, and/or disabled as determined by the Disability Insurance Benefit (DIB) section); and

4. He or she prefers to remain at home with community support services, in an adult family home or congregate care facility; and

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5. He or she has an individual plan of care which will maintain his or her health and safety and the cost is not more than $737.00, excluding the cost of board and room; and

6. The types and frequency of the COPES services required and the identity of the care provider; and

7. Adherence to program requirements, e.g., completion of mandatory reviews, timely client notification of participation liability, COPES contract in place, etc.

52.22 Appropriate Program/Service Outcomes

As a result of the COPES service plan, the client who would otherwise be eligible for ICF/SNF care will:

A. Remain, by his or her choice, in a safe and healthy environment in his or her home.

B. Move to or remain in, by his or her choice, an adult family home or a congregate care facility; or

C. Move, by his or her choice, from a nursing home to a less restrictive level of care at home, in an adult family home or congregate care facility with adequate safeguards for his or her health and safety.

D. Attain a level of independent functioning indicating the COPES service plan may be terminated.

52.30 SERVICE PROCEDURES

52.31 Screening

Clients are screened for case management by target population criteria and/or for appropriateness for COPES.

A. Source of Referrals

Applicants and referrals for COPES services may enter the CSO System by self-referral, referral by relatives, neighbors, friends, hospital staff, or other community agencies. Some persons referred for services may be active DSHS clients at the time of referral while others will be new applicants.

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B. New Applicants

Applicants for COPES or persons referred to the CSO for COPES who are not already determined Medicaid eligible will be screened. The target population criteria is used to determine his or her need for case management services in the period prior to the determination of COPES financial and program eligibility.

C. Active Medicaid Recipients

Active Medicaid clients referred for COPES will be prescreened for appropriateness for skilled nursing care or intermediate nursing care.

D. Process

There is no prescribed form to be completed in the screening for case management or COPES. Persons performing the screening must be thoroughly familiar with the target population criteria in Chapter 41.14.

1. Screening for case management is performed using the target population criteria.

2. Screening by telephone shall be completed within one working day after receipt of a referral.

3. Screening requiring a home visit shall be completed within three days of receipt of a referral.

4. Persons who are ineligible or inappropriate for case management and/or COPES shall be referred for other appropriate services, as indicated.

52.32 Program Eligibility Determination

A. The CSO will initiate a comprehensive assessment within five working days following the CSO screening when:

1. The client needs case management in the period prior to the determination of COPES financial eligibility.

2. The client is financially eligible and/or active on Medicaid at the time of the screening.

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B. In other cases, the CSO will initiate a comprehensive assessment no later than five days following notification of Medicaid eligibility.

52.33 Comprehensive Adult Assessment

A. Purpose of Comprehensive Assessment

The purpose of the comprehensive assessment is to provide a format for evaluating and recording an adult client's strengths and needs. From this assessment and discussion with the client of his or her wishes should come a recommendation for services which will meet the client's needs and support his or her independence in the least restrictive setting possible.

B. Process

1. The DSHS 14-192(X), Comprehensive Adult Assessment, is used for the comprehensive assessment which:

   a. Is conducted on a face-to-face basis, in the client's own home, hospital, or other current residence.

   b. Is performed with maximum client involvement in the procedure to get the most accurate information possible.

   c. Incorporates information as needed from other accurate sources when the client is unable to talk, is confused, or denies the severity or existence of problems.

   d. Observes and honors the client's rights throughout the procedure.

2. A client that is determined ineligible for ICF/SNF care and therefore ineligible for COPES but meets the case management target population criteria will be referred for ongoing case management. If the client does not meet case management target population criteria, he or she will be referred directly to appropriate services.

52.34 Service Plan Development

All COPES DSHS 14-192D, Case Management Service Plans are developed in accordance with the case management service plan development procedures in Chapter 41.33.

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A. Service Plan Development Responsibilities

The client's preferences will be the primary consideration in the development of the plan of care. While relatives, physicians, and other individuals may provide corroborating information, the client is the principal participant.

The CSO will be responsible for service plan development for and with persons who enter the long-term care system at the CSO when:

1. The CSO completed the comprehensive assessment; and

2. The client meets target population criteria for case management; and

3. Financial and program eligibility determinations are pending; or

4. Financial and program eligibility has been established.

5. The CSO case manager who completed the comprehensive adult assessment will:

   a. Convene the in-person case staffing for service plan development within twenty working days following the assessment.

   b. Write the service plan developed in the case staffing; and

   c. Deliver the service plan to the designated ongoing case manager within five days after the case staffing.

B. Case Staffing

The case staffing is mandatory for COPES. Staffing details should be planned to allow the expeditious development of the COPES service plan. In developing the proposed service plan, the service worker and other representatives at the case staffing must determine what assistance is available at no cost to the client and/or the department. Payment for personal care services provided by the informal support system must clearly be to the advantage of the recipient, not the provider. In every instance, the client's circumstances and welfare are the primary objective in establishing a plan of care.

1. Service workers or other professional staff from the CSO system, Aging Network, Developmental Disabilities (DDD), Mental Health (MH), Alcohol and Substance Abuse (ASA), and DSHS nursing staff develop a service plan during a formal case staffing. For example, an 80-year-old female applicant should be staffed by at

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least the service worker, Aging Network staff, and community nurse or nursing care consultant. Other appropriate persons to attend this staffing include a geriatric specialist from the mental health clinic and a family member, etc. It may also be helpful to have a staff person from CSO financial services explain the medical benefits of COPES eligibility.

2. Case staffings must occur prior to implementation of a proposed plan of care. However, for applicants awaiting hospital discharge or in exceptional circumstances, a temporary plan of care, developed with and approved by the recipient, may be implemented prior to the case staffing provided that the staffing takes place within 30 days of initiation of services.

3. Case staffings may also take place at the times of the 30-day, 90-day, and one year reviews and are required when there is very significant change in the service plan.

4. Case staffings are not required at times of regularly scheduled contacts with the client.

5. While details of case staffing such as timing, location, etc., may be determined by the CSO and the Aging Network, case staffings should:

   a. Start and finish on schedule.

   b. Include all key participants, who work toward a consensus on the best service plan for the client. (See Chapter 41.33.)

   c. Be brief and focus only on the information necessary to make an informed decision about the proposed plan of care. Briefly written information about the applicant sent in advance of the staffing will help shorten the time of the meeting.

C. Service Plan Documentation

1. The COPES service plan must adequately meet the health and safety needs of the client and the cost must not exceed ninety percent of the median state nursing home rate.

2. The DSHS 14-225, Community Options Program Entry System (COPES) Eligibility and Benefit Computation, must always be completed an included in the case record of every client offered COPES services. The form summarizes and documents:

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a. The factors of COPES eligibility and the eligibility determination;

b. That the client has been informed of feasible alternatives and has made his or her choice; and

c. That the client has agreed to pay nonexempt income available for participation in the cost of COPES care directly to the COPES care provider.

3. The DSHS 14-192D(X), Case Management Service Plan form summarizes and documents the type and frequency of services necessary to meet the client's health and safety needs and the person responsible for providing for these needs or providing assistance to obtain the services.

4. Entries under the major headings on the DSHS 2-305(X), Service Episode Record should avoid duplicate recording and yet maintain a chronological record. (See Chapter 02.11.)

5. To ensure observance of client's rights and program eligibility criteria, it is essential that assessment and service plan forms are complete and are signed by the client, the case manager, the authorizing service worker and/or the community nurse, as indicated on the forms.

52.35 Congregate Care Service Plan Development

When developing a COPES congregate care service plan, the service worker and other case staffing attendees must:

A. Establish that the applicant/recipient:

1. Requires intermediate nursing care, identifying the specific activities of daily living, and health-related services the client requires; and

2. Is ambulatory, i.e., the resident is physically and mentally able to walk unaided or is able to be independently mobile with the use of a cane, crutches, wheelchair, etc. An ambulatory individual does not need assistance of another person in order to get into and out of bed, to transfer to a chair or toilet, or move from place to place; and

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B. Determine the congregate care facility:

1. Has or will employ sufficient staff with demonstrable skills which:

   a. Meet the client's identified unmet needs; and

   b. Will maintain the client's health and safety; and

   c. Will continue to maintain an acceptable level of service to other facility residents.

2. Will agree to develop an Individual Service Plan for the COPES recipient which will:

   a. Address the client's identified unmet needs;

   b. Preserve the client's strengths and encourage functional independence;

   c. Implement the proposed service plan developed and approved by the department and agreed to by the client.

3. Will document the contracted schedule of COPES add-on services provided and the frequency of provision of those services.

   WAC 248-16-228 defines boarding home medication services. The registered nurse responsible for supervising the medication service may be a staff member, a consultant, or from a home health agency. A licensed practical nurse may actually administer the medications, but must be supervised by an RN. Recipients of medication services must be ambulatory residents of the CCF.

   NOTE: Recipients of COPES CCF services are not simultaneously eligible for the DDD Community Alternatives Program (CAP).

52.36 Client Agreement Regarding Service Plan

A. Eligible applicants and referrals for COPES who are eligible for skilled or intermediate nursing care will be informed of any feasible alternatives under COPES and shall be offered the opportunity to receive those COPES services to meet his or her health and personal care needs.

B. The individual's choice will prevail as to whether to accept the waiver services (personal care, adult family home, or congregate care) or be admitted to a nursing home.

C. The designated ongoing case manager will:

1. Present the proposed DSHS 14-192D, Case Management Service Plan and/or DSHS 14-225, COPES Eligibility and Benefit Computation Summary to the client and/or the client's representative for review and approval; and obtain the client's or the client's representative's signature(s); or

2. Coordinate the development of a revised service plan with the participants of the initial case staffing's service plan development; and

3. Provide the final DSHS 14-192, DSHS 14-192D, and DSHS 14-225, i.e., the documents signed by the client or the client's representative to the CSO authorizing service worker (when different than the ongoing case manager).

D. The client's signature on the DSHS 14-192, DSHS 14-192D, and the DSHS 14-225 forms indicates approval of the plan. The plan is not final and may not be implemented until the forms are signed by the client or the client's representative.

E. If it is not possible to obtain such signatures, the reason(s) must be documented on the DSHS 14-192D and DSHS 14-225.

52.37 Ongoing Case Management/Service Plan Implementation

COPES clients shall receive case management for the duration of the COPES authorization. All service plan implementation activities will be performed as they are needed. (See Chapter 41.21 D.)

52.38 Service Plan Review

The ongoing case manager will:

A. Maintain regular contact with the COPES recipient.

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B. Review the service plan and re-evaluate the recipient's eligibility for ICF/SNF care by scheduling and conducting reviews:

1. Within thirty days after the initial plan was agreed to by the client,

2. Within ninety days after the initial plan was agreed to by the client; and

3. At the first and subsequent anniversaries of the date the initial plan was agreed to by the client.

4. When the case manager determines there has been substantial change in the client's physical condition or in his or her social support system.

C. Document the re-evaluation on the DSHS 14-192B, Comprehensive Adult Reassessment form.

D. Discuss the provider's service delivery with the recipient. It is preferable to do this when the care provider is absent. Review the DSHS 15-51, Individual Provider Service Verification Worksheets for the preceding period. (See 52.51 E. for information regarding review/audit of other care provider records.)

52.39 Service Plan Termination

A. The COPES service plan review may indicate the recipient is no longer eligible for COPES waiver services. Termination of the COPES service plan may occur by mutual agreement of the case manager and the client. However, the case manager may determine, independent of the recipient, that the service plan does not safeguard the client's health and safety. When this occurs, the case manager shall:

1. Convene a case staffing to explore feasible, alternative service plans with the client and/or the client's representative, and other staffing participants.

2. Terminate the invalid service plan.

B. When COPES waivered services are denied or terminated for any of the reasons in Chapter 52.15 F, notify:

1. The client of the denial/termination and his or her right to a fair hearing by sending the client copy of DSHS 14-225 to the applicant/recipient.

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2. Financial services if the client has completed DSHS 14-01, Applicant for Assistance or has been determined eligible for Medicaid. Financial eligibility for other medical programs will be determined. The financial service technician will send the client notification of the financial eligibility decision.

52.40 PROGRAM AID

(See following page)

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52.41 PROGRAM COMPARISON CHART

CHORE ATTENDANT CARE (Code 4202)

Chore Payment	$540.00 (Max)	Increased $50 max for additional client in same home
Room & Board	83.50 (Max)	
Mileage (60 x .20)	+12.00	
	$635.50	

1) FICA deducted/paid by department
2) Possible Chore Service Waiver for additional hours, rates
3) Medical coverage not automatic with CHORE
4) State and SSBG mix

COPES PERSONAL CARE (Code 5256) or (Code 5257)
Maximum $737 Per Client

1. Client must participate countable income over $364 directly to provider
2. FICA - provider's responsibility
3. No room/board allowance available for live-in care provider
4. Eligible for medical coupons
5. Additional eligible client in same home can qualify for COPES benefit
6. Consider Home Health/Day Health in cost of care not to exceed maximums
7. Provides 50% federal matching funds for cost of care

REGULAR ADULT FAMILY HOME (Code 4611)

Basic Rate	$354.55
ADL	79.23 (Max)
Health Related Service	219.42 (Max)
Respite Care	+ 11.57
	$664.77

1) Exempt $35.55 CPI and $20; apply remainder to cost
2) Medical coupons only if SSI, GA-U, or if separate application for medical assistance is submitted and approved
3) All state funds for AFH care

COPES ADULT FAMILY HOME (Code 5217)

Basic Rate	$354.55
ADL	79.23 (Max)
Health Related Service	219.42 (Max)
Respite Care	+ 11.57
	$664.77

1. Exempt $35.55 CPI; apply remainder to cost
2. Eligible for medical coupons
3. Provides 50% federal matching funds for cost of care

REGULAR CCF (Code 4623)
$16.80 x .31 = $520.80 Maximum

1) Exempt $35.55 CPI and $20; apply remainder to cost
2) Medical coupons only if SSI, GA-U, or if separate application for medical assistance is submitted and approved
3) All state funds for CCF care

COPES CCF (Code 5246)

$16.80 x 31 days	$520.80
5.20 x 31 days (Max)	$161.20
	$682.00

Health Services Rates: Added to regular rate

1. $3.61 per day for 1-3 Services plus 1 or more ADLs
2. $4.41 per day for 4 Services plus 1 or more ADLs
3. $5.20 per day for 5 Services plus 1 or more ADLs

A. Exempt $35.55 CPI; apply remainder to cost
B. Eligible for medical coupons
C. Provides 50% federal matching funds for cost of care

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52.42 Task, Frequency and Authorized Hours Guide

COPES TASK, FREQUENCY AND AUTHORIZED HOURS GUIDE

Directions:

1. Assess the level of service the client needs and circle the score in each category in columns 1-4.
2. Assess the level of unpaid service provided to the client and circle the score in each category in columns 1a-4a.
3. Subtract the unpaid services provided score from the services needed score in each category and enter the indicated monthly hours in column 5.
4. Add or subtract score/hours to adjust for special circumstances and enter the difference in column 7.
5. Total column 7 to determine the hours of COPES service required to maintain the client's health and safety in their home.

	Level of Services Needed					Level of Unpaid Needed					COPES SERVICES NEEDED	
Column	1	2	3	4		1a	2a	3a	4a		5	6
	NONE - INDEP. w/or w out AID / MINIMAL - CUING OR STANDBY / MOD. - SOME PHY. ASSIST. / TOTAL/COMPLETE PHY. ASSIST.					NONE / MINIMAL / MODERATE / TOTAL/COMPLETE					INDICATED MO. HOURS PLUS OR MINUS ADJ. FOR SPECIAL CIRCUMSTANCES	HRS. PER MONTH
I. Personal Care												
A. Dressing/Undressing	0	4	7	10	minus	0	4	7	10	equals		equals
B. Grooming/Care of Appearance	0	1	7	5	minus	0	1	3	5	equals		equals
C. Body Care	0	5	10	15	minus	0	5	10	15	equals		equals
D. Bed Transfer	0	1	3	5	minus	0	1	3	5	equals		equals
E. Wheelchair Transfer	0	1	3	5	minus	0	1	3	5	equals		equals
F. Ambulation	0	4	7	10	minus	0	4	7	10	equals		equals
G. Bathing	0	4	7	10	minus	0	4	7	10	equals		equals
H. Toileting	0	5	10	15	minus	0	5	10	15	equals		equals
I. Feeding												
1. Breakfast	0	4	7	10	minus	0	4	7	10	equals		equals
2. Light Meal	0	4	7	10	minus	0	4	7	10	equals		equals
3. Main Meal	0	5	10	15	minus	0	5	10	15	equals		equals
II. Meal Preparation												
(Special Diet Preparation time is included)												
A. Breakfast	0	4	7	10	minus	0	4	7	10	equals		equals
B. Light Meal	0	4	7	10	minus	0	4	7	10	equals		equals
C. Main Meal	0	5	10	15	minus	0	5	10	15	equals		equals
III. Housekeeping												
A. Cleaning	0	1	2	3	minus	0	1	2	3	equals		equals
B. Laundry (When facilities outside home, add to this score)	0	1	2	3	minus	0	1	2	3	equals		equals
C. Essential Shopping and Errands	0	1	3	5	minus	0	1	3	5	equals		equals
IV. Escort												
Escort to Medical Services	0	1	2	3	minus	0	1	2	3	equals		equals
V. Special Functions												
A. Assistance with Medications	0	2	4	6	minus	0	2	4	6	equals		equals
B. Administration of Medications*	0	2	4	6	minus	0	2	4	6	equals		equals
C. Change dressings: Assist with Prescribed Exercises and Skin Care*					minus					equals		equals
D. Lifting Assistance**					minus					equals		equals
E. Handle Personal Business					minus					equals		equals

* May be performed only by licensed health professional or member of immediate family, when a paid service.
** Requires special training.

TOTAL_____

52.50 CONTRACTING PROCEDURES

A. Congregate Care

1. COPES congregate care services may be provided in licensed boarding homes, having the necessary nursing staff, which enter into a contract to provide COPES CCF services.

2. Contracts for licensed boarding homes not having current CCF contracts are made in accordance with the instructions in Chapter 99.

3. Care of COPES clients choosing to enter a COPES CCF, assessed as requiring a supervised living situation and requiring one or more health-related services may be paid through the COPES CCF contract. The services which the CCF is expected to provide will be indicated on the DSHS 14-192(X), Comprehensive Adult Assessment, and DSHS 14-192D(X), Case Management Service Plan, copy to the provider.

4. The rate of payment is the department's established CCF COPES rate.

B. Adult Family Home

There is no special contract or license for adult family homes that serve COPES recipients beyond the usual AFH license and contract requirements. When nonrelated persons provide ongoing personal care to COPES recipients in the nonrelated provider's home, they must be licensed and contracted as an adult family home.

C. Personal Care

1. Personal care services are contracted using:

   a. The COPES Individual Personal Care Provider Contract, DSHS 9-636, and the COPES Personal Care Procedures, Part I, DSHS 14-240, or

   b. The COPES Agency Personal Care Provider Contract, DSHS 9-637 (for CSO/Regional Office use only). To be paid at the agency rate, the agency must be:

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(1) A home health agency certified for insurance reimbursement under the regulations in WAC 248-27-001 through 248-27-120; or

(2) A contracted chore service provider.

2. While the Aging Network case manager shall follow the same general procedures in securing contracting documents for individual providers as the CSO service worker, the authorizing CSO service worker submits the contracting documents directly to the Office of Contracts Management (OCM), Mail Stop, OB-22N, Olympia, as follows:

   a. Two contractor (provider) signed copies of the appropriate (individual or agency) contract, including the Statement of Work, and

   b. For individual providers only, one copy of the Personal Care Provider Procedures, Part 1. (Distribute other copies as shown on the form.)

3. Contracts will be signed effective the date on which they are received in OCM with the exception as in Item 5 below. The contracts will be date stamped by OCM support staff to confirm the date of receipt. Additions to or deletions from the contract including the Statement of Work will cause the contract to be returned by OCM to the originating CSO, unsigned.

4. A CSO service worker designated by the CSO Administrator may verify date of receipt by OCM by telephoning the OCM mail desk (SCAN 234-4595) and requesting the date received by OCM. Based on this telephone confirmation, services may be authorized on the DSHS 14-154/159. Service workers can be assured that the contract will be signed effective the date received in OCM; provided that, neither the CSO service worker, the Aging Network case manager, nor the contractor has made any alterations to the standard format and general terms of the contract including the Statement of Work and/or the checklist. These legal forms must be completed in accordance with these instructions.

5. After the fact signing of the COPES contracts is possible only in emergency situations. An emergent situation is defined as any condition or set of conditions which places the recipient in jeopardy of imminent admittance into a nursing home or hospital; or cause release from such a facility to be delayed or denied; and requires a start date sooner than the date the contract is received in OCM. When an emergency exists:

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a. Services are immediately authorized on the DSHS 14-154/159. At the same time, the contractor (provider) signs the contracts and returns the contracts to the CSO service worker or the Aging Network case manager (who forwards the forms to the CSO). The authorizing CSO service worker places the start date of the contract period in paragraph 4 of the contract. This date must correspond to the date found on the Service Authorization, DSHS 14-154/159, in Block 32, Begin Date, and must not be more than ten working days prior to the date on which the contract is received in OCM.

b. Upon receipt in OCM, the contracting officer will sign the contract after the starting date. The effective date will be the starting date placed in paragraph 4 of the contract by the CSO service worker.

c. Contracts which are submitted to OCM after services have been initiated must be accompanied by a cover memorandum which briefly explains the emergent situation and tells OCM the date services were authorized for payment. Without adequate justification for signing the contract after the fact, the signing by a contracting officer will be delayed until such justification is received.

6. COPES personal care contracts are developed for specific providers. Contracts should be processed through OCM at the time an applicant/recipient for COPES selects a potential provider.

7. Unless terminated, individual and agency contracts are valid for the period of performance entered in paragraph 4 of the contract; another contract shall not be submitted to OCM for processing during the term of the contract.

8. CSO service workers may request that a contract be terminated by sending a memorandum to OCM which gives the reason(s) for termination. OCM, in turn, sends a form letter of termination to the contractor (provider) with copies to the CSO and Regional Office. Terminations will be done in accordance with the terms of the contract.

9. Through the course of the contract period, the provider may decide to perform a task for which he or she did not originally contract. The contract shall be amended by submitting two contract amendment forms, DSHS 9-303(X) (Rev. 9/81). The service

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worker completes the forms which are signed by the contractor (provider) and submitted to OCM. OCM will retain one signed original, send one signed original back to the contractor, one copy to the CSO, and another copy to the Regional Office if requested. The contract amendment may also be used to delete tasks from the Statement of Work and to extend the period of performance of the contract. The amendment is not effective until it is signed by OCM.

10. For case record auditing purposes, a copy of the contract's face sheet and Statement of Work must be maintained in the CSO service record of the COPES recipient for whom the individual contractor provides services. (The contractor shall keep his or her original copy of the finally executed contract. The contractor's original can be copied by the case manager for the CSO case records of subsequent clients.) For auditing purposes, it is sufficient to maintain copies of the finally executed agency contracts in the CSO and/or Regional Office file.

52.51 COPES Provider/Vendor Payments

A. Medical Services and Personal Care Services

1. Payment for physician services, Medicaid certified home health care, Medicaid certified adult day health, and approved medical transportation is made with medical coupons.

2. Medicare may be used in combination with or in place of Medicaid. Medicare payments are not computed as part of the service plan costs.

3. Payments for CCF, AFH, and personal care services are made by SSPS.

B. Client Participation

Income identified by financial services as available for participation in the cost of care must be paid by the recipient directly to the provider. The case manager must inform the recipient of his or her responsibility to pay participation costs. If the recipient refuses to pay the assigned participation, the agreed upon service plan is invalidated.

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1. Congregate Care Participation

The COPES CCF recipient will retain for personal use from his or her monthly income the clothing and personal incidentals (CPI) allowance plus any other income that financial services determines is exempt under the COPES program. The remainder is paid as participation to the facility for food, shelter, and care.

2. Adult Family Home Participation

The COPES AFH recipient will retain for personal use from his or her monthly income the clothing and personal incidentals (CPI) allowance plus any other income that financial services determines is exempt under the COPES program. The remainder is paid as participation to the facility for food, shelter, and care.

3. Personal Care

The COPES personal care recipient residing in his or her own home will retain from his or her monthly income the at-home living standard (SSI standard) plus any other income that financial services determines is exempt under the COPES program.

C. Purchase of Additional Non-COPES Personal Care Services

The recipient, family, friends, or acquaintances of the recipient may purchase additional non-COPES services. Payments may be made from their own funds to a provider for services which are above and beyond the COPES' paid services included in the DSHS 14-225, COPES Eligibility and Benefit Computation Summary estimated monthly cost computation. For example, when a recipient is authorized 160 hours of COPES paid personal care, a friend may purchase an additional 40 hours of personal care from the same provider or a different one. The friend, however, cannot supplement the hourly rate for services authorized on the plan of care. That is, $2 per hour cannot be added to the maximum hourly COPES rate. Additional services provided by family or friends should be stated on the DSHS 14-192D, Case Management Service Plan, but the costs excluded from the estimated monthly costs in the computation.

D. Individual Personal Care Provider as Independent Contractor

Individual personal care providers are considered to be independent contractors and as such the department does not pay FICA, FUTA, Labor and Industries, medical insurance, or other benefits. The department's relationship with personal care providers is contractual, not

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an employer/employee relationship. Providers with tax questions should be referred to IRS. Questions about taxes and benefits from the CSO or Aging Network case managers should be directed to the COPES program manager, Bureau of Aging and Adult Services.

E. Individual Personal Care Provider Performance Records

The personal care contract requires the provider to maintain performance records. Additionally, Medicaid regulations requires that providers maintain records.

1. DSHS 14-240A (12/84), COPES Personal Care Provider Procedures, Part II, advises the individual provider that he or she may be requested to provide documentation to state or federal auditors. It also briefly advises the provider what documents he or she will receive, what purpose they serve, and that they should be retained as a part of his or her personal records.

2. DSHS 15-51(X), Individual Provider Service Verification Worksheet, will enable the client and the provider to keep a daily record of services performed and received. Both the client and the provider retain a copy of the form in their personal records.

F. Congregate Care and Adult Family Home Performance Records

CCFs and AFHs will maintain client records required by the license, the contract, and the Individual Service Plan.

52.60 INTERFACE WITH OTHER DSHS SERVICES

A. Financial Services

Financial services will determine an applicant or recipient's financial eligibility for the COPES program and will notify the authorizing service worker of the eligibility decision. Financial eligibility must be established prior to authorization of waiver services.

B. Out of Area Community Service Offices

The community service office in the area in which the client is physically present is responsible for receiving and taking initial action on a COPES referral even though the client will reside in another county or is an active recipient in another county.

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The CSO in the client's county of residence is responsible for coordination of the service plan development and subsequent appropriate case management activities.

C. Division of Developmental Disabilities

Division of Developmental Disabilities will determine program eligibility for developmentally disabled Medicaid clients. The CSO service worker may be requested to attend a DD client's case staffing as one of the interdisciplinary team members but will not be responsible for service plan development or implementation.

D. Bureau of Nursing Home Affairs

The Bureau of Nursing Home Affairs' nursing care consultant may refer institutionalized clients for COPES services when the individual continues to be eligible for nursing care and his or her health and safety may be maintained at home, in an adult family home, or a congregate care facility.

E. Adjunct or Alternative Community Service Office Services

1. Chore Services may be considered as an alternative plan to maintain aged, disabled, or developmentally disabled persons in their own home and to prevent unnecessary institutionalization.

2. Adult Protective Services may be initiated for investigation of suspected or alleged abuse.

3. Community nurses and nursing care consultants may be contacted to provide assistance in determining medical and nursing needs.

4. Residential placement services may be utilized for individuals for whom in-home care is not a feasible alternative.

52.70 INTERFACE WITH OTHER NON-DSHS SERVICES

A. Area Agency on Aging

Information and Assistance/Case Management staff will provide COPES case management services to recipients 60 years of age and older. The authorizing CSO service worker will act as the department representative and will be responsible for submittal of authorizing documents.

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In the process of joint service plan development and case management coordination, conflicts of opinion and professional judgment may occur. Such conflicts shall be resolved at the direct service level whenever possible. Issues unresolved at that level shall be referred to CSO and aging network supervisors and, if necessary, to the respective administrators for a decision.

B. Medical Vendors

1. Home health agencies provide medically necessary nursing services to noninstitutionalized Medicaid clients and can provide valuable feedback on the efficacy of the COPES service plan in maintaining the recipient's health and safety.

2. Physicians provide treatment plans to home health agencies and are a resource for medical history which may be relevant to determining present care needs.

3. Mental health centers may be contacted for mental health services and for case consultation. Services vary by location; each CSO will establish which services are available in their area.

C. Client Support System

Family and friends may provide additional information regarding the client's strengths and unmet needs. The informal support system may provide direct assistance in the service plan's implementation.

D. Community Agencies and Advocates

Community agencies and advocacy groups may make referrals for COPES services and may wish to take an active role in the service plan development. The services and resources of these community agencies and advocacy groups should be utilized to the maximum extent the client chooses, to develop a broad-based service plan which will satisfy the COPES program's purpose.

52.80 SOCIAL SERVICE PAYMENT (SSPS) CODES

A. Congregate Care

1. SSPS service code 5226 will be used to authorize COPES CCF services.

2. SSPS Reason Codes are used in conjunction with Service Code 5226 to identify the recipients of additional COPES CCF services:

   a. Reason Code A - Up to three health-related services.

   b. Reason Code B - Four health-related services.

   c. Reason Code C - Five health-related services.

3. The present CCF rates are vendor unique. The regular and add-on rates will be supplied to the SSPS provider file by the BAAS CCF program manager. Service workers will be notified of rate changes by SSPS. Current rates may be obtained by accessing the SSPS provider file.

B. Adult Family Home

1. SSPS service code 5217 will be used to authorize COPES AFH services.

2. There are no unique rates for COPES recipients of AFH services. SSPS will publish current AFH rates and will notify service workers about any rate changes.

C. Personal Care

1. The SSPS service code for COPES personal care - individual provider is 5256.

   The SSPS service code for COPES personal care - private or public agency is 5257.

2. Payment rates for COPES personal care are published by SSPS. SSPS will notify service workers about any rate changes.

3. A standby hourly wage of up to $.25 per hour may be paid to individual providers of protective supervision or attendant care during the hours when actual services are not provided but the provider must be with the recipient.

4. There is no COPES board and room allowance or meal reimbursement.

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D. Statistical Data

The SSPS code for COPES federal waiver report is 5655.

Federal reporting requirements have become more exacting. The importance of this code as an essential data collection tool for completion of these stringent federal reports cannot be overemphasized. The complete, accurate information gathered from this code will be used to compare actual recipient count and program cost data to the approved waiver estimates of numbers of recipients and costs.

52.99 Required Forms and Instruction

	FORM NUMBER	FORM NAME	USE	DISTRIBUTION
1.	DSHS 2-305(X)	Service Episode Record	CSO/DDD worker enters form numbers and essential information not duplicated on required form(s).	Filed in CSO/DDD service case record.
2.	DSHS 6-97(X)	Provider File Action Request	CSO/DDD worker initiates form to request: a. Provider file inquiry to obtain specific information on existing or potential providers; b. Adding new individual or agency personal care payee to the provider file; and c. Change to existing provider payee information in the provider file.	Route to the terminal operator for completion of action and return to requestor for action. File in service case record.

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3.	DSHS 9-636(X)	COPES Individual Personal Care Provider Contract	Case manager will initiate form to contract with an individual to provide COPES personal care services.	CSO/DDD worker will submit two completed contracts to the Office of Contracts Management, MS OB-22N, Olympia.
4.	DSHS 9-637	COPES Agency Personal Care Provider Contract	CSO/DDD worker or regional office will initiate form to contract with an agency to provide COPES personal care services.	CSO/DDD worker or regional office will submit two completed contracts to the Office of Contracts Management, MS OB-22N, Olympia.
5.	DSHS 13-336(X)	Client Profile	CSO/DDD worker will receive form from the Nursing Care Consultant WITH COPES referral of ICF/SNF client and will use in the assessment process.	Same as DSHS 14-192 when used as part of assessment documentation.
6.	DSHS 14-12(X)	Authorization to Release Information	Enables the department to obtain and release confidential client information.	To obtain information: .Original to CSO case record. .1 copy to client.
7.	DSHS 14-84(X)	Financial/ Social Services Communications	FST and CSO/DDD service workers initiate this form to provide or obtain client information.	.1 copy to financial record. .1 copy to service record.

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8.	DSHS 14-139	Social Services Application	NOT REQUIRED. (Financial Services will determine sources and amounts of income and resources available to COPES client.)	----------
9.	DSHS 14-154(X) and 14-159	Social Services Authorization/Change of Authorization	CSO/DDD worker completes form to authorize and/or change COPES service authorization	.Original to Data Control for paper batch or terminal input .1 copy to client. .1 copy to CSO/DDD service case record. .1 copy to individual or agency care provider. .1 copy to case manager if different than CSO authorizing service worker. .1 copy to client representative, if appropriate.

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10.	DSHS 14-192(X)	Comprehensive Adult Assessment	CSO/DDD/Aging Network worker. Completes form to determine the client's eligibility for ICF/SNF care by assessing his or her functional assets and deficits in psycho-social and health areas.	.Original to CSO/DDD service case record. .1 copy to client. .1 copy to client representative if appropriate. .1 copy to case manager, if different than CSO authorizing service worker. .1 copy to agency provider (for administrative use only).
11.	DSHS 14-192(B)	Comprehensive Adult Reassessment	CSO/DDD Aging Network worker completes at the 30-day, 90-day, and annual service plan review and re-evaluation of ICF/SNF eligibility and whenever there is significant change in client's condition.	.Original to CSO/DDD service case record. .1 copy to client. .1 copy to client representative, if appropriate. .1 copy to case manager, if different than CSO authorizing service worker.

12.	DSHS 14-192D	Case Management Service Plan	(Replaces item IXD in DSHS 14-192.) CSO/DDD/ Aging Network worker enters the client's specific problem and unmet needs which will be addressed in service plan development or service plan revision.	.Original to CSO/DDD service case record. .1 copy to client. .1 copy to client representative if appropriate. .1 copy to case manager, if different than CSO authorizing service worker. .1 copy to the agency contractor, the AFH, or the CCF. .1 copy to the care provider of the section related to the type and frequency of the tasks the individual contractor will be authorized to provide.

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13.	DSHS 14-225(X)	Community Options Program Entry System Eligibility and Benefit Computation	CSO/DDD Aging Network worker completes to compute service plan costs, document program eligibility determination, and obtain the client's signature.	.Original to CSO/DDD service case record. .1 copy to client. .1 copy to client representative, if appropriate. .1 copy to case manager, if different than CSO authorizing service worker.
14.	DSHS 14-240(X)	COPES Personal Care Provider Procedures Part I	CSO/DDD/Aging Network worker uses to obtain and dispense contract information in conjunction with DSHS 9-636 and DSHS 14-240A	.Original to Office of Contracts Management. .1 copy to provider. .1 copy to CSO/DDD service case record. .1 copy to case manager, if different than the CSO authorizing case worker. .Individual personal care provider.
15.	DSHS 14-240A(X)	COPES Personal Care Procedures Part II	CSO/DDD/Aging Network worker provides form to explain individual care provider paper work, documents and records in conjunction with DSHS 9-636 and DSHS 14-240.	.Individual personal care provider.

16.	DSHS 14-248(X)	COPES/CAP Program Notification	FST completes to notify the applicant/recipient of COPES eligibility and participation amount.	.Original to client. .1 copy to authorizing service worker for file. .1 copy to financial case record.
17.	DSHS 15-51(X)	Individual Provider Service Verification Worksheet	Individual provider enters services provided daily and uses information for completing service invoice accurately; retains for personal records.	Provider and client retain forms for review by CSO/DDD/Aging Network workers. Forms may be submitted regularly in special situations (provide prepaid addressed envelope).