AX CA ESSENTIAL RECORDS

DIVISION: (Required Field)	Program and Policy
DOCUMENT TYPE: (Required Field)	Manual
MEDIA:	**Select Media**
TOPIC: (Required Field)	Manual Revision
DOCUMENT TITLE:	Manual G Chapter: 46
DOCUMENT DATE/RANGE: (Required Field)	
DAN NUMBER:	**Select DAN Number**
RESTRICTED OR LITIGATION HOLD:	**Select Restricted or Litigation Hold**
NOTES:	

DO NOT MAKE PHOTO COPIES OF THIS!
(Always print copies directly from this electronic document)

00000005000

06/06/2017

CHAPTER 46 - PLACEMENT SERVICES

46.10 Definition

46.14 Eligibility

46.20 Goals

46.24 Preventing or Remedying Neglect, Abuse or Exploitation

46.28 Preventing or Reducing Inappropriate Institutional Care

46.32 Securing Referral of Admission for Institutional Care

46.36 Family Homes for Adults

46.38 Congregate Care Facilities

CHAPTER 46 - PLACEMENT SERVICES
1700 - Program Code rom SSRS

46.10 DEFINITION (WAC 388-15-140)

These are those services necessary to select the appropriate community or institutional placement to meet the particular needs and desires of eligible individuals, including placement in Family Homes for Adults, CCFs, ICFs and SNFs and periodically reviewing the placement for appropriateness. Close cooperation with the Department's Nursing Care Consultants is essential to be certain that individuals with medical problems are placed, or replaced in settings where their medical needs are most appropriately and adequately met.

Resource development is also an inevitable part of this service, since appropriate placements in family homes, congregate care facilities, or ICFs cannot be made if no such resources exist in the community or adjacent communities. Hence, recruiting, studying and licensing or approving Family Homes for Adults is an integral part of placement services, as well as encouraging the development of CCFs and ICFs. (See Chapter 38.18)

46.14 ELIGIBILITY

1. Individuals eligible for placement services are those who are receiving SSI plus state supplementation or recipients of Medicaid and other individuals whose monthly gross income does not exceed 80% of the state median gross income for a family of four, adjusted for family size. (See Chapter 10.08.)

2. In some instances recipients of Aid to Families with Dependent Children or individuals whose needs are taken into account in determining the needs of AFDC recipients may be eligible for placement in ICFs or SNFs.

46.20 GOALS

Placement Services may be provided to meet the following goals; however, only one goal may be pursued at any one time. Goals may be changed at any appropriate time, and the goal change reflected in a revision of the DSHS 14-140(X) Primary Recipient Form. It also may be necessary to revise the DSHS 14-141(X) Social Service Record to change or add services provided. (See Chapter 99)

46.24 PREVENTING OR REMEDYING NEGLECT, ABUSE OR EXPLOITATION

That is, removing an individual who has been neglected, abused or exploited or who has been living in a setting dangerous to his health and welfare, from his damaging environment and placing him in a Family Home for Adults, CCF, ICF or SNF as is most appropriate to his needs and desires.

1. Activities to accomplish this service may consist of any of the following:

   a. Determining with client & relatives the best form of alternate care.

   b. Providing information regarding nursing homes, ICFs, or CCFs.

   c. Taking clients on preplacement visits to family homes for adults.

   d. Establishing ability to take care of basic health needs.

   e. Establishing client's desire for placement (referral may be initiated by second party).

   f. Establishing reasons for inability to continue in present living situation.

   g. Identifying client preferences and dislikes.

   h. Observing sponsor/client interactions.

   i. Arranging transportation.

   j. Making placements in nursing homes, ICFs, CCFs, or family homes for adults.

   k. Making follow-up visits after placement to evaluate continuing adjustments.

   l. Conferring with family home sponsors, SNF, ICF and CCF staff regarding client needs.

   m. Conferring with NCC as necessary on initial placement and during the course of service activity.

   n. Conferring with staff from mental hospitals or schools for the retarded concerning the needs of individuals returning to the community.

   o. Mediating conflicts between client and sponsor.

   p. Providing necessary services to client to enhance success of placement and eventual move to independent living situation.

46.28 PREVENTING OR REDUCING INAPPROPRIATE INSTITUTIONAL CARE

The timely placement of an individual no longer able to live alone, in a Family Home for Adults, or CCF so that institutional placement in an ICF, SNF, or other institution may be avoided or deferred as long as possible.

1. Activities to accomplish this service may consist of any of the following:

   a. Determining with client and relatives the best form of alternate care.

   b. Providing information regarding family homes for adults or CCFs in the community.

   c. Taking clients on preplacement visits to family homes for adults.

   d. Establishing ability to take care of basic health needs.

   e. Establishing client's desire for placement (referral may be initiated by second party).

   f. Establishing reasons for inability to continue in present living situation.

   g. Identifying client preferences and dislikes.

   h. Observing sponsor/client interactions.

   i. Arranging transportation.

   j. Making appropriate placements.

   k. Making follow-up visits after placement to evaluate continuing adjustments.

   l. Mediating conflicts between client and sponsor.

   m. Providing necessary services to client to enhance success of placement and eventual move to independent living situation.

   n. Conferring with family home sponsors and CCF staff regarding client needs.

   o. Conferring with NCC as necessary on initial placement and during the course of service activity.

46.32 SECURING REFERRAL OR ADMISSION FOR INSTITUTIONAL CARE

That is, placing individuals in ICFs, SNFs or arranging for their admission to other institutions when no other placement is available or suitable.

1. Activities to accomplish this service may consist of any of the following:

   a. Providing information regarding skilled nursing facilities, ICFs or other institutions.

   b. Establishing reasons for inability to continue in present living situation.

c. Making placements in SNFs or ICFs.

d. Making home visits or other field visits as necessary to fulfill service plans.

e. Conferring with NCC as necessary on initial placement and during the course of service activity.

f. Conferring with staff from mental hospitals or schools for the retarded concerning the needs of individuals returning to the community.

46.36 FAMILY HOMES FOR ADULTS

For procedures concerning recruiting, studying, licensing, approving and ongoing supervision of Family Homes for Adults, see Chapter 38.18 and following.

46.38 CONGREGATE CARE FACILITIES

For procedures concerning the Congregate Care Facilities Program, securing and renewing the CCF Agreement, ongoing supervision of the home and residents, as well as other details, see Chapter 38.40 and following.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-235
ISSUED: 12/04/85

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

SECTIONS REVISED:
46.40, 46.41, 46.42
and 46.99 C and D

EFFECTIVE: 1/01/86
FOR INFORMATION CALL:
Bonner Gordon
SCAN 234-4921 or
Non-SCAN 753-4921

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

SUBJECT: ADULT FAMILY HOME, CONGREGATE CARE FACILITY - REGULAR AND COPES AFH/CCF CONTRACT ADMINISTRATION CHANGES

Place this notice in front of the Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-235 was entered.

Remove Green Notice Nos. G-202, G-205, G-212, and G-220.

BACKGROUND

In order to implement the proposals to revise BAAS programs and comply with decisions regarding the development of a simplified nonmedical residential care program, the following AFH/CCF contract administration changes are initiated.

A. Effective January 1, 1986, Adult Family Home, Congregate Care Facility - Regular and COPES AFH/CCF Contract Administration will be centralized in the Bureau of Aging and Adult services and the Office of Contracts Management.

B. BAAS and Office of Contracts Management have developed a new simplified contract to be used for both AFHs and CCFs as well as accommodating COPES AFH/CCF services. This new contract will be implemented January 1, 1986, and will rely primarily upon minimum AFH and CCF licensing requirements to ensure quality of care standards.

C. Clients will continue to be assessed by department staff to determine the appropriate level of residential care required and, as in the past, placement of DSHS clients will not take place without prior department authorization.

SS Manual - 1789
David v.

ACTION REQUIRED

A. Delete 46.40, 46.41, 46.42, and 46.99 C and D.

B. Effective January 1, 1986, CSOs shall no longer be responsible for AFH/CCF - Regular and COPES AFH/CCF contract negotiation.

C. Effective January 1, 1986, CSOs shall discontinue their AFH/CCF - Regular and COPES AFH/CCF contract monitoring activities. Contract monitoring will occur at headquarters by exception and Operations Review audit.

D. Effective January 1, 1986, new AFH/CCF - Regular and/or COPES AFH/CCF providers desiring to contract with the department shall be referred to the Bureau of Aging and Adult Services for subsequent contract negotiation. The Office of Contracts Management will provide information copies of all ratified contracts to the appropriate regional office.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-237
ISSUED: 12/06/85

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

SECTIONS REVISED:
46.16 A. 2.
Notice No. G-206

EFFECTIVE: 01/01/86
FOR INFORMATION CALL:
William Peckham
SCAN 234-4429 or
Non-SCAN 753-4429

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

SUBJECT: CHANGE IN PAYMENT RATES CONGREGATE CARE FACILITIES - MENTAL HEALTH AND ADULT RESIDENTIAL TREATMENT FACILITIES

Place this notice in front of the Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-237 was entered.

A. Congregate Care Facilities - Mental Health (CCF-MH)

1. Effective January 1, 1986, the rate for large CCF-MH's (more than 15 licensed beds) is increased 2.5 percent to $20.19 per day.

2. Effective January 1, 1986, the rate for small CCF-MH's (15 licensed beds or less) is increased 4.5 percent to $23.59 per day.

B. Adult Residential Treatment Facilities (ARTF)

This changes only those rates listed in Notice No. G-206. All other parts of that notice remain in effect.

1. Effective January 1, 1986, the rate for ARTF-Intensive is increased 3 percent to $46.35 per day.

2. Effective January 1, 1986, the rate for ARTF-Transitional is increased 3 percent to $30.90 per day.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-238
ISSUED: 12/23/85

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

SECTIONS REVISED:
46.16 B., 46.17

EFFECTIVE: 01/01/86
FOR INFORMATION CALL:
Dorothy Jeffries,
SCAN 234-1249 or
Non-SCAN 753-1249

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

SUBJECT: AFH/CCF VENDOR RATE INCREASES
SSA/SSI INCREASES
CPI INCREASE
WAIVERS TO SPONSOR TRAINING

Place this notice in front of the Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-238 was entered.

BACKGROUND

As of January 1, 1986, AFH/CCF vendor rates will be adjusted to include the 3% inflationary increase granted by the legislature; SSI/SSA benefits will increase 3.1%; and the CPI standard will be raised from $33.55 to $36.62 per month.

CCF rates effective January 1, 1986:

CCF regular.....$17.30 per day
CCF COPES.....$22.66 per day

The AFH basic rate will include a respite allowance.

SSPS will terminate AFH Respite (Service Code 4616) effective 12/31/85. In addition, they will increase the AFH/CCF rates, and in cases where SSI amounts are $327.75 (Area I) or $307.30 (Area II), they will adjust for the CPI allowance increase and accommodate the SSI income change. It will not be necessary for the CSO to make the changes on DSHS 14-159.

AFH/CCF contracts have been promulgated reflecting rate changes.

A copy of the 3.1% SSI/SSA changes is attached for your information.

As an interim measure, waivers to AFH sponsor training may be granted at the CSO level. Complete instructions will be included in the revision of Chapter 46 now in process.

ACTION REQUIRED

A. Adult Family Homes

1. Amend 46.16 B. as follows:

a. The basic rate is $377.11. It includes a respite allowance.

b. Service payment rates for activities of daily living are:

(1) One through three services for $37.68
(2) Four through seven services for $56.50
(3) Eight through twelve services for $81.61

c. Service payment rates for health-related services are $25.11 per month for each service authorized, up to a maximum of nine services.

d. AFH-COPES $20.98 per day. (SSPS cannot automatically update AFH-COPES service payment.)

e. Add 46.16 B. 4. as follows:

Waivers to the training requirements in 46.16 B. 2. and 46.16 B. 3. may be granted by the CSO administrator upon evidence and documentation that the sponsor is qualified to provide the services without further training.

2. Amend 46.17 A. as follows:

The Clothing and Personal Incidental (CPI) allowance is $36.62.

Attachment

	Standard	Federal SSI Benefit	State Supplement
Area I			
Living Alone Individuals	$364.00	$336.00	$ 28.00
Couples Both eligible	526.00	504.00	22.00
With essential person	526.00	504.00	22.00
With ineligible spouse	526.00	336.00	190.10
Area II			
Living Alone Individuals	343.55	$336.00	$ 7.55
Couples Both eligible	504.00	504.00	--
With essential person	504.00	504.00	--
With ineligible spouse	496.15	336.00	160.15
Area I/II			
Shared living Individuals	229.81	224.00	5.81
Couples Both eligible	342.30	336.00	6.30
With essential person	342.30	336.00	6.30
With ineligible spouse	342.00	224.00	118.37

These standards will be effective January 1, 1986.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

COMMUNITY SERVICES DIVISION
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO. G-223
Issued: June 24, 1985

FROM: Bruce Ferguson, Assistant Secretary
Community Services OB-44

SECTIONS REVISED:
46.15, 46.31, 46.33

EFFECTIVE: 8/1/85
FOR INFORMATION CALL:
Gary Johnson
Non-SCAN 753-0663 or
SCAN 234-0660

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

SUBJECT: CLIENT ASSESSMENT FORMS FOR ADULT MENTAL HEALTH RESIDENTIAL PROGRAMS-DSHS 14-192(E)

Place this notice in front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No G-223 was entered.

BACKGROUND

The Mental Health Division's residential programs for mentally ill adults consists of three levels of care. These include congregate care (CCF-MH), intensive care and rehabilitation, and transitional care. Procedures for determining client eligibility and authorizing payment for these programs are described in Chapter 46 (46.15(2), 46.31, and 46.33) and in Green Notice No. G-206.

Client need for the three types of residential programs shall be based on an assessment of client's: a) Prior treatment and placement history; and b) Current level of functioning. The attached Mental Health Residential Guidelines specify the need criteria for the respective programs. The attached assessment form, Mental Health Supplement (DSHS 14-192(E)), and accompanying instructions detail the information necessary to decide whether a client meets these criteria.

The Mental Health Supplement (DSHS 14-192(E)), has been developed after six months of field testing. The new form and instructions (see Manual G, Chapter 99) supersede all forms and instructions used in the field test.

ACTION REQUIRED

1. Effective August 1, 1985, complete the Mental Health Supplement (DSHS 14-192(E)) in conjunction with the Comprehensive Adult Assessment (DSHS 14-192) for all clients referred to adult mental health residential programs.

2. Compare the client data obtained in the assessment to the "Mental Health Residential Guidelines" to decide the most appropriate type of placement.

3. Forward one copy (pink) to the Adult Residential Program Administrator, Mental Health Division, OB-42F.

4. See the DSHS 14-192(E) form and instructions in Chapter 99.

5. Direct requests for training on the Mental Health Supplement to the Mental Health Division.

MENTAL HEALTH RESIDENTIAL PLACEMENT GUIDELINES

RESIDENTIAL PLACEMENT	TREATMENT AND PLACEMENT HISTORY		BEHAVIOR MANAGEMENT PROBLEMS		SELF-CARE/ PRACTICAL LIVING SKILLS		COMMUNICATION SOCIAL FUNCTIONING
Inappropriate for Community Mental Health Residential Programs	Meets one of the following: - Primary diagnosis of mental retardation, alcoholism, drug abuse or personality disorder. - Severe organic etiology. - Multiple physical problems. - Physical or mental deterioration.	OR	1.0 to 1.5	OR	1.0 to 1.5	OR	1.0 to 1.5
Intensive Care and Rehabilitation	Meets two of the following: - Unable to maintain self in community. - Resistant to community MH treatment efforts. - Unable to reintegrate into community living.	OR	2.0 to 5.5	OR	2.0 to 3.5	OR	2.0 to 3.5
Transitional Care	Meets two of the following: - Able to maintain self in community. - Cooperative with community MH treatment efforts. - Potential for reintegrating into community living.	AND	6.5 to 8.0	AND	4.0 to 6.5	OR	4.0 to 5.0
Congregate Care	Must meet the following: - History of failure in independent living.	AND	5.5 to 8.0	AND	3.0 to 6.5	AND	2.0 to 8.0

SS Manual - 1798
David v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

COMMUNITY SERVICES DIVISION
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-208
Issued: October 31, 1984

FROM: Bruce Ferguson, Assistant Secretary
Community Services MS OB-44

SECTIONS REVISED:
46.47

EFFECTIVE: Upon Receipt
FOR INFORMATION CALL:
Bureau of Aging and
Adult Services
Non-SCAN 753-2502 or
SCAN 234-2502

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

SUBJECT: CHANGE NURSING HOME INCOME EXEMPTION TO MEDICAL INSTITUTION INCOME EXEMPTION

Place this notice in front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-208 was entered.

BACKGROUND

Nursing home income exemption provides up to $180 a month allowance for DSHS-funded clients entering a nursing home for a short time (not to exceed six months) to assist in retaining their own home. In order to more fully comply with Title XIX intent, i.e., WAC 388-95-360(4)(d), eligibility for income exemption will apply to clients residing in medical institutions, which include hospitals and nursing homes. (Title XIX certified medical institutions are defined by WAC 388-95-300.)

ACTION REQUIRED

1. Change 46.47 title to read "Medical Institution Income Exemption."

2. Change all 46.47 references to "nursing home(s)" to read "medical institution(s)."

3. Preface 46.47 H. 3. with the words "When client is a resident of a nursing home . . . ."

4. All other program criteria and specifications remain unchanged.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

COMMUNITY SERVICES DIVISION
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-206
Issued: October 23, 1984

FROM: Bruce Ferguson, Assistant Secretary
Community Services MS OB-44

SECTIONS REVISED:
N/A

EFFECTIVE: 11/01/84
FOR INFORMATION CALL:
Non-SCAN 753-2502 or
SCAN 234-2502

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

SUBJECT: RESIDENTIAL REHABILITATION PROGRAMS FOR MENTALLY ILL ADULTS

Place this notice in front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-206 was entered. This notice supersedes and cancels Green Notice No. G-189. Remove Green Notice No. 189 and note on the Green Notice Control Sheet the date Notice No. 189 was removed.

BACKGROUND

The Mental Health Division has established two new levels of residential care for mentally ill adults. These programs include: a) intensive care and rehabilitation, and b) transitional care. The new programs have been created by converting approximately 230 existing CCF-MH beds. Together with the current mental health congregate care program, the programs will provide a range of residential options for mentally ill clients with varying levels of need for training, supervision, and mental health treatment.

Intensive care and rehabilitation programs will provide long-term, facility-based mental health treatment and rehabilitation services for those individuals whose psychiatric symptoms, functional levels, or maladaptive behaviors make them inappropriate for other community residential settings. The transitional care program will offer a residential milieu which maximizes the opportunities to gain self-sufficiency for clients showing potential for more independent living. Transitional care services will include independent living skills training and appropriate vocational or prevocational experiences.

SS Manual - 1799
David v.

Some administrative and procedural changes will be necessary to accommodate the new mental health residential programs. The purpose of this notice is to specify the procedures to be used for these programs. The Community Mental Health Services Act (RCW 71.24) gives the counties the option of administering the new residential program. Most counties will exercise this option and will contract directly with providers for the intensive care and transitional care beds. However, the CSO will retain responsibility for determining financial eligibility and client participation, preplacement screening and assessment, and authorization of services.

ELIGIBILITY

The CSO shall establish financial and service eligibility for clients referred for intensive care and transitional care programs. Service eligibility should reflect the following criteria.

A. Intensive Care and Rehabilitation

A facility providing intensive care and rehabilitation program is licensed as an adult residential treatment facility (WAC 248-25) and has entered into a contract with the department or county to provide such services.

1. Persons eligible for intensive care and rehabilitation must:

   a. Meet the definitions for chronically mentally ill (WAC 275-56-015(5)), seriously disturbed (WAC 275-56-015)(34)), or acutely mentally ill (WAC 275-56-015(1)). Clients may be either voluntary or on less restrictive placement or conditional release under civil (RCW 71.05) or criminal (RCW 10.77) commitment.

   b. Be adults eighteen years of age or over.

   c. Be recipients of supplemental security income (SSI) or state general assistance (GA-U).

   d. Possess at least a minimal capacity to respond to treatment and/or skills development.

   e. Exhibit sufficient psychiatric symptoms, maladaptive behaviors, or severe dysfunction in personal care, social or communication skills to preclude placement in less intensive community residential settings.

   f. Unable to participate in, or benefit from, traditional mental health outpatient or day treatment programs.

2. Persons shall be excluded from the intensive care and rehabilitation program on the basis of:

   a. Having a primary diagnosis of mental retardation, alcoholism, substance abuse or personality disorder.

   b. Presenting an imminent risk of danger to others.

   c. Requiring medical or nursing care available only in a hospital or nursing home.

3. Placement in intensive care and rehabilitation programs should be based on the following priorities:

   a. Individuals who are currently residing in a state hospital or an evaluation and treatment facility and no longer require that level of care.

   b. Individuals who have had two or more psychiatric hospitalizations in the past two years.

   c. Individuals who have failed in a less intensive community program in the past year (as reflected by rehospitalizations, termination from treatment, etc.).

B. Transitional Care

A facility providing transitional care is licensed as a boarding home (WAC 248-16) and has entered into a contract with the department or county to provide such services.

1. Persons eligible for transitional care must:

   a. Meet the definitions for chronically mentally ill (WAC 275-56-015(5)) or severely disturbed (WAC 275-56-015(34)). Clients may be either voluntary or on less restrictive placement or conditional release under civil (RCW 71.05) or criminal (RCW 10.77) commitment.

   b. Be adults eighteen years or over.

   c. Be recipients of Supplement Security Income (SSI) or state assistance (GA-U).

   d. Require 24-hour supervision, but exhibit minimal symptom interference and demonstrate a readiness to participate in skills development and vocational or prevocational training.

e. Have potential for placement in more independent living settings within one year.

2. Persons shall be excluded from transitional care programs on the basis of:

   a. Having a primary diagnosis of mental retardation, alcoholism, substance abuse, or personality disorder.

   b. Presenting an imminent risk of danger to self, others, or property.

   c. Requiring medical or nursing care which exceeds that allowable under boarding home licensure.

3. Priority for placement in transitional care programs will be given to individuals who:

   a. Are currently residing in a state hospital or an evaluation and treatment facility and no longer require that level of care.

   b. Are currently residing in a nursing home, intensive care and rehabilitation facility, mental health congregate care program, or would otherwise be admitted to such facility if a transitional program were not available.

   c. Have demonstrated an inability to integrate successfully into community life, or remain in a less structured setting, e.g. adult family home or semi-independent living.

DETERMINATION OF NEED

The CSO shall designate one or more community nurses or service workers to perform assessments for all mentally ill clients referred for residential care. The designated community nurse or service worker will complete the Comprehensive Adult Assessment (DSHS 14-192(X)), as well as the mental health supplemental form. Representatives from the referring agency and the contracted mental health agency or provider serving the area in which the client will be placed should participate in the assessment process. The client information will be used in conjunction with the Mental Health Division's prescribed placement guidelines to recommend an appropriate level of residential care.

Placement of a given client in a specific facility also requires the concurrence of the residential provider and the client. Client placements should reflect the recommended level of residential care. Exceptions to the recommended level must be documented. In the event that a bed at the recommended level is not available, placements may be made in a CCF-MH facility or another residential program offering similar or less intensive levels of care.

If placement of a mental health client is made into a regular CCF bed, provision of appropriate services to meet the client's mental health needs must be arranged outside the CCF (WAC 388-15-562(1)(f)).

AUTHORIZATION OF SERVICES

The CSO will continue to authorize services, using DSHS 14-154/159s. In those counties electing to administer the residential programs, the appropriate county agency will be designated payee. The mental health coordinator of the counties administering the new residential programs shall receive a copy of all service authorizations. The residential provider will be required to inform the CSOs of any changes in resident status, e.g., transfers, discharges, rehospitalizations, etc., within 24 hours of such action, or on the first working day thereafter, using DSHS 15-31(X), Notice of Action Adult Residential Services.

The service codes reflect the types of residential programs - intensive care and rehabilitation (RTF) and transitional care (Trans) - and whether the prime contract is with county or the facility.

The appropriate service code from the list below should be used:

Service Code	Rate
4627 Mental Health RTF County	$45.00 day
4628 Mental Health RTF Facility	$45.00 day
4629 MHCCF Trans-County	$30.00 day
4630 MHCCF Trans-Facility	$30.00 day

Current policies and procedures governing participation in the cost of care for SSI and GA-U clients will continue to apply.

CONTRACT MONITORING

Negotiation of contracts and monitoring of contract performance for the intensive care and rehabilitation and transitional care programs will be the responsibility of those counties electing to administer the programs or Mental Health Division staff. CSOs will continue to monitor the CCF-MH contract performance of all facilities holding current contracts, including those offering intensive and transitional care programs. CSO staff will not be required to complete annual reviews of the continued need for residential care for those clients placed in intensive care or transitional care programs. Discharge readiness will be determined by the respective mental health and residential providers.

REDUCTION OF CCF-MH BEDS

The current number of CCF-MH beds will be reduced because of conversions to the new residential programs. The Mental Health Division will coordinate the effective date of these reductions to reflect the implementation schedule of the new programs. If necessary, CSOs should assist residential providers in relocating mentally ill clients identified as not qualifying for the enhanced residential programs.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO. G-196
Issued: June 25, 1984

FROM: Bruce Ferguson, Asst. Secretary
Community Services Division

FOR INFORMATION CALL:
Bureau of Aging and
Adult Services
753-2502 or SCAN 234-2502

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

SUBJECT: VOLUNTARY PRIVATE PAY NURSING HOME PRESCREENING

Place this notice in front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No G-196 was entered.

BACKGROUND

When a request for nursing home services is made by eligible department clients living at home or hospitalized from home, an assessment of the client's needs is done with the client and/or the client's family by a Community Nurse (CN), a CSO service worker, or Area Agency on Aging as appropriate. As a result of this assessment, a plan of care is developed and discussed with the client. Upon receipt of this notice, identical assessment/plan of care development services will be offered to private pay individuals who voluntarily request such services.

Action Required

1. Add to 46.21, Program Expectations/Response Time

   M. Private pay individuals who voluntarily request nursing home preplacement screening shall be provided an in-person assessment of their need using the DSHS 14-192(X), Comprehensive Adult Assessment form (see 46.31), and will have a plan of care developed (see 46.32).

2. It shall be the responsibility of the regions/CSOs to inform Area Agencies on Aging, Hospitals, Nursing Homes, and other community agencies within their service areas that voluntary private pay nursing home prescreening is now available.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-181
ISSUED: February 10, 1984

FROM: Judith M. Merchant, Director
Division of Income Assistance

Charles Reed, Director
Bureau of Aging and Adult Services

FOR INFORMATION CALL:
(206) 753-7137
SCAN 234-7137

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

SUBJECT: CHANGE IN PAYMENT SYSTEM FOR CONGREGATE CARE FACILITIES (CCFs)

Place this notice in front of Chapter 46, Manual G and note on Green Notice Control Sheet the date Notice No. G-181 was entered.

Effective with the conversion of congregate care facility (CCF) payments from the Medical Maintenance Information System (MMIS) to the Social Service Payment System (SSPS), the following changes in social service and financial responsibilities will occur:

Social Services

1. Social services will compute client participation in the cost of care for CCFs. (Follow instructions in Manual G, Chapter 46.18 and Green Notices G-165 and G-173.)

2. Social services will complete the Service Authorization (DSHS 14-154(X)) or Change of Service Authorization (DSHS 14-159(X)) to authorize the CCF vendor payment. This form will replace the Authorization and Computation of Grant (DSHS 7-01(X)) as the document generating the CCF vendor payment.

3. Social services will send a copy of the DSHS 14-154(X)/159(X) to financial services, to the client and to the vendor to indicate the amount of any participation the client must make to the vendor. This form will replace the Notice to Recipient in Congregate Care Facility (DSHS 15-83(X)) as the award letter.

4. Social services will review changes of circumstance and update the amount of participation in the cost of care and/or complete the DSHS 14-159(X) as indicated.

THE FOLLOWING IS INFORMATIONAL ONLY:

Financial Services

1. Financial services will no longer compute participation for CCF vendor payments.

2. Financial services will continue to complete the DSHS 7-01(X) upon receipt of authorization from social services in the following cases:

   a. To authorize medical coupons for SSI beneficiaries in CCFs. (Code the DSHS 7-01 as if the client is living in their own home.);

   b. To authorize the CPI payment and medical coupons for GAU recipients in CCFs. (Continue to use shelter code 5 and the applicable additional requirements code to identify these individuals.); and

   c. To authorize medical assistance for non-grant Categorically Needy and Medically Needy individuals in CCFs using procedures in Manual F, Chapters 30 and 31.

3. Financial services will no longer complete the DSHS 15-83(X) to notify the client and vendor of any participation. This form is being replaced by the DSHS 14-154(X)/159(X) as the award letter and authorization for CCF ayment.

4. Financial services will continue to complete an award letter to notify the client of eligibility for a GAU financial grant and/or medical coverage.

These changes will be incorporated in a forthcoming revision to Manual G and Manual F.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-173
ISSUED: December 28, 1983

FROM: Bruce Ferguson, Assistant Secretary
Community Services

FOR INFORMATION CALL:
Bureau of Aging and Adult
Services at (206) 753-2502
or SCAN 234-2502 M.S. OB-43G

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

SUBJECT: SSI/SSA BENEFIT LEVEL INCREASES JANUARY 1, 1984
CONGREGATE CARE/ADULT FAMILY HOME CLIENT PARTICIPATION

Place this notice in front of Chapter 46, Manual G and note on Green Notice Control Sheet the date Notice No. G-173 was entered.

BACKGROUND

Effective January 1, 1984, client participation for SSI recipients residing in Adult Family Homes and Congregate Care Facilities will increase. This notice is meant to supplement, not supersede or revise, Manual G 46.18, Client Participation in Cost of Care (CCF/AFH).

ACTION REQUIRED

A. Effective January 1, 1984, persons receiving Supplemental Security Income (SSI) will receive an SSI benefit increase. SSI individual recipient benefits including state supplementation will increase to $352.30 in Area I and to $331.85 in Area II. For persons residing in congregate care facilities (CCFs) or adult family homes (AFHs) who receive SSI, the DSHS 14-159 service code 4612 or 7215 must be updated to reflect the increased participation.

B. Effective January 1, 1984, persons receiving Social Security will receive a Social Security benefit increase. If the Social Security recipient is not receiving SSI, the client's participation should be increased by the new Social Security amount. DSHS 14-159 Service Code 4612 or 7215 must be updated to reflect the increased participation.

C. A copy of the DSHS 14-159 must be sent to the client, the vendor, and financial services. Service code 4612 or 7215, CCF/AFH client participation must appear on the same DSHS 14-159 as the CCF/AFH rate authorization.

D. After 1/1/84, SSI recipients always participate $317.80 in Area I and/or $297.35 in Area II. If an SSI recipient has an SSI overpayment, the worker must request SSI to waive repayment. If SSI refuses, an Exception to Policy (ETP) may be requested to reduce participation by the amount of repayment on the SSI overpayment. Participation may not be reduced until the ETP is approved.

E. Persons not receiving SSI or a GAU cash grant participate the amount of their income less $54.50. There is no participation required for clients residing in an intensive inpatient alcohol treatment facility. A review of client participation entries in the SSPS data base indicates that a significant number are incorrect. Therefore, these income amounts shown on the DSHS 14-159 must be manually updated and cannot be corrected by a computer recertification. OIS is sending a computerized special notice to CCF clients; BAAS is sending the attached special notice to AFH clients.

F. $20 Income Exclusion

The $20 income exclusion is allowed for some clients and not for others based on federal regulations. Medicaid regulations (WAC 388-92-025(6)(G)) and SSI rules stipulate that the first $20 of earned and unearned income is exempt only if that income is not based on need. Therefore, recipients of SSI only and cash recipients of GAU only and VA Pensions do not receive the $20 income exclusion while persons with earned income, social benefits, veterans' retirement, etc., do receive the $20 income exclusion.

PROCEDURES

The following provides additional information to be used in calculating client participation amounts for clients who are residing in CCFs or adult family homes. The information is outlined in six sections: definitions; SSI recipient participation; non-SSI recipient participation; client participation payments to the facility; review of client participation; and, participation calculation for clients entering/terminating from a facility.

A. DEFINITIONS

1. "Client Participation" means the amount of money the client is required to pay toward the cost of residential services purchased on their behalf by the Department of Social and Health Services. Client participation is deducted from the total amount to be paid by the department to the facility. Whenever the amount of participation is greater than the cost of services used and claimed, the client is responsible for the total cost of the service.

2. "SSI benefit" means the Supplemental Security Income benefit payment for aged, blind, or disabled clients as determined according to 20 CFR 416, Subpart D.

3. "Income" means the receipt by an individual of cash or in-kind that can be used to meet the individual's needs for food, clothing, or shelter. 20 CFR 416.1103 provides definitions of things not considered as income.

4. "Earned Income" means income received as wages or as net earnings from self-employment. 20 CFR 416.1110 defines "wages" and "net earnings" from self-employment.

5. "Unearned income" means income that is not earned income, including: annuities, pensions and other periodic payments such as social security benefits, disability benefits, veterans benefits, and unemployment insurance benefits; alimony and support payments; dividends, interest, and royalties; rents; proceeds of life insurance policy; prizes and awards; gifts and inheritances; and support and maintenance in-kind. 20 CFR 416.1121 defines types of unearned income.

6. "GA-U" means the state funded, continuing General Assistance program which provides financial and medical assistance to an individual who is: unemployable due to an incapacitating condition which will last at least sixty days from the date of application; meets the financial eligibility criteria as specified in Manual F, Chapter 29.10; and, not eligible for a federal assistance program. Chapter 388-37 WAC and Manual F, Chapter 29 define GA-U eligibility and program provisions.

7. "CPI" means the state standard allowance for clothing and personal incidentals.

8. "Disposable income" is the amount available to the clients after earned and unearned income dividends are calculated and participation is applied.

B. SSI RECIPIENT PARTICIPATION - CONGREGATE CARE AND ADULT FAMILY HOMES

1. An SSI recipient is an individual receiving an SSI benefit payment. An SSI recipient may also be receiving other earned or unearned income.

2. Client participation for an SSI recipient shall be the SSI area standard less the state CPI allowance.

   a. Effective January 1, 1984, resident participation for SSI recipients is:

	Area I	Area II
SSI Area Standard	$352.30	$331.85
Less CPI Allowance	- 34.50	- 34.50
Client Participation	$317.80	$297.35

Although the client participation amount is the same for all SSI recipients in a given area, the amount of disposable income for personal use varies according to the clients' earned or unearned income exemptions.

The Social Security Administration employs a retrospective monthly accounting method wherein recipient's income from two months back is used to determine the SSI amount. For example, in September the Social Security Administration would use July's income to compute the recipient's October SSI payment.

a. For example, an SSI recipient receiving $200.00 per month in Social Security benefits would have $54.50 in disposable income. The amount is determined by SSI as follows:

SSI Computation:	
SSA Payment	$200.00
Less Income Exclusion	- 20.00
Nonexempt Income	$180.00
SSI Area I Standard	$352.30
Less Nonexempt Income	- 180.00
SSI Payment	$172.30
CSO Computation:	
SSA Payment	$200.00
SSI Payment	+ 172.30
Total Income	$372.30
Less Client Participation	- 317.80
Disposable Income	$ 54.50

b. For example, an SSI recipient earning $200.00 per month would have $177.00 in disposable income. The amount is determined by SSI as follows:

SSI Computation:	
Earned Income	$200.00
Less Income Exclusion	- 20.00
	$180.00
Less Earned Income Deduction	- 65.00
of $65.00 plus one-half	$115.00
the remaining balance	x .50
Nonexempt Income	$ 57.50
SSI Area I Standard	$352.30
Less Nonexempt SSI Income	- 57.50
SSI Payment	$294.80
CSO Computation:	
Earned Income	$200.00
SSI Payment	294.80
Total Income	$494.80
Less Client Participation	- 317.80
Disposable Income	$177.00

c. For example, an SSI recipient earning $100.00 per month and receiving $100.00 per month in social security benefits would have $137.00 in disposable income. The amount is determined by SSI as follows:

SSI Computation:	
SSA Payment	$100.00
Less SSI Income Exclusion	- 20.00
Nonexempt Income	$ 80.00
Earned Income	$100.00
Less Earned Income Deduction	- 65.00
of $65.00 plus one-half the	$ 35.00
remaining balance	x .50
Nonexempt Income	$ 17.50
SSI Area I Standard	$352.30
Less Total Nonexempt Income	- 97.50
SSI Payment	$254.80

CSO Computation:	
SSA Payment	$100.00
Earned Income	100.00
SSI Payment	$254.80
Total Income	$454.80
Less Client Participation	- 317.80
Disposable Income	$137.00

C. NON-SSI RECIPIENT PARTICIPATION

1. Client participation standards for non-SSI recipients are based upon SSI income eligibility standards specified in 20 CFR 416, Subpart K, and DSHS Manual G, Chapter 46.18.

2. Participation is based on income actually available or "in hand" at the first of the month.

3. For determination of client participation, non-SSI recipients are classified as an individual receiving:

   (1) Only unearned income (other than SSI)
   (2) Only earned income;
   (3) Both unearned (other than SSI) and earned income;
   (4) GA-U (see note below); or
   (5) No income.

NOTE: GAU RECIPIENTS IN CCFs DO NOT PARTICIPATE IN THE COST OF CARE. The payment standard for GAU in a CCF is the CPI amount. Any earned or unearned income received is considered totally nonexempt and is deducted dollar for dollar from the CPI amount.

If the income exceeds the CPI amount, the individual is not eligible for GAU. If the income does not exceed the CPI amount, the client is eligible for GAU and a financial grant is issued for the difference between the income and the CPI amount. The balance of the cost of care is paid directly to the vendor.

4. Client participation for a non-SSI recipient, who is receiving only unearned income, shall be their total unearned income received for the month, less:

   (1) $20.00 income exclusion; and
   (2) State CPI allowance.

   The exclusion and CPI allowance are applied in the order listed.

   For instructions on how to consider the unearned income of a GAU client in a CCF, see section C. 3. above.

   a. For example, an individual receiving $400.00 per month in social security benefits would be required to pay $345.50 towards their cost of residential program care. The participation amount is determined as follows:

Unearned income	$400.00
Less income exclusion	- 20.00
	380.00
Less CPI allowance	- 34.50
Resident participation	$345.50

5. Client participation for a non-SSI recipient, who is receiving only earned income, shall be their total earned income for the month, less:

   (1) $20.00 income exclusion;
   (2) Earned income deduction of $65.00 plus one-half of the remaining earned income for the month; and
   (3) State CPI allowance.

   The exclusion, income deduction, and CPI allowance are applied in the order listed.

   For instructions on how to consider earned income of a GAU client in a CCF, see section C. 3. above.

   a. For example, an individual receiving $400.00 per month in earned income would be required to pay $123.00 towards their cost of residential program. The participation amount is determined as follows:

Earned income	$400.00
Less income exclusion	- 20.00
	380.00
Less earned income deduction	- 65.00
of $65.00 plus one-half	315.00
of the remaining balance	x .5
	157.50
Less CPI allowance	- 34.50
Resident participation	123.00

6. Client participation for a non-SSI recipient, who is receiving both earned and unearned income, shall be their total earned income and unearned income for the month less:

   (1) $20.00 income exclusion. The income exclusion should first be applied against unearned income. Any portion of the $20.00 exclusion which has not been excluded from unearned income should be next applied against earned income;

   (2) An earned income deduction of $65.00 plus one-half of the remaining earned income; and

   (3) The CPI allowance.

   The income exclusion, earned income deduction, and CPI allowance should be applied in the order listed.

   For instructions on how to consider earned and unearned income of a GAU client in a CCF, see section C. 3. above.

   a. For example, an individual receiving $200.00 per month earned income and $200.00 per month unearned income would be required to pay $213.00 towards their cost of residential program. The participation amount is determined as follows:

Unearned income	$200.00	
Less income exclusion	- 20.00	
Nonexempt unearned income	$180.00	
Earned income	$200.00	
Less earned income deduction	- 65.00	
of $65.00 plus one-half of	135.00	
the remaining balance	x .5	
Nonexempt earned income	$ 67.50	
Total nonexempt income	$247.50	($180.00 + $67.50)
Less CPI allowance	- 34.50	
Resident participation	$213.00	

   b. For example, an individual receiving $10.00 per month unearned income and $390.00 per month earned income would be required to pay $123.00 towards their cost of residential program care. The participation amount is determined as follows:

Unearned income	$ 10.00
Less income exclusion	- 20.00
Remaining income exclusion	- 10.00
Earned income	390.00
Less remaining income exclusion	- 10.00
	380.00
Less earned income deduction of	- 65.00
$65.00 plus one-half of the	315.00
remaining balance	x .5
	$157.50
Total non-exempt income	$157.50
Less CPI allowance	- 34.50
Resident participation	$123.00

7. GAU recipients in AFHs participate the amount of their earned and/or unearned income up to the board and room standard, less the CPI amount. If their income exceeds the board and room standard less CPI, they are not eligible for GAU. If their income does not exceed the board and room standard and less CPI, then they participate the amount of their income less the CPI amount. The balance of the cost of care is paid by the department directly to the vendor.

8. Client participation for a non-SSI recipient, who has no earned or unearned income, is zero amount. The client should be referred to their service worker for GAU eligibility determination. A CPI allowance can be authorized under the GA-U Program.

D. CLIENT PARTICIPATION PAYMENTS TO THE FACILITY

Although the department reimburses providers for services at the end of each service month, providers shall obtain client participation payments payments at the beginning of each month.

E. REVIEW OF CLIENT PARTICIPATION

1. Client participation shall be reviewed and redetermined as necessary using the same review cycle as the Department requires for social service eligibility. The review cycle is as follows:

   a. When the service worker receives information on a change in a client's income;

   b. At six-month intervals for non-SSI recipients who have earned income;

   c. At twelve-month intervals for SSI recipients and for non-SSI recipients who do not have earned income;

d. When the service worker is notified of a change in SSI, Social Security benefits, CPI allowance, or other income benefit levels.

2. Clients, guardians, representative payees, and the vendor are responsible for notifying the Department when there is a change in a client's prior month income.

The residential provider should notify a client's service worker by the tenth of the month when an income change has occurred. The service worker shall notify the client of the participation determination via a revised social service authorization.

Pursuant to WAC 388-15-030(6), clients receiving an increase in their participation amount will also be notified of their right to request a fair hearing regarding the participation determination. The client notification must be made at least ten days prior to the effective date of the new participation amount. The notification of a fair hearing option can be made in the "Special Instructions" section of the client's social service authorization form.

F. PARTICIPATION CALCULATION FOR CLIENTS ENTERING/TERMINATING FROM A FACILITY

For persons entering/terminating from a CCF/AFH, see Manual G 46.18 F, G, and H.

Attachment

PARTICIPATION IN COST OF CARE -- CCF/AFH CLIENTS	
SOURCE OF INCOME	PARTICIPATION AMOUNT
SSI Only	SSI Standard less $34.50
SSI with other Income not based on need	SSI Standard less $34.50
GA-U Cash Grant	AFH Client - GA-U Board and Room Standard CCF Client - No participation because GA-U check only includes $34.50 CPI amount
Railroad Retirement, Social Security Income	Income amount less $54.50 If person has earned income, allow addition earned income disregards
Other Income based on need such as Veteran's Pension	Income amount less $34.50

PERSONS ELIGIBLE FOR $20 INCOME EXCLUSION	
Recipient	Comment
SSI Recipients with other income not based on need, such as Social Security	SSI computes the income exemption participation as the SSI Standard, less $34.50
Persons with income not based on need - Railroad retirees, Social Security beneficiaries, etc.	CSO/DDD computes the income exclusion. Participation is the non-exempt income amount less $54.50

PERSONS NOT ELIGIBLE FOR $20 INCOME EXCLUSION
Persons receiving SSI who have no other income
Persons Receiving a GA-U Cash Grant

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-169
ISSUED: October 6, 1983

FROM: Bruce Ferguson, Assistant Secretary
Community Services

FOR INFORMATION CALL:
Bureau of Aging and Adult
Services at (206) 753-2502
or SCAN 234-2502 M.S. OB-43G

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

SUBJECT: 1. AFH RATE INCREASE
2. AFH RESPITE CARE

Place this notice in front of Chapter 46, Manual G and note on Green Notice Control Sheet the date Notice G-169 was entered.

BACKGROUND

The 1983-85 biennial budget contains funding to increase the basic rate for adult family home care and to add a respite care allowance equal to one day of client care per month. The respite care allowance is authorized through SSPS.

There is a need to establish clear procedures to waive the training requirements for AFH sponsors who are qualified by education and/or experience to provide some or all of the activities of daily living and health-related services.

ACTION REQUIRED

1. Revise 46.16 B 1 as follows:

   1. The basic adult family home rate is $344.22 per month (SSPS Service Code 4611).

2. Add items e and f to 46.16 B 2 to read as follows:

   e. Waivers of training requirements may be granted by the Director of the Bureau of Aging and Adult Services when it can be documented that the sponsor is qualified by education and/or experience to provide the service.

   f. Copies of all waivers granted shall be given to the sponsor.

3. Add item 4 to 46.16 B to read as follows:

4. The respite care allowance is $11.32 per month.

   a. The respite care allowance is not prorated. The sponsor having a client in care on the first day of a calendar month receives the allowance for that month. In the event client participation exceeds the cost of care for a partial month's service the respite allowance will still be paid by the department.

   b. The SSPS code for the respite care allowance is 4616.

   c. The respite care code is opened effective the first of the month following placement unless the client was placed effective the first of a calendar month. The respite care code is closed the date a client leaves a home.

   d. To assure timely payment of the correct adult family home rates and respite care all adult family home service authorizations should be reviewed, the basic rate increased and the respite allowance authorized as soon as possible retroactive to October 1, 1983.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-165
ISSUED: September 1983

FROM: Bruce Ferguson, Assistant Secretary
Community Services

FOR INFORMATION CALL:
Bureau of Aging and Adult
Services at (206) 753-2502
or SCAN 234-2502 M.S. OB-43G

IF NOT DELIVERABLE RETURN TO: MANUAL PRODUCTION UNIT MS OB-45

SUBJECT: 1. CCF COPES ADD-ON RATE FOR SOME COPES RECIPIENTS
2. GAU RECIPIENTS IN CCF/AFH

Place this notice in front of Chapter 46, Manual G and note on Green Notice Control Sheet the date Notice G-165 was entered.

BACKGROUND

Congregate Care Add-On Rate for Some COPES Recipients

In order for Congregate Care to be a viable option for COPES recipients who require hands-on help with activities of daily living and health-related services, a COPES - CCF add-on rate has been approved. Only COPES clients assessed by the Department as requiring these additional services are eligible for the add-on. Only facilities who have contracted to provide this service are eligible to care for these clients.

GAU Recipients in Adult Family Homes

Revision 70 of Manual G incorrectly indicates that GAU recipients in Adult Family Homes receive GAU grants in the same amount as do recipients in Congregate Care Facilities. This notice revises Manual G 46.18B to be consistent with Manual F 14.25. Changes in participation required by this interpretation are not retroactive. GAU recipients shall be immediately referred for SSI determination.

ACTION REQUIRED

COPES CCF Add-on

SS Manual - 1820
David v.

1. Revise 46.19 C.1.a. as follows:

   a. For COPES recipients assessed as requiring hands-on help with one or more activities of daily living and up to three health-related services, authorize an add-on rate of $3.50 per day if the CCF agrees to a contract amendment to provide such service.

b. For COPES recipients assessed as requiring hands-on help with one or more activities of daily living and four health-related services, authorize an add-on rate of $4.28 per day if the CCF agrees to a contract amendment to provide such service.

c. For COPES recipients assessed as requiring hands-on help with one or more activities of daily living and five health-related services, authorize an add-on rate of $5.05 per day if the CCF agrees to a contract amendment to provide such service.

2. Delete the 46.19 C.1.a. item which allows medication administration add-on of $23.67 per month since medication administration will be paid for as outlined in items a, b, or c above.

3. Add items a through c above as 46.16 A.6.

4. 46.19 C 1 b - Add the following:

   Because CCF rates are vendor unique, the add-on amounts described in a. above will be supplied to the SSPS Provider file by the CCF program manager (BAAS) upon receipt of the CCF contract amendment for a given facility.

GAU Recipients in Adult Family Homes

1. Revise 46.18 B as follows:

   GAU recipients in adult family homes pay to the adult family home sponsor the amount of the GAU board and room standard ($212.35). They retain the CPI amount of $34.50. GAU recipients in congregate care receive only the CPI amount from GAU. They therefore have no funds to pay to the CCF toward cost of care.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-158
ISSUED: June 29, 1983

FROM: Bruce Ferguson, Assistant Secretary
Community Services

FOR INFORMATION CALL:
Bonner Gordon, SCAN 234-4921
or Non-SCAN 753-4921

IF NOT DELIVERABLE RETURN TO: WP/MANUAL SECTION MS OB-45

SUBJECT: CHANGE IN PAYMENT RATES: ADULT FAMILY HOMES AND REGULAR CONGREGATE CARE FACILITIES

Place this notice in front of Chapter 46, Manual G, and note on the Green Notice Control Sheet the date Notice No. G-158 was entered.

A. REGULAR CONGREGATE CARE FACILITIES

1. Effective July 1, 1983, the congregate care regular rate is increased 2.5 percent to $16.31 per day.

2. For facilities of 15 or fewer licensed beds which had CCF contracts as of December 31, 1981, the rate is $19.09 per day. Any new contracts or revisions in contracted beds will be at $16.31 per day.

B. ADULT FAMILY HOMES

Effective July 1, 1983, a 2.5 percent adult family home rate increase will be implemented as follows:

1. Basic Rate	$329.22/mo.
2. Activities of Daily Living Services	
1-3 services	$35.51/mo.
4-7 services	53.25/mo.
8-12 services	76.92/mo.
3. Health Related Services - each service	$23.67 mo.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO. G-230
Issued: 09/13/85

FROM: Bruce Ferguson, Asst. Secretary
Community Services Division

SECTION REVISED:
46.19 C. 4. b.

EFFECTIVE: Immediately
FOR INFORMATION CALL:
Bureau of Aging and
Adult Services
SCAN 234-2502 or
Non-SCAN 753-2502

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

SUBJECT: REVIEW OF COPES SERVICE PLANS AND TERMINATION OF COPES PAYMENT AUTHORIZATION FOR SPOUSE AND NONQUALIFYING RELATIVE PROVIDERS

Place this notice in front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-230 was entered.

BACKGROUND

The COPES Request for Medicaid Waiver submitted to, and approved by, the Health Care Financing/Administration (HCFA) stated:

> "Services to be furnished include . . .COPES Personal Care Services provided by chore service vendors which contract with the department, by family member (other than the spouse), or by individual providers. Family members will only be paid if they otherwise would qualify for assistance."

An amendment to remove the restriction on authorizing COPES payments to spouses providing personal care services was not approved by HCFA. HCFA denied the amendment since, "It is likely in many cases such services are now being provided free of cost and it is also likely the spouse is sharing the same residence as the recipient of waiver services. . . We do not believe it would be cost effective to provide for payment of spousal services in your waiver program."

On December 27, 1984, the Bureau of Aging and Adult Services issued MB-BAAS-RO-85-01 and MB-BAAS-AAA-85-01 requiring that ". . .no new authorizations of spouses are approved and submitted for payment." The restrictions on payment of relatives was included in the Management Bulletin.

ACTION REQUIRED

A. Spouse Provider

Terminate all Service Authorizations for COPES payments to the spouse of COPES clients for provision of personal care services. The termination shall be effective on or before October 31, 1985.

B. Relative Provider

Terminate all Service Authorizations for COPES payments to the non-qualifying father, mother, son, or daughter of COPES clients for provision of personal care services. The terminations shall be effective on or before October 31, 1985 unless:

1. There are extenuating circumstances; or

2. The relative will not provide the care unpaid, and

3. The relative's income, including spousal income, is less than the Medically Needy Income Level (MNIL) adjusted for family size.

PROCEDURES

A. Case Record Review

1. Review the SSPS output document, "CSO Client Listing by Service."

2. Pull the service records of COPES recipients with service code 4656, "COPES Per Care - Indiv."

3. Locate the COPES Personal Care Procedures, Part 1, DSHS 14-240, in the service record. Review Section 8 for the provider's statement of his or her relationship to the person for whom he or she is providing personal care services.

4. Take no action if the contracted and authorized personal care provider is not the spouse, father, mother, son, or daughter of the COPES client.

5. Notify the Aging Network case manager of the proposed action if the authorizing CSO service worker is not the COPES case manager.

B. Payment Authorization Termination

1. Spouse Provider

When the spouse is the authorized COPES personal care provider, the authorizing service worker shall:

a. Send a notice of intent to terminate COPES payment to the client and/or his or her representative (Attachment A).

b. Code the COPES Service Authorization, DSHS 14-159, to terminate the payment to the spouse effective on or before October 31, 1985.

c. Append the following notation in the Special Instruction Section:

"A spouse may no longer be authorized to receive COPES payment for providing personal care services. The COPES payment authorization is terminated effective (enter date)."

2. Relative Provider

a. When the father, mother, son, or daughter is the authorized COPES personal care provider, the authorizing service worker shall review the service plan for extenuating circumstances which indicate there will be harmful effects if the established care plan is disrupted. When, in the judgment of the service worker, there will be harmful effects:

(1) Submit a request for exception to the CSO Administrator and:

(a) Describe the traumatic and potentially harmful effects on the recipient which will likely result from the disruption; and/or

(b) Explain the reasons there are no appropriate or available alternative individual or agency COPES provider to provide services to the recipient.

(2) File approved exception requests in the CSO service record. Take no action to evaluate the relative provider's circumstances when the exception request is approved.

b. When the father, mother, son, or daughter is the authorized service worker and there are no extenuating circumstances, the authorizing service worker shall:

(1) Send a notice of intent to terminate the COPES payment to a nonqualifying relative provider to the client and/or to his or her representative (Attachment B).

(2) Specify the information required to determine if the relative qualifies as a COPES relative provider (Attachment C).

(3) Evaluate the relative provider's declaration of his or her circumstances to determine if he or she qualifies under the restrictions.

(a) Find the MNIL for household size in the table below. Subtract the relative provider's gross monthly income from the MNIL. If the remainder is zero or a minus figure, the relative does not qualify to be paid as COPES care provider.

(b) If the relative will provide the care without payment, the relative does not qualify to be paid as a COPES care provider.

Medically Needy Income Level (MNIL)

Family Size	MNIL Standard (effective 1/1/85)
1	364
2	517
3	544
4	561
5	646
6	731
7	847
8	936
9	1,028
10	1,117

(4) Take no further action if the relative provider qualifies for COPES payment.

(5) When the relative care provider does not return the required information or does not qualify to be paid for COPES personal care services, the authorizing CSO service worker shall:

(a) Code the COPES Service Authorization, DSHS 14-159, to terminate the payment to the relative provider effective on or before October 31, 1985.

(b) Append the following notation in the Special Instruction section:

> (Enter relative provider's name) does not qualify for payment as related COPES care provider. The authorization for COPES personal care service payment is terminated effective (enter date)."

(c) Send a copy of the 14-159 and the Declaration of Circumstances to the Aging Network case manager if the authorizing CSO service worker is not the COPES case manager.

C. Payment Termination Follow-Up and Service Plan Review

For clients having spouse or relative provider payment terminated, at the earliest opportunity, the COPES case manager shall:

1. Discuss termination of payment to the spouse or relative provider with the client and/or his/her representative.

2. Review the service plan to determine the services the client requires which may be provided only by an immediate family member or a licensed health professional.

3. Explore possible alternative COPES individual or contracted agency care providers.

4. Develop a plan of care with the client and/or his or her representative which will ensure the client's health and safety.

5. Consider a referral to the CSO chore service worker for an eligibility determination, with the spouse as the provider, when there is no appropriate or available alternative individual or contracted agency COPES provider to provide the required services.

6. Consider a referral to the CSO for residential placement if the informal support system in conjunction with available COPES services is not sufficient to provide adequate safeguards for the client's health and safety in his or her own home.

Attachments: (The attachments are not numbered forms and may not be ordered.)

Attachment A - Suggested format for Notice of Intent to Terminate COPES Payment to Spouse Provider

Attachment B - Suggested format for Notice of Intent to Terminate COPES Payment to Nonqualifying Relative Provider

Attachment C - Suggested format for Relative Provider Declaration of Circumstances

SUGGESTED FORMAT FOR NOTICE OF INTENT TO TERMINATE
COPES PAYMENT TO SPOUSE PROVIDER

SUGGESTED FORMAT FOR NOTICE OF INTENT TO TERMINATE COPES PAYMENT TO SPOUSE PROVIDER

ATTACHMENT A

_____ Date_____

_____

_____ Case Number_____

Dear_____:

As you know the COPES program offers an array of services, including personal care in a person's own home. These services are offered under Medicaid to persons who would otherwise require care in a skilled nursing facility or an intermediate nursing facility.

In the past you have received these COPES personal care services from your spouse who was authorized to receive payment for providing the services.

We regret to inform you that this payment to your spouse will discontinue. This action is taken to conform with federal regulations. It has been determined that the payment of a spouse is not an approved waivered service in the COPES program.

Effective Oct. 31, 1985 a spouse will no longer be authorized to receive COPES payment for providing personal care services.

The COPES service plan will be reviewed with you. The availability and appropriateness of alternate COPES individual or agency personal care providers will be explored with you to determine a plan to safeguard your health and safety.

Sincerely,

_____
(Case Manager)

Telephone:_____

cc: CSO Service Record

SS Manual - 1830
David v.

SUGGESTED FORMAT FOR NOTICE OF INTENT TO TERMINATE
COPES PAYMENT TO NONQUALIFYING RELATIVE PROVIDER

SUGGESTED FORMAT FOR NOTICE OF INTENT TO TERMINATE COPES PAYMENT TO NONQUALIFYING RELATIVE PROVIDER

ATTACHMENT B

_____ Date_____

_____

_____ Case Number_____

Dear_____:

As you know, the COPES program offers an array of services, including personal care in a person's own home. These services are offered under Medicaid to persons who would otherwise require care in a skilled nursing facility, in an intermediate nursing facility or an intermediate nursing facility for the mentally retarded.

In the past you have received these COPES services from a member of your immediate family who was authorized to receive payment for providing the services.

We regret to inform you this payment to the family member providing your COPES personal care will discontinue on Oct. 31, 1985 **unless:**

1. The relative will not provide the care unpaid and
2. The relative's income, including spousal income, is less than the Medically Needy Income Level adjusted for family size.

Please request your related COPES care provider to complete the enclosed Declaration of Circumstances and return it in the enclosed stamped and addressed envelope before August 15. If not returned before August 15, 1985 your relative cannot qualify to continue as your COPES care provider.

The completed Declaration of Circumstances will be used to determine if your relative qualifies to continue as your personal care provider. If your relative qualifies, no further action will be taken and he or she may continue as your paid COPES provider.

If the relative does not qualify under the restrictions above, you and the relative provider will be notified. The COPES service plan will be reviewed with you. The availability and appropriateness of alternative COPES individual or agency personal care providers will be explored with you to determine a plan to safeguard your health and safety.

Sincerely,

_____
(Case Manager)

Telephone:_____

cc: CSO Service Record

SUGGESTED FORMAT FOR RELATIVE PROVIDER DECLARATION OF CIRCUMSTANCES (send with a stamped and self-addressed envelope)

ATTACHMENT C

Declaration of Circumstances

Note: This form is to be completed by the father, mother, son or daughter of an eligible COPES client when the relative wishes to be paid as the client's COPES personal care provider. Return this form promptly in the enclosed self-addressed stamped envelope.

My name is _____
(relative/provider)

My relationship to _____
(client name)

is **father** **mother** **son** **daughter**
(circle one)

I am willing to provide personal care services to my relative without being paid.

yes **no**
(circle one)

My earned and unearned gross income, including my spouse's earned and unearned income, is

$_____ per month.
(enter total amount)

The name(s) of my spouse and my children residing in my household is/are:

1. _____ (spouse)

2. _____ (child) _____ (age)

3. _____ (child) _____ (age)

4. _____ (child) _____ (age)

5. _____ (child) _____ (age)

I hereby certify under penalty of perjury that the statement above is true, correct and complete to the best of my knowledge. I understand the information reported on this declaration shall be used only for the purpose of determining whether I qualify as a relative/provider of COPES personal care.

Signature of relative/provider _____

Date _____

Office Use Only

Authorization of the relative/provider above is in compliance with Washington Administrative Code 388-15-630(4).

yes **no**
(circle one)

cc: CSO Service Record

SS Manual - 1833
David V.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-232
ISSUED: 09/16/85

FROM: Bruce Ferguson, Asst. Secretary
Community Services MS OB-44

SECTIONS REVISED:
46.30 A.

EFFECTIVE: 10/01/85
FOR INFORMATION CALL:
Bureau of Aging and
Adult Services
Non-SCAN 753-2502 or
SCAN 234-2502

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

SUBJECT: DELETE CONGREGATE CARE - REGULAR PROGRAM REGIONAL LIDS

Place this notice in the front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-232 was entered.

BACKGROUND

The Department of Social and Health Services has experienced over the past several years CCF-regular program expenditures within budget allocations. There are a number of reasons why this has occurred, including internal department program management and policy decisions, as well as external market forces.

The department has, therefore, decided to lift the contractual CCF-regular program "bed lids" adopted in 1981 as a cost containment measure and will now contract with individual CCF vendors, not to exceed boarding home licensed capacity. This change will provide for greater program flexibility and should serve to ease any disproportionate CCF bed availability. Clients will continue to be assessed by department staff to determine the appropriate level of residential care required and, as in the past, placement of DSHS clients will not take place without prior department authorization.

ACTION REQUIRED

1. Delete 46.39 A.

2. The number of CCF-regular contracted beds and COPES CCF beds are no longer allocated to the regions by the Bureau of Aging and Adult Services.

3. The Bureau of Aging and Adult Services will prepare and promulgate directly to CCF-regular providers appropriate contract amendments that will modify the existing CCF-regular contracts to allow for the removal of contractual bed limitations -- not to exceed boarding home licensed capacity.

SS Manual - 1835
David v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-249
Issued: 07/01/86

FROM: Thelma Struck, Asst. Secretary
Community Services MS OB-44J

SECTIONS REVISED:
46.46 B., 46.46 E.,
46.46 F.

EFFECTIVE: Immediately
FOR INFORMATION CALL:
Dorothy Wilke
SCAN 234-0993
Non-SCAN 753-0993

IF NOT DELIVERABLE RETURN TO: DSHS STOCKROOM MB FB-11

SUBJECT: NURSING HOME DISCHARGE ALLOWANCE

Insert this notice in front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-249 was entered.

BACKGROUND

WAC 388-15-145 was amended effective 5/31/86. The changes are:

1. To clarify that persons are eligible who have an existing residence which cannot be re-established without monetary assistance.

2. The maximum discharge allowance is changed to $400 for all clients. The sliding scale for determining discharge allowance amounts based on the client's cash resources under $600 is deleted.

ACTION REQUIRED

1. Revise section 46.46 B.1. to read:

   "Clients are eligible who:

   a. Have no existing independent residence, OR

   b. Have an existing residence which cannot be re-established without monetary assistance."

2. Add to section 46.46 E.:

   "Costs up to $400 may be authorized."

3. Delete section 46.46 F.

SS Manual - 1837
David v.

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

MANUAL G: CHAPTER 46

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

DEPAR

Olympia, Washington

TO: HOLDERS OF MANUAL G

NOTICE NO.: G-251
Issued: 08/05/86

FROM: Thelma Struck, Asst. Secretary
Community Services MS OB-44J

SECTIONS REVISED:
46.46

EFFECTIVE: 09/01/86
FOR INFORMATION CALL:
Bureau of Aging and Adult Services
SCAN 234-2502 or
Non-SCAN 753-2502

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

SUBJECT: NURSING HOME DISCHARGE ALLOWANCE PAYMENT CHANGE

Insert this notice in front of Manual G, Chapter 46, and note on the Green Notice Control Sheet the date Notice No. G-251 was entered. Insert the new Green Notice Control Sheets containing Green Notice numbers G-251 through G-450 after the Green Notice Control Sheets already in Manual G. Do not remove the Green Notice Control Sheets already there.

BACKGROUND

Nursing Home Discharge Allowances have been paid through the A-19 process. The A-19 Invoice Voucher process requires several weeks to issue payment. This change will allow discharge allowance payment to be made through SSPS. This will reduce paperwork and the time it takes for a check to be issued. Changes in SSPS code 4642 will be issued at the same time.

ACTION REQUIRED

1. Delete from 46.46 G. 5. the first sentence of the paragraph: "Route copy to clerk for completion of A-19."

2. Delete 46.46 H. in its entirety.

3. Change 46.46 I. to 46.46 H.

4. SSPS will reissue Service Code 4642 Nursing Home Discharge Allowance to make the payment type a one-time payment. See SSPS Basic Instructions section 20.15 for a description of one-time payments.

SS Manual - 1838
David v.

CHAPTER 46
RESIDENTIAL SERVICES FOR ADULTS

Table of Contents

PAGE

46.00 PROGRAM AUTHORITY 3

46.10 POLICY 3

46.11 Purpose of Service 3
46.12 Service Description 3
46.13 General Policies Related to this Service 4
46.14 Priorities Related to this Service 5
46.15 Eligibility 6
46.16 Payment Rates 17
46.17 Clothing and Personal Incidentals (CPI) 18
46.18 Client Participation in Cost of Care (CCF/AFH) 18
46.19 Community Options Program Entry System (COPES) 20

46.20 PROGRAM STANDARDS 27

46.21 Program Expectations/Response Time 27
46.22 Appropriate Program/Service Outcomes 27

46.30 SERVICE PROCEDURES 28

46.31 Determination of Client Need - Residential Care 28
46.32 Plan of Care Development 28
46.33 Service Authorization 31
46.34 Discharge/Relocation Services 31
46.35 Transfer/Relocation - AFH/CCF 32
46.36 Transfer/Relocation - NH 32
46.37 Individuals Refusing Discharge or Relocation from NH/CCF/AFH 36
46.38 Annual Reassessment of Client Need for CCF/AFH 37
46.39 Congregate Care Regional Lids 37
46.40 CCF Contract Negotiation 38
46.41 AFH Contract Negotiation 40
46.42 Contract Monitoring CCF/AFH 41
46.43 AFH Licensure 42
46.44 Selection of Facility 43
46.45 Placement Outside Catchment Area 43
46.46 Nursing Home Discharge Allowance 43
46.47 Nursing Home Income Exemption 46
46.48 Social Leave and Medical Leave 49
46.49 Community Nurse 51
46.51 Case Recording 52
46.52 Alcoholism Referrals 52
46.53 Drug Abuse Referrals 52
46.54 Title XIX Facility Inspection of Care 53

SS Manual - 1839
David v.

TABLE OF CONTENTS (cont.)

Page

46.55 DSHS 14-154/159, Authorization for New Nursing Home Clients 54
46.56 Referrals from State Mental Hospitals 55
46.57 Special Placement Services for Hard-To-Place Mentally Ill Clients 56

46.97 INTERFACE WITH OTHER DSHS SERVICES 56

46.98 INTERFACE WITH NON-DSHS SERVICES 57

46.99 REQUIRED FORMS AND INSTRUCTIONS 58

SS Manual - 1840
David v.

CHAPTER 46
RESIDENTIAL SERVICES FOR ADULTS

46.00 PROGRAM AUTHORITY

Federal: 45 CFR 228

State: RCW 74.08.043; 74.08.044; 74.08.045; 74.15; WAC 248-16-001 through 248-16-999; 388-15-010; 388-15-020; 388-15-140; 388-15-145; 388-15-551 through 388-15-555; 388-15-560 through 388-15-568; 388-29-125; 388-29-130; 388-29-280; 388-34-010 through 388-34-384; 388-37-060; 388-83-140; 388-88-001 through 388-88-117.

46.10 POLICY

46.11 Purpose of Service

The purpose of residential services is to provide safe residential care living situations for adults 18 years of age and older for whom an in-home service plan cannot be developed.

46.12 Service Description

Residential services for eligible adults include those activities necessary to:

A. Assess need for residential services (except alcohol and drug treatment) of individuals living at home or in the hospital (having been admitted from home) who are requesting residential care;

B. Develop a plan of care to meet the assessed needs;

C. Authorize or refer for in-home support services for those who can be maintained at home;

D. Authorize residential care (SNF/ICF/CCF/AFH) for those who cannot be maintained at home;

E. Provide relocation services to individuals who must move to another facility because of termination of the residential care provider's contract, decertification or closure of the facility, revocation of the provider's license or emergency license suspension, or because they are dangerous to self or others;

F. Provide relocation services to persons who require a different level of care;

G. Provide discharge planning services to those who no longer require residential care;

SS Manual - 1841
David v.

H. Reassess at least annually the CCF/AFH client's continuing need for care;

I. Negotiate and renegotiate CCF-Regular/MH, and AFH contracts;

J. Monitor provider compliance with CCF-Regular, CCF-Regular/MH, CCF-MH and AFH contracts terms, conditions and Statement of Work; and

K. Provide licensure of adult family homes.

46.13 General Policies Related to this Service

A. In providing residential services, the department authorizes the least restrictive and most normal living arrangement which meets an adult client's total physical, medical and social needs when an arrangement other than the client's home is necessary.

B. All requests for placement in NHs, CCFs, or AFH for persons who are at home or hospitalized from their home and the disposition of such requests are the responsibility of the Community Services Office (CSO) or Division of Developmental Disabilities (DDD) Field Service Office in whose area the client is physically present, even though the client is requesting placement in another county or is an active recipient in another county. (See 46.31A.)

C. The client shall receive an in-person comprehensive assessment of his/her strengths and unmet needs to ensure that he/she receives care in the least restrictive setting.

D. The client has a right to be involved in the process of deciding the most appropriate array of services for which he/she is eligible that will meet his/her needs. The client has a responsibility to provide information on his/her needs and resources in order for the department to make an informed decision about services. The client's family and significant others may provide information when the client is unable to do so. Clients unable to participate in the decision regarding placement may have care authorized, if eligible, after the doctor, relative, or person acting in his/her behalf has negotiated the admission.

E. Service plans are to be designed to maximize the independence of the client while minimizing the cost to the public sector.

F. Informal sources of care provided by family, friends, and volunteer organizations are to be encouraged and supported. Maximum use of existing family and community resources and imaginative and innovative utilization of other services shall be encouraged.

G. When a client shows a persistent inability to manage his/her funds to meet basic needs and obligations or is incompetent or not fully competent (under certain circumstances), a protective payee or limited guardianship may be established. (See Chapter 44.34 and 44.35.)

H. No residential treatment facility which provides nursing or other care may detain a person within such a facility against their will. A guardian may not authorize such detention. Detention is defined as: to arrest, check, delay, hinder, hold, or keep in custody, restrain, keep from proceeding, stay or stop.

I. All NH placements of a child under age 18, require the prior written approval of the Director of the Bureau of Nursing Home Affairs.

J. When CSO staff find instances of vendors or sponsors soliciting or accepting payment for residential care in excess of the departmental standard, the SO program manager is to be promptly notified in writing via Regional Office.

K. All assessment of need of a DDD client for AFH, CCF, ICF, NH, NH discharge allowance and NH income exemption and the authorization of such services are the responsibility of DDD Field Services staff. The DDD Field Services staff works in full cooperation with the financial staff of the CSO to verify eligibility of the individual before placement and to notify the CSO financial staff in writing of any change of circumstances which could affect payment.

It is of utmost importance that the line of communication among DDD Field Services, BNHA and the CSO be kept open and timely in order to avoid problems, delays and/or any lack of information which could affect client services. DDD Field Services staff will coordinate the placement and relocation of DDD clients in and out of non-IMR nursing homes as covered in the DDD/BNHA interagency agreement and WAC 388-88-105.

L. Maintenance payments for NH care will be authorized by CSO financial services. Effective date will be the placement authorization date for new admissions. Social service staff will authorize the supplemental vendor payment for AFH/CCF and the discharge allowance following procedures in 46.33 and 46.46.

M. Mental health clients referred for residential care are served by CSO staff following procedures described in this chapter.

46.14 Priorities Related to this Service

A. Recipients of Supplemental Security Income (SSI), General Assistance (GA), Medicaid or Medical Care Services will be served in the following priority:

1. Preplacement assessment and authorization for persons at home or in hospital having been admitted from home.

2. Relocation required by facility closure, decertification, involuntary termination or nonrenewal of contract or revocation or suspension of license.

3. Relocation required by client's need for a level of care which the facility is not certified/licensed to provide.

4. Discharge planning for persons no longer needing residential care.

5. Adult Family Home licensure.

6. Adult Family Home Contract Monitoring.

7. CCF contract monitoring.

8. Annual review of CCF/AFH clients need for care.

9. Inspection of Care Team participation.

B. Social Services Block Grant Clients

These clients are adults, with income at or below the 80 percent State Median Income Adjusted for Family Size (SMIAFS), needing assessment and/or counseling about their need for residential services and services to remain in the least restrictive setting, even though they are financially ineligible for SSI, GA, or Medicaid (Title XIX).

46.15 Eligibility

A. General social service eligibility is determined by CSO social service workers per Chapter 03. Eligibility for financial/maintenance payments are determined following WAC regulations as described below.

B. Congregate care - A congregate care facility is a licensed boarding home or a licensed private establishment which has entered into a congregate care contract with the department.

1. Persons are eligible to receive regular program congregate care who:

   a. Are adults eighteen years of age or over;

   b. Are recipients of supplemental security income and state supplementation, or are recipients of continuing general assistance;

   c. Are unable to maintain a safe environment in an independent living arrangement or require personal care and supervision, assistance with activities of daily living and/or health-related services;

   d. Do not require nursing care in excess of that described in RCW 18.20.160 and the provisions of WAC 248-16-228;

   e. Do not require developmental disabilities specialized services as described in WAC chapter 275-36 unless there is a plan of care developed to provide for these specialized services apart from regular CCF services provided by the congregate care facility;

f. Are not eligible for mental health CCF program as described in subsection 2. e. of this section unless there is a plan of care developed to provide for mental health specialized services apart from the regular congregate care services provided by the CCF facility; and,

g. Do not require alcoholism and/or drug treatment as described in subsection 3. of this section.

2. Persons are eligible to receive mental health congregate care who:

a. Are adults eighteen years of age or over;

b. Are recipients of supplemental security income and state supplementation, or are recipients of continuing general assistance;

c. Are unable to maintain a safe environment in an independent living arrangement or require personal care and supervision, assistance with activities of daily living and/or health-related services;

d. Do not require nursing care in excess of that described in RCW 18.20.160 and the provision of WAC 248-16-228;

e. Meet the following mental health client criteria:

(1) Have been discharged from a state psychiatric hospital or a local psychiatric inpatient facility within the past twelve months; or

(2) Be expected, as a result of a mental disorder, to continue to exhibit one or more of the following characteristics for an extended period:

(a) Inability to perform basic living skills without supervision,

(b) Inability to maintain or develop a personal support system,

(c) Have a combination of physical, cognitive, or emotional disabilities leading to serious behavioral problems; or

(3) In the opinion of a mental health specialist (as defined by WAC 275-25-710) psychiatric hospitalization is imminent unless placement in an extended care facility is secured;

f. Are actively involved in mental health treatment as defined in the client's individual treatment plan or on a waiting list to receive such treatment. A client shall be ineligible for the mental health rate after a sixty-day period of refusal of mental health treatment.

3. Persons are eligible to receive alcoholism and/or drug treatment congregate care who:

   a. Are adults eighteen years of age or over;

   b. Are recipients of supplemental security income and state supplementation, or are recipients of continuing general assistance;

   c. Are unable to maintain a safe environment in an independent living arrangement or require personal care and supervision, assistance with activities of daily living and/or health-related services;

   d. Do not require nursing care in excess of that allowed by boarding home or private establishment licensure;

   e. For drug treatment congregate care, are using a controlled substance once a week or more and are at least mildly dysfunctional due to drug use as defined by the Office of Drug Abuse Prevention. Clients recently released from jail or prison or a treatment program are eligible when judged by the drug treatment professional to be in imminent danger of recidivism without treatment;

   f. For alcoholism congregate care, manifest any physical and/or behavioral problem due to the use or abuse of alcohol as determined by staff of a state-approved alcohol treatment facility. Alcohol clients payment shall be terminated a maximum of 20 days from the date of entry into the CCF.

4. Placement is limited to facilities having available DSHS contracted beds.

5. Benefits of the congregate care program shall not be available to residents of other states who enter the state of Washington for the primary purpose of obtaining congregate care. However, when a person can no longer be considered a resident of another state and/or expresses his/her intention to remain permanently in Washington, his/her eligibility shall be determined as a resident of Washington (see WAC 388-26-055). If there is evidence that the person is maintaining a home in another state, see WAC 388-28-420(4) about sale of resource.

6. Determination of need.

   Using the Comprehensive Adult Assessment, DSHS 14-192(X) or 14-192A(X) as appropriate, the department, after consultation with the individual, shall determine if the individual requires congregate care. Consideration will be given to other alternative care arrangements.

7. Placement in facility.

   Selection of a congregate care facility is to be made by the individual, or his/her relatives or others acting on his/her behalf from those facilities having available contracted beds.

8. Payment standards.

   a. All nonexempt income of a person placed in a congregate care facility shall first be applied to the person's clothing, personal maintenance and necessary incidentals. Any remaining nonexempt income shall be applied to the cost of the congregate care. See Manual G 46.16 E.

   b. Payment is limited to the level of care approved by the department for the type of care authorized, i.e., regular, mental health or alcoholism and/or drug treatment. There is no specialized congregate care program rate for developmentally disabled persons.

   c. The department shall pay to the congregate care facility, for those services provided, a sum not to exceed the rates set forth in the most recent schedule of rates established and published by the department.

C. Adult Family Homes - An Adult Family Home (AFH) is a private home licensed to care for no more than four residents which has entered into a service delivery contract with the department.

1. Determination of need.

   The department, in consultation with the individual, shall assess if the individual requires adult family home care. Adult family home services include those necessary for activities of daily living, such as eating/dining, community mobility, etc., and health-related services such as diet and ambulation. Consideration will be given to other services available for the client including community services such as home health aide, etc., as well as other residential services available. DSHS 14-192(X), Comprehensive Adult Assessment, shall be used to assess initial need. DSHS 14-192A(X) shall be used annually to reassess AFH need.

2. Persons are eligible to receive adult family home care <u>placement</u> services who:

   a. Have income less than eighty percent State Median Income Adjusted for Family Size (SMIAFS);

   b. Require less than skilled nursing care. See WAC 388-88-081;

   c. Are unable to maintain a safe environment in an independent living arrangement, or require training, supervision or assistance with activities of daily living services and/or health-related services. Need for help with ADLS and/or health-related services must be documented on the DSHS 14-192 or DSHS 14-192A and updated at least annually.

d. Activities of daily living include:

(1) Communication - A training service will be provided when clients suffer from deafness, visual or speech impairment. It may also be necessary when communication skills are limited due to mental retardation and/or mental illness.

(2) Community Resources - A training, supervision or performing service will be provided when the client has not demonstrated the ability to: use protective agencies (such as the police and fire departments), public facilities (such as libraries and schools); discriminate between legal and illegal activities; exercise civil and legal rights including entering into appropriate contracts; or find and take part in leisure activities in and outside the adult family home.

(3) Eating/Dining - A performing service will be provided for those who require assistance in eating due to physical limitations. A training or supervision service will also be provided when the client has not demonstrated appropriate use of: eating utensils; condiments; public and private eating establishments; or acceptable manners in a normal community and residential environment.

(4) Clothing Care - Training, supervision or a performing service will be provided when the client has not demonstrated the ability or is unable to: dress; undress; select and maintain appropriate clothing and footwear; or use implements for sewing, washing and ironing personal clothing.

(5) Household Management - A training service will be provided for residents who have potential for increased self-sufficiency or semi-independent living. This may include training in normal household tasks such as dishwashing, cooking, marketing, personal room maintenance and household budgeting.

(6) Health Care - A training or supervisory service will be provided when the client does not recognize or understand proper diet and nutrition, weight control, oncoming illness and dental problems, self treatment of simple infections, use of birth control measures, prevention of communicable and venereal disease, or needs guidance in the use of prescription medications and "over the counter" remedies.

(7) Survival Skills - A training or supervisory service will be provided when the client lacks any of the following abilities to such a degree that a personal safety hazard is posed: evacuate a building in an emergency; use the telephone; communicate emergency situations to appropriate agencies or persons; discriminate between dangerous and

SS Manual - 1848
David v.

safe situations (i.e., strangers, dark alleys, etc.); take necessary precautions in the face of hazards (i.e., pedestrian and bicycle); or find route home (becomes disoriented or wanders away).

(8) Behavior Supervision - A supervisory or training service will be provided when the client has behaviors that are disruptive to others such as: uncooperativeness; failure to follow instructions; hypersensitivity; bossiness with peers; unauthorized use of the property of others; ruses to gain attention; or distractive traits such as rocking, continuous singing or mumbling.

(9) Social Skills - A training service will be provided when the client needs to: more appropriately relate to peers, sponsors and others in an adult family home; improve relationships outside the home, such as with prospective employers, community groups and relatives; participate in support groups to increase capacity for social and personal functioning; develop friendships and reduce social isolation; or learn to respect the privacy of others.

(10) Community Mobility (Including Transportation) - A training, supervisory or performing service will be provided when assistance is required in transportation or special orientation to insure client gets to place of employment, medical facilities, recreational facilities, church, educational facilities, etc. This will also include special training required in the use of public transportation.

(11) Personal Hygiene and Grooming - A training, supervisory or performing service will be provided when the client has not learned, or is unable to: care for toilet needs; blow nose; wash hands, use deodorant; clean fingernails; attend to menstrual cycle needs; wear clean clothing; bathe frequently; or care for hair.

(12) Money Management - A training, supervisory or performing service will be authorized when the client has requested assistance or has demonstrated lack of ability to handle money appropriately. The sponsor will maintain records on expenditures, receipt of funds and current balance for the client. The sponsor will assume responsibility for the client's budgeting and use of money, and the necessary training to assist client in becoming financially responsible.

e. Health-related services include:

(1) Incontinence/Bowel and Bladder Retraining - A health-related service may be authorized for occurrences of more than two daytime and/or nighttime wettings per week which

require additional care and supervision. Bowel and bladder retraining service may be provided when authorized by a health practitioner and performed by a person trained by the health practitioner.

(2) Ambulation - When there exists need to physically assist the client in personal mobility, transfer in and out of bed, chair, tub, shower, etc., a health-related service may be authorized.

(3) Diet - If a special diet is prescribed for the client by a physician, and the diet requires extra effort in preparation, additional payment may be authorized.

(4) Behavior - A health-related service may be authorized for overt, bizarre or extraordinary behavior traits that require continuous supervision (i.e., destructiveness, sexual acting out, theft, temper tantrums, hollering at cars, etc.). The payment is for the extra time and efforts required of the sponsor.

(5) Medication Management - The service is authorized for the sponsor's administration and supervision of all oral medications, including observation of side effects of the medication.

(6) Injections - This service is authorized for the sponsor's administration of all intra-muscular or subcutaneous injections, including observation of side effects.

(7) Colostomy/Catheter Care - In providing this service, the sponsor is expected to assist with equipment and supplies, supervision of procedures (i.e., irrigation/changing of bags), reinforcement of techniques and procedures relative to colostomy care, assistance and support to patient in acceptance of ostomy. Catheter care includes, but is not limited to, reinforcing good perineal care and supervision of that care if necessary.

(8) Sterile Dressings - Payment for this service requires the sponsor to supervise and assist with changing dressings and to use aseptic techniques.

(9) Range of Motion (R.O.M.) - This health-related service provided by a sponsor includes any exercise or therapy prescribed by physicial or registered physical therapist, in order to rehabilitate the patient. It includes supervision and assistance with exercises.

3. Persons are eligible to receive adult family home payment services whose:

   a. Nonexempt income exceeds the basic cost of care; but

   b. Is less than the cost of their individual plan of care as assessed by department staff.

   c. Cash or liquid resources do not exceed $1,500.00.

4. Placement in facility.

   Selection of an adult family home is to be made by the individual, his/her relatives or others acting on his/her behalf. DSHS 14-154/159(X), Social Services Authorization, is to be used to authorize AFH payment.

5. Payments--Standards.

   All nonexempt income of a person placed in an adult family home shall first be applied to the person's clothing, personal maintenance and necessary incidentals. Any remaining nonexempt income shall be applied to the cost of adult family home care. See Manual G 46.18.

   a. Nonexempt income is gross income less the first twenty dollars of any earned or unearned income (except GAU) plus the next sixty-five dollars of the earned income plus one-half the remainder of the earned income.

   b. Adult family home residents may also retain up to fifteen hundred dollars in cash or other liquid resources. Any resources in excess of this limitation are considered nonexempt income to be applied to cost of care and services. Also see WAC 388-29-280 and 388-92-045 for standards and resources.

D. Nursing Home Care - A Nursing Home (NH) is a facility which provides 24-hour convalescent care and/or care for the chronically ill. It is licensed and certified by the Bureau of Nursing Home Affairs (BNHA), DSHS. A contract between the facility and the BNHA is required to provide care for Medicaid clients. A nursing home can be classified as a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Intermediate Care Facility for Mentally Retarded (IMR).

   1. Eligible persons are those Medicaid or state-only medical care clients who are assessed by the community nurse, CSO service worker or DDD field service staff as requiring:

SS Manual - 1851
David v.

      a. Skilled Nursing Care (SNC):

         Clients requiring skilled nursing home care are clients whose condition, needs, and/or services are of such complexity and sophistication so as to require frequent or continuous observation and intervention of a registered nurse and the

supervision of a licensed physician. These patients require ongoing assessments of physiological and/or psychological needs, and the development and implementation of a comprehensive total plan of care involving multidisciplinary input and coordination. Patient needs include ongoing evaluations, care plan revisions and the teaching necessary to provide for those whose condition is unstable and/or complex.

b. Intermediate Nursing Care (INC):

Clients requiring intermediate nursing care are those whose physiological and/or psychological functioning is stable, but require ongoing individually planned treatment and services under the daily direction of a registered nurse and the supervision of a licensed physician. The program is directed toward maintenance of maximum independence and return to the community whenever possible. The program includes an established treatment regimen involving more than supervision, assistance with personal care, and protection.

c. Intermediate Care for Mentally Retarded (IMR):

IMR residents are those developmentally disabled individuals who require active treatment and have health-related conditions. IMRs include community facilities and state residential habilitation centers, which are licensed and certified by BNHA. The Division of Developmental Disabilities (DDD) Case Services will make all IMR placements. Individuals who are not developmentally disabled may not be placed in an IMR facility.

3. Determination of need:

a. Persons at home or residing in an AFH/CCF or admitted to the hospital from home or in a DD residential facility requesting nursing home care will have their need assessed in person by the community nurse, CSO social service worker and/or DDD field service staff using the DSHS 14-192(X), Comprehensive Adult Assessment. If the Region/Area Agency on Aging preplacement screening agreement so stipulates, the aging network staff will participate in the assessment of those age 60 and older. Prior to authorization of placement using the DSHS 15-154/159(X), the social service staff (CSO/DDD) will obtain financial eligibility determination from CSO financial section, and will give consideration to other appropriate caregiving options. See Manual G 46.56 for state mental hospital referral procedure.

b. Persons who are Medicare or private pay nursing home residents seeking Medicaid nursing care payment will have their financial need determined by CSO financial staff. Bureau of Nursing Home Affairs (BNHA) Nursing Care Consultant will assess need for nursing home care within thirty days of receipt of the DSHS

15-31(X), Notice of Action-Adult Residential Services. No service worker assessment or authorization is required. If the person is found not to need nursing home care, the NCC will notify the client, facility, CSO services and financial staff by letter #1440B.

c. Hospitalized Medicaid nursing home residents readmitted to a nursing home will have their need for nursing care assessed by the BNHA Nursing Care Consultant within thirty days of readmission. No service worker assessment or authorization is required. Former residents of freestanding ICFs will return to freestanding ICFs only if they do not need a different level of care.

d. DDD Field Service staff will follow the DDD/BNHA interagency agreement and WAC 388-88-105 when placing or relocating DDD clients into/out of SNF/ICFs.

4. Placement in facility:

Selection of a facility is to be made by the individual, his or her relatives or others acting in his or her behalf from Title XIX certified facilities. Placement is authorized by use of the DSHS 14-154/159(X), for first-time residential care admissions.

5. Payment--Standards.

a. All nonexempt income of a person placed in a nursing home shall first be applied to the person's clothing, personal maintenance and necessary incidentals. Beginning the first day of the first full calendar month of eligibility, the clients nonexempt income shall be collected by the nursing home.

b. Payment is limited to the cost-reimbursement rate established for the particular facility.

E. Nursing Home Discharge Allowance - The discharge allowance is a one-time payment of up to $400 which may be issued to DSHS-funded nursing home residents to help them obtain an independent living situation when they no longer require nursing home care.

1. Eligible persons are Medicaid or state-funded medical care nursing home residents who

a. Have no existing independent residence;

b. Do not have a spouse or dependent living in an independent living situation to which they could return, and

c. Have no more than $600 in cash or other liquid resources which could be converted at face value to cash within 30 days.

2. Determination of need:

CSO or DDD field service staff upon receiving a referral from the BNHA Nursing Care Consultant that the client no longer needs nursing home care or prefers independent living

a. Establishes that the client meets criteria 1. a., b., and c. above, and

b. Obtains estimates of cost to effect discharge.

3. Payment standards:

Payment authorized shall be at the least amount up to $400 which will allow the client to obtain independence. Family, friends and the community will be encouraged to participate in the cost of setting up an independent living situation. Client liquid resources shall be used as follows:

a. If the client's cash resources are between $0 and $300, authorize actual cost not to exceed $400.

b. If cash resources are between $301 and $400, authorize the actual cost not to exceed $300.

c. If the client's cash resources are between $401 and $500, authorize actual cost not to exceed $200.

d. If cash resources are between $501 and $600, authorize the actual cost not to exceed $100.

F. Nursing Home Income Exemption - Up to $180 per month of a Medicaid recipient's income may be used for a single person to maintain his/her home if his/her physician has indicated his/her need for nursing home care will not exceed six months.

1. Eligible persons:

Medicaid recipients entering nursing home care for six months or less who have income and a home which would be unavailable unless they paid to retain it are eligible.

2. Determination of need:

CSO or DDD field service staff determine the client meets the eligibility requirements and determines minimum necessary to retain the independent living situation. Individual circumstances will be reviewed after 90 days.

3. Exemption standards:

Up to $180 per month for a maximum of six months may be exempted.

SS Manual - 1854
David v.

46.16 Payment Rates (Effective July 1, 1983)

A. Congregate Care

1. Regular Program - $16.31 per day. For facilities of 15 or fewer licensed beds which had CCF contracts as of December 31, 1981, the rate is $19.09 per day. Any new contracts or revisions in contracted beds will be at $16.31 per day.

2. Mental Health Program - $19.13 per day. For facilities of 15 or fewer licensed beds which had CCF contracts as of December 31, 1981, the rate is $21.91 per day. Any new contracts or revision in contracted beds will be at $19.13 per day.

3. Drug Abuse Program - Facilities of 1-15 licensed beds - $21.12 per day; facilities of 16+ licensed beds - $16.30 per day.

4. Alcohol - Facilities of 1-15 licensed beds - $23.93 per day.

   Facilities of 16+ licensed beds:

   Intensive Inpatient - $16.30 per day
   Long Term - $19.12 per day
   Recovery House - $19.12 per day*

   *Pioneer Center receives $16.30 per day.

5. For purposes of establishing initial eligibility for congregate care, the monthly cost is the daily rate multipied by 31 days.

B. Adult Family Home

1. The basic rate is $329.22 per month.

2. Service payment rates for Activities of Daily Living are:

   a. One-three services = $35.51 per month.

   b. Four-seven services = $53.25 per month.

   c. Eight-twelve services = $76.92 per month.

   d. Payment for activities of daily living services will be made only after sponsors have been trained and the need for such services are supported by a current DSHS 14-192(X), Comprehensive Adult Assessment, or DSHS 14-192A(X), Annual CCF/AFH Client Re-eligibility Review.

3. Service payment rates for health-related services are $23.67 per month for each service authorized to a maximum of nine services. Sponsors who are licensed RNs or LPNs may provide any of the health-related services authorized by the plan of care. Other sponsors may, after successful completion of AFH sponsor training, provide

SS Manual - 1855
David v.

only incontinence/bowel and bladder retraining, ambulation, diet and behavior health-related services authorized by the plan of care. Even though the sponsor is qualified to provide health-related services, no more than two (2) of the clients may be provided that additional service at any one time.

C. Nursing Homes

Each facility has an individually determined, cost-related composite rate. The same rate applies to both INC and SNC patients in a particular nursing home.

46.17 Clothing and Personal Incidentals (CPI)

A. The standard allowance for CPI for a client in an AFH, CCF, or NH is $34.50. Clients whose income is less than $34.50 receive a check for the difference from DSHS authorized by the CSO financial service section.

B. Clients in nursing homes who have earned income from a DSHS-approved training or rehabilitative work program may retain up to $343 of earned income which includes a CPI allowance. The training or work program must be designed to prepare the individual for less restrictive placement and may be approved by the CSO caseworker, the DD case service worker or the DVR counselor working with the client.

46.18 Client Participation in Cost of Care (CCF/AFH)

A. SSI recipients always participates the SSI standard plus state supplementation less the CPI amount (SSI handles earned and unearned income exemptions).

B. GAU recipients without income do not participate in cost of care since the GAU warrant only includes the CPI amount. GAU recipients with income participate the amount of their income less the CPI amount.

C. Persons not receiving SSI and not receiving GAU always participate the amount of their income reduced by $20.00 and by the CPI amount. (See D below.)

D. Short-term (up to six-month stay) nursing home residents with income other than SSI or GAU may retain up to $180 per month (in addition to the CPI) as an income exemption to maintain an existing home if the resident has no spouse or dependents able to maintain the home. The physician must indicate that such individuals will be able to return home within six months.

E. All nonexempt income of a person placed in an adult family home or a congregate care facility shall first be applied to the person's clothing, personal maintenance, and necessary incidentals. Any remaining nonexempt income shall be applied to the cost of the care in the form of client participation. The participation amount is to be figured by the service worker and recorded on a DSHS 14-154/159 using the SSPS AFH/CCF participation code, 4612. See Manual G 46.18 A-D.

F. AFH/CCF participation is not a prorated service. The amount in "Auth Amount" (Item 43) is the amount the client is to pay for the service given during that month regardless of the service begin and end dates. If a client goes into care after the first of the month, the amount of participation paid the first (partial) month of care will be determined by the nonexempt income available to the client. As much of the full amount of participation as possible should be paid by the client; however, if the money has already been spent, used, or disbused and is less than $1,500.00 in cash or other liquid resources that the client may retain, the department will pay all of the client's first partial month's normal participation payment. That is, the client is expected to participate in the cost of the first partial month only if his/her resources (including exempt income) are more than $1,500.00. If less than the full ongoing participation amount is to be paid the first month, the service worker should open the participation code for the actual amount to be paid by the client for the partial month. This amount and the dates will need to be updated to reflect the ongoing participation amount. If no participation is to be paid for the partial month, the service worker should open the participation code effective the first day of the next month.

G. If a client changes placement mid-month, he/she is responsible for making the full participation payment for that total month. The service worker is responsible for determining the amount of participation to be paid to each provider and completing the DSHS 14-154 and DSHS 14-159 accordingly. The participation payment can be made to the first facility, the second facility, or split between the two facilities. However, the amount of participation paid to one facility cannot exceed the prorated payment for the service given by that facility. The following formula should be used to prorate the service to determine the payment due each facility.

$$\frac{*(\text{total cost of services})}{30.42} \times \text{\# of days service was provided}$$

Total cost of service = (AFH rate + ADL rate + HRS rate)

This is the amount the facility should be paid for the care of the client. If participation exceeds this amount for one facility, it can be split between the two facilities or paid entirely to the other facility.

When a client prepays the participation and does not stay in the facility long enough to use the entire amount of service covered by the participation, the facility must refund the unused portion to the client. See Manual G 46.99 E. The service worker will determine the amount to be refunded to the client. If the facility is unable to immediately refund any or all of the participation, the amount owed to the client will be paid to the second facility by the department. The service worker will need to set up the new DSHS 14-154 to show the participation payment for the partial month as the regular participation amount minus the amount the first facility owes the client. This will need to be updated on the DSHS 14-159 to reflect the entire participation amount for subsequent months. The amount paid by the department in place of the client's participation is to be set up as an overpayment to the first facility.

H. When a client leaves care during the month, the service worker is responsible for figuring the payment due for services rendered. This should be done using the proration formula stated above. The client is responsible for this amount or the entire amount of the participation payment, whichever is less. If the entire payment for services rendered is less than the regular participation amount, the DSHS 14-159 participation code must be changed to reflect the lower amount and the entire authorization promptly closed to reflect the last day of payment. If the client prepays the participation and does not stay in the facility long enough to use the entire amount of service covered by the participation amount, the facility must refund the unused portion to the client. See Manual G 46.34 A.

46.19 Community Options Program Entry System (COPES)

A. Service Description

1. The department has been granted a Medicaid waiver to develop a program which will provide in-home and community based services to persons found eligible to receive nursing home care. This program is called the Community Options Program Entry System (COPES). Services offered under COPES are:

   a. Congregate Care

   b. Adult Family Home Care

   c. Personal Care

   d. Case Management

   e. Home Health (Supplemental Service)

   f. Adult Day Health (Supplemental Service)

2. Persons eligible for COPES are categorically related Medicaid recipients (i.e., aged, blind, and disabled persons) over 18 years of age who:

   a. Have gross monthly income which is less than $912.90 (300% of SSI); and

   b. Have resources at or below the SSI standard; and

   c. 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 for the mentally retarded; and

   d. Choose to remain in their own homes or in licensed congregate care facilities or adult family homes; and

e. Have a plan of care for COPES services, including the at-home living standard, that costs less than $918 per month (80% of the average nursing home rate).

3. Additionally, COPES eligible recipients are eligible for medical services reimbursed by Medicaid, just as if these recipients were residing in a nursing home.

4. The cost of COPES services (excluding the at-home living expense, medical costs, and case management), cannot exceed $575 per month. This amount is determined by subtracting the allowance for at-home living expenses, which is $343, from 80 percent of the nursing home rate, which is $918. For example, if a recipient receives personal care at a cost of $450 per month, this recipient has $125 remaining with which to purchase another COPES service, such as adult day health. Medical and case management costs are not included in the individual recipient's plan of care and are not subtracted from the $575.

5. When a recipient has income of more than $343 per month, the COPES benefit (the amount paid by the department) is $575 less the amount in excess of $343. For example, a recipient whose income is $403 has a COPES benefit of $575 - $60, or $515. In this example the department pays $515 for the cost of services. If the total cost for care is $575, the $60 must be paid by the recipient directly to the provider.

B. Eligibility Determination

1. Service workers and Developmental Disabilities case services staff at the time of regularly scheduled reviews of their chore services, AFH, and CCF recipients should determine if any of these recipients are potentially eligible for COPES. If a recipient is thought to be eligible, he or she should be contacted and given the opportunity to participate in COPES.

2. Applicants requesting nursing home care or other community services, such as chore services, CCF/AFH, should be informed about COPES. 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 a preliminary determination of eligibility. This brief determination may be done face-to-face, over the telephone or through a third party. The service worker must establish, generally, through this preliminary eligibility determination the applicant's age, income, amount of resources, and disability.

3. Once the service worker prequalifies the applicant, the formal eligibility process follows these steps:

a. The service worker or community nurse administers the Comprehensive Adult Assessment, DSHS 14-192(X), according to the procedures established in Manual G, Chapter 46.

b. Service workers or other professional staff from the CSO or centralized services, Aging Network, Developmental Disabilities (DDD), Mental Health (MH), Alcohol and Substance Abuse (ASA), and DSHS nursing staff review each individual applicant, as appropriate, during a formal case staffing. For example, an 80-year-old female applicant should be staffed by at 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 to explain the medical benefits of COPES eligibility. Case staffings must occur prior to completion of the plan of care (see paragraph e.). For applicants awaiting hospital discharge, a plan of care may be developed and implemented prior to the case staffing; provided that, the staffing takes place within 30 days of initiation of services. Case staffings can also take place at the times of the 30-day, 90-day, and one year reviews. The CSO will plan and preside at each case staffing. The format of the staffing and composition of the reviewers will be determined by CSO policy. The department's rules regarding confidentiality apply to these case staffings. Therefore, it is necessary to obtain a signed release of information from the applicant.

c. If eligible, the applicant is referred to financial services for a financial eligibility determination. A DSHS 14-84 is used to transmit information to financial services. The DSHS 14-84 should explain that the applicant is applying for COPES and give the applicant's address. If the service worker assists the applicant in completing the DSHS 14-01, Application for Assistance, the service worker should attach the DSHS 14-01 to the DSHS 14-84 and write "COPES Application" at the top of the DSHS 14-01. NOTE: Completion of a DSHS 14-139 is not necessary for COPES applicants.

d. Financial eligibility for COPES is determined by the Financial Services Technician within the Community Services Office using the guidelines in Manual F, Chapters 30 and 32. Essentially, COPES applicants are treated the same as nursing home applicants. To be eligible for COPES, a person must have gross income that is less than $912.90 and not have resources that exceed the SSI standard. Only the income and resources of the client are used in determining financial eligibility. Income and resources of a spouse or parent are not counted. After the recipient is determined to be financially eligible, medical coupons are issued.

e. Upon completion of the case staffing, the service worker prepares the COPES Plan of Care, DSHS 14-225. The DSHS 14-225 is prepared with the applicant or a knowledgeable informant. The DSHS 14-225 must be approved and signed by the applicant

before COPES services are provided. One copy each of the DSHS 14-192(X) and DSHS 14-225 are given to the recipient. The recipient's income is based on the eligibility determination provided by financial services.

f. Participation in COPES, like all Medicaid services, is voluntary.

C. COPES Services and Payment Procedures

1. CCF - Regular COPES Services

a. Congregate care facilities provide services as described in Section 46.15 B. In addition, CCF's may provide medication assistance. The CCF rate for medication administration to COPES recipients is an additional $.75 cents per day, to a maximum of $23.67 per month. This rate is available for COPES recipients only. To receive this rate, CCF's must meet the boarding home licensing standards for medication administration, and the contract must be amended to show the additional rate.

b. SSPS service code 4626 will be used for COPES recipients authorized CCF care.

c. Payment for COPES CCF services will be made by provider services.

d. COPES clients will not occupy existing CCF beds. New beds will be contracted for, using the amendment example in Section 46.99. A CCF bed lid for COPES recipients will be established for each region.

e. An applicant is not eligible for COPES if his or her income is equal to or exceeds his or her total cost of care in a CCF.

f. The room and board portion of the CCF rate is $288.50. The balance of the cost of care less the remaining exempt income is the COPES benefit.

2. AFH Services

a. Adult family homes will provide services as described in Section 46.15 C.

b. The same AFH SSPS service codes will be used for COPES recipients, except that reason code E must be used.

c. Payment for COPES AFH services will be made by SSPS.

d. An applicant is not eligible for COPES if his or her income is equal to or exceeds his or her total cost of care in an AFH.

e. The room and board portion of the rate is $288.50. The balance of the cost of care less the remaining exempt income is the COPES benefit.

3. Home Health and Adult Day Health Services

a. Applicants requiring only adult day health or home health services are not eligible for COPES.

b. For a description of these services, contact the home health agency or adult day health facility directly.

c. Payment for home health services is made by medical coupon. The COPES recipient receives Medicaid coupons when determined eligible for COPES services. Not all adult day health centers are eligible for Medicaid reimbursement. Only those centers which accept medical coupons can serve COPES recipients.

d. When completing the plan of care, the average statewide monthly costs are used for estimating the costs for home health and adult day health. The average statewide monthly cost for home health is $210 and $159 for adult day health. These are the maximum amounts allowed each month for home health and adult day health.

4. Personal Care Services

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

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

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

(3) Transfers to and from bed, wheelchair, and bathtub.

(4) Preparation of food, to include meal planning and food selection, buying, and cooking.

(5) Transportation and escort to medical services, including medical laboratories (for tests) and specialized treatment.

(6) 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.

SS Manual - 1862
David v.

(7) 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.

(8) Assistance with medications which are ordinarily self-administered. Administration of medications is allowed only when the provider is a licensed health practitioner.

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

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

(11) Protective supervision when the recipient has diminished mental capacity or judgment.

(12) Assistance with other necessary activities of daily living such as telephoning, writing, and shopping.

(13) Attendant care.

b. 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 of any degree, except for spouses.

c. The payment rate for personal care services will be at least the federal minimum wage ($3.35 per hour) for individual providers, but cannot exceed $3.85 per hour. A standby hourly wage of up to $.25 per hour may be paid to providers of attendant care during the hours when actual services are not provided, but the provider must be with the recipient. Private or public social/health service agencies, such as chore services contractors or home health agencies, may provide personal care at a unit rate not to exceed $5.81 per hour.

d. Payment for personal care services will be made by SSPS. Unlike individual provider chore services, payment for COPES personal care is made directly to the provider, not the recipient.

e. The SSPS service code for COPES personal care - individual provider is 4656.

The SSPS service code for COPES personal care - private or public agency is 4657.

f. Recipients of COPES personal care cannot also be authorized chore services. Personal care cannot be provided in a CCF or AFH.

5. Case Management Services

a. Section 46.32 B. 2. defines case management. Case management is always provided as an integral part of the plan of care for persons receiving COPES CCF, AFH or personal care, but it is not provided as a single and independent service.

b. The SSPS service code for COPES case management is 4655.

6. Providers of COPES services must complete the Community Options Entry System Provider Agreement, DSHS 14-227. This form serves as an amendment to current CCF and AFH contracts. The DSHS 14-227 is the contract for individual provider or agency provided COPES personal care. After the provider has signed and dated two originals of the Provider Agreement, the forms must be submitted to the COPES Program Manager, Mail Stop OB-43G. One original will be returned to the CSO after being signed. The Provider Agreement can be effective for up to two years.

D. Ineligibility for COPES Services

1. An applicant may be denied COPES services when:

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

b. He or she has income which exceeds 300 percent ($912.90) of SSI; or,

c. The cost of services on the plan of care exceeds $575 per month; or,

d. 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; or,

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

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

g. The applicant's income is equal to or exceeds the total cost of his or her care in a CCF or AFH.

2. When services are denied, this should be indicated on the DSHS 14-225. The applicant must be informed of his or her right to a fair hearing.

46.20 PROGRAM STANDARDS

46.21 Program Expectations/Response Time

A. Persons requesting residential care (except alcohol or drug treatment) who are living at home or hospitalized from home will receive an in-person assessment of their need using the DSHS 14-192(X), Comprehensive Adult Assessment form.

B. In-home services will be provided whenever the client is eligible and an in-home plan can be implemented.

C. CSO service workers or DDD field service staff will provide relocation services to individuals who must move to another facility because of termination of the residential care provider's contract, decertification or closure of the facility, revocation of the provider's license, or emergency license suspension.

D. Relocation services will be provided to individuals who require a different level of care.

E. Individuals who no longer require residential care will be helped to locate independent living situations.

F. CCF-Regular, CCF-MH and AFH clients' continuing need for CCF/AFH care will be reassessed at least annually by the CSO or DDD field services staff using DSHS 14-192A(X).

G. CSO service staff will negotiate and renegotiate CCF/AFH contracts.

H. Provider compliance with CCF-Regular, CCF-MH and AFH contract terms, Conditions and Statement of Work will be monitored at least annually.

I. Licensure of AFH sponsors will be accomplished by designated CSO licensors (see Manual G, Chapter 06).

J. Need for NH Discharge Allowance and NH Income Exemption will be assessed.

K. Client will receive a copy of DSHS 14-154(X)/159 indicating participation requirement, updated as necessary.

46.22 Appropriate Program/Service Outcomes

A. Eligible individuals who can remain at home will be enabled to remain at home.

B. Eligible individuals who require residential care will be authorized such care.

C. Continuing need for CCF/AFH care will be assessed by CSO or DDD Field Services.

D. AFH licenses will be issued by the CSO.

E. Congregate Care and Adult Family Home contacts will be negotiated and monitored by the CSO.

46.30 SERVICE PROCEDURES

46.31 Determination of Client Need - Residential Care

A. When a request for residential services is made by an individual living at home or hospitalized from home, a review and assessment of the client's needs will be done with the client and/or the client's family, using DSHS 14-192(X). DSHS 14-192(X) is not required for nursing home or mental hospital residents determined by the NCC not to be in need of nursing home care. The DSHS 14-192A(X) will be used to assess need of nursing home residents being considered for CCF/AFH care. See Manual G, Sections 46.34 and 46.56A 2.

1. For clients under 60:

   a. When Community Nurses (CN) are assigned to a CSO, they will assess the client's needs as requested as part of the face-to-face team assessment with the service worker and will participate in a case staffing to develop the plan of care.

   b. In areas where no CNs are assigned, the service worker will perform the face-to-face assessment.

2. For clients 60 years of age or older:

   The procedure outlined in the Regional/Area Agency on Aging Pre-screening Agreement will be followed.

In instances in which residential care is anticipated, the Community Nurse (if assigned) will complete the DSHS 14-192(X), Sections I through IX. In locations where there is no Community Nurse, the CSO service worker will complete all parts of the DSHS 14-192(X). The DDD service worker will complete the DSHS 14-192(X) for DDD clients needing SNC, INC, CCF or AFH care.

B. The client's functioning should be reviewed and assessed per DSHS 14-192(X) Instructions and Service Guidelines.

46.32 Plan of Care Development

A. Each applicant for residential care or COPES services will have a plan of care developed. The plan of care describes the needs of the applicant and services required to meet those needs, and designates the agency responsible for case management. The plan of care is developed in conjunction with the applicant and professional staff from other agencies who may participate in a case staffing.

SS Manual - 1866
David v.

B. Procedures

1. Case Staffing

a. To comply with federal regulations, COPES applicants must always receive a formal case staffing in accordance with procedures found in 46.19 B. 3. b.

b. Each applicant for residential care should receive a case consultation. Consultations are an informal means of sharing necessary information to develop an appropriate plan of care, and may include telephone as well as in-person contacts. Participants may include those indicated for case staffings. (See section d., below).

c. Case staffings are not required at times of regularly scheduled reviews.

d. Participants at case staffings include the service worker and professional staff from the Aging Network, Developmental Disabilities, Mental Health, Alcohol and Substance Abuse, and DSHS Nursing staff, as appropriate. Staff from other community agencies and health practitioners may also attend staffings when they are knowledgeable of the applicant. Area Agency on Aging prescreening agreements and similar agreements with other agencies should specify the need for their participation in case staffings, when required. Other persons to attend case staffings may include family members and the client or his or her representative.

e. The CSO is responsible for planning and presiding at the case staffing. The purpose of the case staffing is to share information about the applicant necessary to develop an appropriate plan of care. Ultimately, it is the service worker's responsibility to decide on the best plan of care for the applicant, keeping in mind the applicant's preferences and needs.

f. Case staffings should:

(1) Start and finish on schedule. A written agenda should be provided to the participants several days prior to the meeting.

(2) Include all key participants.

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

(4) Generally, arrive at a consensus of the best plan of care for the applicant.

2. Case Management

a. Primary responsibility for case management is designated through local agreements and arranged during the case staffing. Case managers may be CSO service workers, Aging Network staff, Division of Developmental Disabilities case services staff, mental health professionals employed by Mental Health Centers, etc. Written agreements between the region and these various agencies defining the respective roles for case management will make it easier for the service worker to determine the appropriate case manager.

b. The case manager is responsible for the implementation of the plan of care and for ensuring services are delivered to the recipient and that those services adequately support the recipient at home or in community-based care.

c. A formal request for case management is made by the service worker using the Communication/Referral Form, DSHS 2-306/306A(X), or State Form 1. Attached to the Communication/Referral Form are copies of the DSHS 14-192(X), the DSHS 14-225, and the DSHS 14-154/159. The agency to whom the recipient is referred for case management has ten working days to acknowledge responsibility for case managing the recipient. Each recipient normally has only one case manager.

d. For COPES recipients, the 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 DSHS 14-192 must be completed at the time of the year review and whenever there is a substantial change in the recipient's condition or circumstances.

e. Changes to the plan of care and/or authorization can be made only by the CSO or DDD service worker. Case managers should advise the service worker when changes are necessary. A case staffing may be appropriate when changes in services are requested by the case manager. Service workers and/or case managers should act promptly when a change in the plan of care is necessary.

3. Plan of Care

a. The service worker will discuss with the client and/or his/her relatives the array of services for which he/she is eligible which will meet the assessed need.

b. The plan of care developed will be discussed with the client. If the client or legal guardian agrees to the plan of care, it will be implemented. If the client or legal guardian does not agree to the plan of care, a revised plan must be developed.

c. For individuals whose plan of care requires residential placement, the individual, family, or person acting in his/her behalf will be asked to locate a facility and report to the case manager the name of the facility selected which has agreed to provide care.

d. If the plan of care indicates in-home services are required, necessary home support services for which the client is eligible will be arranged by the case manger.

e. For COPES recipients only, the COPES Individual Plan of Care, DSHS 14-225, will be completed and signed by the recipient and the service worker.

f. For all recipients, the (Individual Service Plan (ISP) should indicate the:

(1) Date of and participants at the case staffing or case consultation.

(2) Services recommended - services authorized.

(3) Designated case manager.

46.33 Service Authorization

DSHS 14-154(X)/159 is used by CSO/DDD service worker to authorize the required service. See Manual G, Chapter 04, Section 4600 for instructions. Eligibility factors and policies outlined in Manual G, 46.12 - 46.16 shall be followed. Placement is not to be authorized until financial and service eligibility has been established. Persons requiring AFH special service shall be placed only in an AFH which has met the requirements to provide those special services. See Manual G, 46.16 B. 2. d. and B. 3.

46.34 Discharge/Relocation Services

A. CSO/DDD service worker provides assistance to persons no longer requiring residential care and for those requiring relocation to another level of care and to those who must be relocated because the facility is no longer able to provide care because of closure, decertification or licensure deficiencies. (See Chapter 06.48-49 and WAC 388-88-100 through 388-88-102.)

B. For nursing home residents who no longer need nursing home care but do need CCF/AFH care, the DSHS 14-192A(X) substitutes for the DSHS 14-192(X). The DSHS 13-336(X), Client Profile, provides other necessary information.

46.35 Transfer/Relocation -- AFH/CCF

A. At times, clients residing in an AFH or CCF may become abusive or assaultive or are for other reasons no longer appropriate for continued residence in CCF/AFH. The following general policies are to be followed:

1. Facilities/sponsors are required by licensing standards to monitor resident behavior and medication.

2. Close communication is necessary between facilities/sponsors and service workers to deal with serious overt behavioral problems as they arise.

3. The service workers have a responsibility to know the local resources available to help facilities deal with assaultive, abusive clients including:

   a. Community Mental Health Centers

   b. County Mental Health Board

   c. Local, city and county law enforcement representatives

4. Facilities/sponsors have the final responsibility to take appropriate actions to remove clients manifesting overt assaultive and destructive behavior and to so inform the CSO.

5. CSO/DDD cannot remove the client involuntarily.

B. If an AFH or CCF chooses not to renew its license or contract or if the department does not renew a license or contract because of lack of compliance, the relocation of clients shall be carried out in a manner aimed at minimizing transfer trauma. (See Chapter 06.48 and 06.49.)

1. Clients shall be given 30 days' notice, plus services to mitigate transfer trauma.

2. Reason for the move shall be clearly explained by the service worker to the client and his/her family.

3. Preplacement visits shall be arranged if the service plan calls for relocation to another type of residential facility, i.e., AFH, CCF or NH.

46.36 Transfer/Relocation - NH

A. The service worker will ensure the preparation of a relocation plan designed to minimize transfer trauma for persons who must move. (See Manual G, 46.34.) Factors to be considered in assessing an individual's susceptibility to transfer trauma include at least the following:

SS Manual - 1870
David v.

1. The extent to which the patient's intellectual capacity, memory and orientation to time, place and person have been impaired.

2. Physical disabilities.

3. Length of residence in the facility. (Extent patient's sense of safety/well-being is derived from identification with current facility.)

4. Family ties and the degree of involvement with relatives in the immediate area.

5. Age of the patient.

6. Health of the patient.

B. Facility Initiated Transfer (Nursing Home Residents)

1. A facility may request the relocation of a patient for one of the following reasons:

   a. Inability of the facility to meet the needs of the patient.

   b. The welfare of the patient or that of other patients.

   c. Nonpayment for services received.

2. The facility requests the relocation or discharge of the individual in writing to BNHA with a copy to the CSO administrator. The request must indicate the reasons for relocation and must fall within reasons outlined above.

   a. The BNHA will approve or deny the request following assessment by the NCC.

   b. The CSO administrator will be notified by the BNHA of the decision and will assist with relocations approved by BNHA meeting the criteria outlined in Manual G, 46.36 B, 1.

   c. If the facility's request is approved, the BNHA shall notify the patient, or the patient's next of kin or guardian, or responsible party of the decision, in writing. The effective date of the relocation shall be in excess of 30 days to ensure orderly transfer and recognition of the individual's rights to a fair hearing.

   d. The patient may move any time within the 30-day period providing he/she (or representative person) requests the move in writing and waives all or part of the 30-day notice requirement.

e. In the event BNHA denies the request for the transfer and the patient does not wish to leave voluntarily, the matter is closed unless there is a change in the situation. In that case the request may be resubmitted.

C. Voluntary Transfers

Patients and/or the person acting in his/her behalf may negotiate the transfer and notify CSO financial services when transfer has been accomplished. Service staff are not required to assist in such transfers to the same level of care.

D. Relocation Due to Reclassification (Nursing Home Residents)

1. As federally mandated, the NCC routinely reviews the care needs and the appropriateness of services provided to each individual patient/resident, and makes a classification determination. Reviews may also be done when requested by the facility, family, CSO or BNHA.

2. When reclassification results in relocation, the following steps must be taken:

   a. BNHA-NCC sends a letter notifying the patient and/or representative person of reclassification.

   b. A copy of this letter is sent to the facility, the physician and the CSO/DDD service worker.

   c. The service worker will follow up with a face-to-face contact with the patient.

3. If the reclassification necessitates relocation, and if this is acceptable to the patient and there is no indication of a possible request for fair hearing, the service worker shall work with the patient toward the move including arranging for pretransfer visits if the patient's condition permits.

4. If the patient elects to contest the reclassification, he/she has the right to request a fair hearing. The effective date of the reclassification may be modified according to the decision of the fair hearing officer. The service worker continues to try to locate feasible relocation options while fair hearing is pending.

5. In the case of an upward classification of an individual in a facility certified only for ICF care, the patient's transfer must be expedited. Federal and state regulations prohibit a facility from retaining an individual whose needs cannot be met.

6. If it is not possible to arrange for a relocation option within 30 days, the CSO prepares a memo justifying such delay to the Regional Administrator with cc's to the Deputy Assistant Secretary for Community Services, Director of Bureau of Nursing Home Affairs, and Director of the Bureau of Aging and Adult Services.

SS Manual - 1872
David v.

E. Decertification, Termination or Non-renewal of Contract

1. Such actions require a stop payment of Title XIX funds but do not affect the facility's right to operate as a nursing home. When termination of federal funds is contemplated, Medicaid patients must be informed. Should a Medicaid patient elect to remain in a facility that can no longer be reimbursed for care at the level the department had determined the patient to require, he/she would be free to remain but would have to make other financial arrangements. (See Manual G, 46.37.)

2. The BNHA will notify the CSO administrator by telephone and letter of confirmation of pending decertification, termination or non-renewal of contract advising him/her to prepare for possible patient moves and implementation of stop-placement procedures. Copies of pertinent correspondence from the BNHA to the facility regarding negative action will be sent to the CSO administration immediately.

   a. All new admissions, readmissions, and transfers-in are prohibited.

   b. Requests for exception to the stop-placement shall be made to the BNHA. The BNHA will notify the CSO administrator of the final decision by telephone and confirm the decision in writing.

   c. The BNHA will notify the CSO administrator by telephone and confirm by letter the effective date of removal of the stop-placement order.

   d. The CSO will provide the BNHA a list of names, including level of care and Personal Identification Code (PIC) No. of all medical care patients in the facility whose contract is being terminated. The service worker will consult with the NCC to confirm current patient classifications.

   e. After the period for requesting a hearing expires or a hearing opinion upholding decertification or non-renewal of a contract is rendered, the BNHA shall notify by letter, the medical care patients or their next-of-kin, guardian, or responsible party, that 30 days after the mailing date of that letter, the cost of their care will no longer be reimbursed by state and/or federal monies if they remain in the facility.

   f. The CSO Adult Services Unit supervisor/designee will notify the BNHA by telephone on the day that the last medical care patient has been transferred from the facility.

   g. The CSO will subsequently send the BNHA a list of all transferred patients giving their name, PIC or case number, date moved and the receiving facility.

F. Revocation or Suspension of the Nursing Home License

1. Revocation or suspension of the nursing home license shall result in immediate movement of Medicaid patients or those patients who agree to such movement.

2. The BNHA will notify the CSO administrator by telephone and in writing of pending revocation or suspension action and advise him/her to prepare for possible patient moves and implementation of stop-placement procedures.

3. The CSO will provide the BNHA a list of the names, including level of care and PIC No., of all medical assistance patients in the facility.

4. Patients will not be notified until a definite determination has been made to close the facility.

5. Patients and their next-of-kin, guardian or responsible party will be notified by letter from the BNHA that 30 days after the mailing date of the letter, the facility will no longer be allowed to operate as a NH, and that they, therefore, will be required to relocate PROVIDED, that nothing in this section shall require that pretransfer notice be given when the Secretary determines that an immediate threat to health and/or safety exists or that moves may be accomplished sooner at the request of the patient or with the patient's consent.

6. Involuntary transfers will be coordinated by BNHA with the counsel of the Attorney General. The CSO shall provide the BNHA with a list of involuntary transfers.

7. The CSO shall notify the BNHA by telephone on the day that the last patient (both medical recipient and/or private pay) has been transferred from the facility.

8. The CSO shall send the BNHA a list of all transferred patients/recipients, giving their name, PIC or case number, date moved, and the receiving facility.

46.37 Individuals Refusing Discharge or Relocation from NH/CCF/AFH

A. Payment of care for individuals refusing services or who refuse to move to available-appropriate level care will cease thirty days following such refusal or thirty days after a Fair Hearing decision affirming the client no longer is eligible for residential care.

B. For such residents of nursing homes, the CSO/DDD service worker is to notify the NCC and CSO financial staff by memo.

C. For residents of CCF, the CSO/DDD service worker will arrange for termination of payment with the CSO financial staff.

SS Manual - 1874
David v.

D. For AFH residents, the service worker will cease payments, so notifying the client and AFH sponsor.

46.38 Annual Reassessment of Client Need for CCF/AFH

A. CSO/DDD service staff completes DSHS 14-192A(X), to record review findings.

B. If it is determined that congregate care or AFH care is no longer needed, the service worker is responsible for working out a new living arrangement with the client and assisting with discharge planning.

C. If the review determines CCF or AFH service is inappropriate because the client needs nursing care, a referral for consultation with the CN, where assigned, or NCC shall be made and the client's physician shall be notified.

D. The service worker shall notify the client of his/her right to an administrative hearing if the client does not agree with any service level increase or decrease resulting from a review.

E. Continued need for special AFH/CCF services shall be reviewed. If the CCF/AFH is not providing the services, authorization will be decreased and if the client continues to need those services, relocation shall be arranged unless the client refuses. See Manual G, 46.42 F.

F. CCF/AFH residents with health-related needs shall be referred for COPES assessment (see 46.17).

46.39 Congregate Care Regional Lids

A. Congregate Care - Regular Program

1. The number of CCF - Regular contracted beds and COPES CCF beds are allocated to the Region by the Bureau of Aging and Adult Services.

2. The Region determines the number of beds to be contracted for each facility.

3. To be considered in revising the contracted bed levels for particular facilities are:

   a. Quality of care provided by the contractor.

   b. Regional need for beds in particular locations.

   c. Contract amendment procedures. (See DSHS 9-571(X), Congregate Care Contract.)

4. When decisions to transfer regular beds between regions occur, it is the responsibility of the involved regional directors to request such transfer of Bureau of Aging and Adult Services.

5. Any new bed allocations will be based on the region's proportion of the population age 60 and older.

B. Congregate Care - Mental Health Program.

1. The Mental Health Division allots to each region the number of CCF - Mental Health beds.

2. In all procedures relating to increases or decreases of mental health beds the initial and primary contact will be with the Director of the Regional Office in whose area the Congregate Care Facility is located. The Regional Director, in consultation with the Regional Mental Health Representative, is responsible to approve all such bed allocations occurring within the region.

3. When decisions to transfer mental health beds between regions occur, it is the responsibility of the involved Regional Directors to notify the Mental Health Division concerning such planned transfers. Approval of inter-regional transfers rests with the Mental Health Division and is required prior to such actions.

C. Alcohol and Drug Abuse Congregate Beds

The Bureau of Alcoholism and Substance Abuse determines the number of contracts and the level of patient days.

46.40 CCF Contract Negotiation

A. Prerequisites for a congregate care contract

1. A facility must have a valid boarding home license or be licensed as a private establishment (alcoholism treatment facility) in order to obtain a congregate care contract. Application for these licenses may be made to the Health Services Division, Licensing and Development Section, MS LJ-18, Olympia, WA 98504.

2. A nursing home license is not acceptable for a congregate care contract.

3. Publicly operated alcoholism treatment centers receive a letter of certification in lieu of licensing. The letter of certification is issued jointly to the facility by the Health Services Division, Licensing and Development Section and the department's Bureau of Alcohol and Substance Abuse, MS OR-44W, Olympia, WA 98504.

4. In addition to a boarding home license, drug treatment facilities must be certified by the department's Bureau of Alcohol and Substance Abuse, Olympia.

SS Manual - 1876
David v.

SS Manual - 1877
David v.

B. Application

1. The CCF operator wishing to serve Regular or Mental Health clients contacts the CSO service staff to apply for a CCF contract. (If the contract is for alcoholism or drug abuse, the operator shall be referred to Bureau of Alcohol and Substance Abuse Regional staff.)

2. The service worker shall:

   a. Establish a case record for the facility according to local procedures.

   b. Visit the facility. Use DSHS 9-571 D or E Congregate Care Contract Compliance form to evaluate potential compliance with terms of the contract.

   c. Determine that the operator will have adequate supervisory staff on premises at all times.

   d. Discuss the CCF contract with the operator. If there is evidence the facility cannot comply with terms and conditions, note that on the DSHS 9-571 D or E and give a copy to the operator, with a follow-up visit planned.

   e. Explain use of DSHS 15-31(X), Notice of Action-Adult Residential Services.

C. Contract Approval

1. Regional office approval is based upon the CSO recommendation and the determination of need within the lid. If the operator decides to pursue a contract, the service worker will have the operator sign two copies of the DSHS 9-571(X), Congregate Care Facility Contract.

2. The CSO recommendation regarding approval is indicated in a cover letter to the Regional Office. The DSHS 9-571(X), along with completed DSHS 9-202(X), Contract Processing Action Request form, unsigned, are forwarded to the Regional Office for signature.

3. Regional Director or designee signs the DSHS 9-202(X) and mails it to DSHS Headquarters Contracts Office if these beds are within the allocated level.

4. When the signed copy of the CCF contract is returned to the CSO, it should be filed in the facility service record.

5. A signed copy of the contract is sent directly to the CCF operator by the Contracts Office, with a copy to BAAS or MHD State Office program manager.

6. Payment for residential care may not be authorized until SO Contracts Office has processed the contract.

7. Alcohol and drug abuse contracts are the responsibility of the Bureau of Alcohol and Substance Abuse.

D. Contract Denial

1. The service worker shall explain the reason for the CCF-Regular and Mental Health contract denial to the operator.

2. If after the explanation the operator still wishes to sign the contract, the service worker routes all forms to the Regional office with an explanatory memorandum.

3. If the operator withdraws the application, no further action is required by the CSO.

4. Denial letter is sent to the applicant if request is denied.

E. Contract Renewal

1. The CSO service worker has the responsibility of preparing CCF Regular and Mental Health contracts for contract renewal for submittal to the contract office sixty days prior to expiration.

2. If periodic monitoring has shown adequate care has been provided to the department's CCF clients and funding is available, the contract may be renewed.

3. If resident care has been inadequate, contract compliance has been irregular, multiple stop-placements have been imposed, etc., the service worker should proceed as under Termination of Contract. (See 46.42 C. and TERMINATION and TERMINATION PROCEDURES on the DSHS 9-571(X).)

4. Contract renewals are to be submitted by the CSO service staff via Regional Office to the Contracts Office 60 days prior to the contract expiration for timely renewal. Contract renewals and routine changes should be accommodated by utilizing DSHS 9-303(X), Contract/Grant Amendment Modification or Change Order form.

5. If the facility chooses not to renew the CCF Contract, the provider must let the CSO staff know 60 days prior to the proposed termination.

46.41 AFH Contract Negotiation

A. CSO service worker determines that the home has a current AFH license.

B. CSO service worker reviews terms and conditions and statement of work with the sponsor.

C. DSHS 9-73A(X), Annual AFH Contract Compliance Review, is completed to determine the sponsor is in compliance with the contract terms and conditions. If there is evidence of deficiencies, these are to be noted on the DSHS 9-73A(X) and a follow-up visit scheduled. Enter sponsor name in the upper right-hand corner of the DSHS 9-73A.

D. If the sponsor meets the terms of the contract, the sponsor is asked to sign the DSHS 9-73(X).

E. The DSHS 9-73(X) and the completed DSHS 9-202(X) is forwarded via regional office to SO Contracts Section for Department signature prior to the sponsor providing services to the Department's clients.

F. CSO service worker arranges for AFH sponsor training if required. See Manual G, 46.16 B.

46.42 Contract Monitoring CCF/AFH

A. CCF/AFH contractor's compliance with contract terms will be monitored at least annually by a visit to the facility.

1. DSHS 9-571 D or E or DSHS 9-73A(X) will be used. Copy to the contractor, copy to facility file. Enter facility name in the upper right-hand corner of the DSHS 9-73A or DSHS 571 D or E.

2. Contractor not in compliance with terms of the contract will develop a corrective action plan entered on the DSHS 9-571 D or E or DSHS 9-73A with a compliance date.

3. Follow-up visit(s) regarding noncompliance will be made on the compliance due date.

4. Contractor not in compliance following the planned date will receive a letter requesting compliance.

5. Facilities failing to comply with terms of the contract shall be reviewed with the Regional Office, Contracts Officer and SO CCF/AFH Program Manager to determine whether stop-placement and/or termination of contract is indicated.

B. Stop-Placement

1. When a contractor is not meeting the terms of the contract, the CSO administrator shall effect stop-placement of departmental clients until the facility complies or a decision is made to terminate the contract.

2. A letter shall be sent to the contractor outlining the reasons for and duration of the stop-placement. A copy of the stop-placement notification letter shall be sent to the Regional Director and to the SO CCF/ AFH program manager.

SS Manual - 1879
David v.

3. Stop-placements take effect immediately and do not require relocation of clients in the facility.

4. Stop placement shall be initiated only when evidence of noncompliance has been obtained and there is no plan for prompt return to compliance.

5. When the contractor provides evidence of compliance, the stop-placement will be lifted by letter to contractor, regional office and SO CCF/AFH program manager.

C. Termination of Contract

Noncompliance which is not rectified shall require review by the Regional Office, Contracts Officer and SO CCF/AFH Program Manager, to determine whether contract termination shall be instituted.

1. When it is deemed necessary to terminate a CCF/AFH contract, the CSO shall follow procedures for TERMINATION and TERMINATION PROCEDURES on DSHS 9-571(X) or DSHS 9-73(X), and

   a. Notify the SO CCF/AFH program manager via the regional office of the agreed upon action.

   b. Submit a memorandum of the facts leading to the action via the Regional Office to the SO CCF/AFH program manager and contracts officer.

   c. Coordinate via the Regional Office all actions concerning the termination or nonrenewal of the contract with the SO CCF/AFH program manager and contracts officer.

2. When the contractor decides to terminate the contract, the same procedures as in 1. above will be followed.

D. Monitoring of alcohol and drug facilities is the responsibility of the Bureau of Alcohol and Substance Abuse.

E. The monitoring of facilities is designed to ensure that CCF/AFH contract terms, conditions and stipulations are met. Monitoring also includes ensuring that complaints concerning facilities in the catchment area are dealt with promptly, and that any departmental actions specific to CCF/AFHs are handled promptly.

F. If the AFH is not providing the special services authorized, the payment shall be reduced and the client relocated as soon as possible.

G. If it appears a resident is being abused or neglected, an Adult Protective Service investigation shall be arranged.

46.43 AFH Licensure

See procedures outlined in Manual G, Chapter 06.

46.44 Selection of Facility

The individual or person acting in his or her behalf will select the facility at the level of care the department has authorized. When the facility has agreed to accept the person:

A. Individuals who had requested residential placement while at home or in the hospital having been admitted from home will notify the CSO/DDD service worker of the facility selected. The service worker will complete DSHS 14-154 authorizing service.

B. Residents of nursing homes as private patients who need nursing home payment through DSHS will have their presence reported to the Department by the facility submitting DSHS 15-31(X) to the CSO financial sections and NCC along with a financial application. See Manual G, 46.15(D)(3)(b).

C. Hospitalized Medicaid NH residents returning to a Title XIX certified NH will have their readmission reported by the NH submitting DSHS 15-31(X) to the CSO financial section and NCC. See Manual G, 46.15(D)(3)(c).

46.45 Placement Outside Catchment Area

A. CSO/DDD service worker authorizing placement outside the CSO catchment area shall alert the CSO in the other catchment area to obtain approval of the placement:

   1. Confirmation of CCF bed use (regarding lid) will be obtained prior to placement authorization.

   2. Confirmation that the facility is not in decertification or stop-placement action will also be obtained.

B. Authorizing office will complete all financial and social services paperwork relative to the placement prior to case record transfer. Authorizing office requests transfer of record to receiving offices even though the record may be in a third office: For example, Olympia has the person for placement in Tacoma, but the case record is in Elma. Olympia contacts Elma and has them transfer record to Tacoma and transfers Olympia's record to Tacoma.

C. The case is transferred as an active case.

D. For alcohol treatment placement, see Manual G, 46.52; for drug treatment placements, see Manual G, 46.53.

46.46 Nursing Home Discharge Allowance

The discharge allowance with a maximum of $400, is a one-time payment to the nursing home client ready for discharge or to his /her representative payee. It is authorized as follows:

A. The CSO/DDD service worker assesses the need for the discharge allowance.

1. DSHS-funded clients are clients whose nursing home care costs are paid for by either Medicaid or the state-funded medical program.

2. A client is determined ready for discharge when the CSO/DDD receives a copy of the letter from the NCC indicating client no longer needs nursing home care.

3. Clients who have not yet been determined as not in need of NH care but who indicate a desire to leave the NH and who can manage in their own home with in-home services may also be considered for the allowance. Contact the NCC and NH staff to discuss discharge planning.

B. For clients who can return to independent living with or without support of in-home services, the CSO/DDD service worker reviews eligibility for the discharge allowance with the client or his/her representative and obtains his/her/their agreement to leave the NH. Eligibility criteria:

1. Client cannot have an existing independent residence.

2. Client must not have a spouse or dependent living in an independent residence to which the person could return.

3. Client may have no more than $600 in cash or liquid resources. Liquid resources are financial instruments which can be converted to cash within 30 days at face value such as, but not limited to, stocks, savings, checking accounts, mutual funds shares, mortgages or promissory notes.

4. No payment may be made to clients who do not meet all the above criteria without an Exception to Policy approved by BAAS. Approval by BAAS is also necessary to pay a discharge allowance to cover reasonable needs of the client whose relocation expenses are not identified at the time of discharge or whose relocation expenses are met with exempt cash resources.

C. The client or his/her representative payee or relatives have primary responsibility for locating housing and determining what housing supplies are needed. CSO/DDD service workers will refer clients when necessary to I & A workers or Mental Health Clinics, other community agency staff, or volunteers for help in locating and arranging housing.

D. Discharge allowance is available to people who will be living alone in houses or apartments, to couples who could both leave the NH, and to individuals who plan to share housing and expenses equally with other adults.

E. After housing is located, the CSO/DDD service worker must determine the cost of obtaining the housing and the need for requested housekeeping supplies.

SS Manual - 1882
David v.

1. Such costs may include those directly relatable to obtaining an independent living situation, such as damage or utility deposits, furniture, purchase of initial supply of bedding, towels, kitchen utensils, toilet articles and food to last through the end of the month of discharge. It is not necessary to obtain exact cost of each sheet, blanket, or spoon, etc., for each individual client.

2. If two individuals being discharged from a nursing home plan to share housing, each can be issued a discharge allowance.

F. After computing the total costs, determine the amount of discharge allowance to be paid.

1. If the client's cash resources are between $0 and $300, authorize the actual cost not to exceed $400.

2. If the client's cash resources are between $301 and $400, authorize the actual cost not to exceed $300.

3. If the client's cash resources are between $401 and $500 dollars, authorize the actual cost not to exceed $200.

4. If the client's cash resources are between $501 and $600 dollars, authorize the actual cost not to exceed $100.

If expenses exceed the amount allowable, clients must meet the additional costs from their own resources. For example, if the cost of obtaining housing is $430 and the client has $400 in cash resources, discharge allowance would be $300. The client will use $130 of his/her own money to obtain housing.

G. Complete DSHS 14-154(X)/159, Social Services Authorization/Change of Service Authorization, to authorize payment. Use SSPS Service Code 4642, NH Discharge Allowance.

1. In items 7, 9, 10 and 11, enter the name and address of the client or representative payee.

2. In item 8, enter the provider number assigned to the client or representative payee. (According to local office procedure, if a provider number has not been assigned previously, complete a DSHS 6-97, Provider File Action Request, and obtain a provider number.)

3. In special instructions section, enter the specific cost items and amounts, i.e., "damage deposit - $50.00, utility deposit - $25.00, kitchen utensils - $35.40, total $110.40, client resources equal $435.00." This list is to be entered on the A-19 when it is completed.

4. Obtain supervisor's signature on lower portion of special instruction section.

5. Route copy to clerk for completion of A-19. Send a photocopy to financial services marked "Financial" in bottom of form if client is applying for financial assistance or food stamps.

6. Give a copy to client/representative payee as notice of authorization of the discharge allowance.

H. Completion of A-19

1. Request clerical to complete an A-19, Invoice Voucher, in four copies, entering discharge allowance items, and return all copies to the service worker.

2. When A-19 is completed and returned:

   a. Check for accuracy.

   b. Enter case number above section F.

   c. Enter "approved by" and sign section F.

   d. Have client or representative payee sign section D.

3. Send original and two copies to Bureau of Aging and Adult Services, OB-43G, Olympia.

   a. Indicate the expected date of discharge in the upper right-hand corner.

   b. If the client needs the money earlier than within seven working days, write "RUSH" on the routing slip to expedite payment.

4. File the last copy in record.

I. When the client receives the discharge allowance, provide for further assistance as needed with his/her relocation as was agreed upon initially.

46.47 Nursing Home Income Exemption

If nursing home care is needed, the CSO/DDD service worker shall determine the client's need and eligibility for an income exemption for housing maintenance.

Short-term residents of nursing homes may retain up to $180 per month (in addition to the CPI) as an income exemption to maintain an existing home if the resident has no spouse or dependents able to maintain the home. The physician must certify that such individuals will be able to return home within 6 months.

SS Manual - 1884
David v.

A. All clients placed in nursing homes must be reviewed against the following criteria:

1. The client lives alone.

2. The client has income in excess of the CPI that will not be reduced if he/she resides in the nursing home (SSI benefits are reduced to $25 the first full calendar month of residence in a Title XIX facility).

3. The doctor has certified that the client will remain in the nursing home for no more than six months from the first of the month following date of admission or the date of eligibility for individuals changing from private to Medicaid eligibility.

B. If criteria 1 or 2 are not met, continue with regular placement procedures.

C. If criteria 1 and 2 are met, and criterion 3 is not met, because no prognosis has been made, contact the physician for certification of the length of time the client will need nursing home care.

D. If the physician anticipates that the client will be unable to return home within six months, continue with regular placement procedures.

E. If the physician certifies the client can return home in six months, determine if the home can be retained without authorization of income exemption. If not, discuss the nursing home income exemption program with the client.

1. Explain the eligibility factors, stressing the income exempted must be used to maintain the existing residence.

2. Determine the cost of retaining the home.

a. List expenses which must be paid (rent, mortgage, taxes, insurance, utilities, etc.).

b. Verify the amount of the expenses by checking the financial application and/or making confirming calls to landlord, utility companies, etc., as necessary.

c. If the expenses vary from month to month, figure a total for the six months and allow 1/6 of the total cost each month.

3. Complete the amount of income the client may retain.

a. Subtract the allowance for CPI from the total income first.

b. Subtract the amount of the cost of maintaining the residence up to $180 from the remaining income. The rules limit the exemption to $180 per month.

c. If the cost exceeds $180 (or the client's income), assist the client in negotiating acceptance of the available amount with landlords, utility companies, and etc.

F. Use DSHS 14-154(X)/159, Service Code 4643, NH Income Exemption, to authorize nursing home income exemption. In the special instructions section, list the monthly expenses allowed and enter the total amount, not to exceed $180 in sections 41 and 43. Mark "Financial" on the bottom of a copy of the form and send to financial services.

G. At the end of the first three month's authorization, review to determine if long-term care is necessary or continued need for income exemption exists. If need exists, reauthorize for the additional time needed, not to exceed a total of six months.

1. Review the client's medical status on DSHS 13-336(X), Client Profile, which will provide information to assist in determining the client's need for continuing care.

2. If the necessary medical information is not available, contact the NCC to have DSHS 13-395(X), Interim Review, and or 13-336(X) updated.

H. If the client requires long-term care or will not leave the nursing home within the required six-month period because of gross deterioration of client's condition or other changes in circumstance, advise the client the income exemption will be terminated effective the first of the month following determination or receipt of the information.

1. Send Financial a copy of DSHS 14-159, entering appropriate termination code and mark "Financial" on bottom of form. Enter the date income exemption is to cease as the end date in Item 33. (Send a copy to the Bureau of Aging and Adult Services, MS OB-43G.)

2. Financial will change the participation amount and send a new award letter to the client and the facility operator.

3. Send nursing care consultant a copy of DSHS 14-159 with termination information on it and mark "NCC" on bottom of form.

I. When the client is discharged from the nursing home to an independent living situation, the income exemption ceases.

1. If the client is discharged to a hospital or another medical facility, the income exemption continues and the six-month time limit is still in effect.

2. If the client is discharged to an AFH, the income exemption ceases the first of the month following the move.

J. Special Circumstances.

1. If the client has reasonable expenses which are not listed above or exceed $180 a month, but are within the purpose of income exemption program, and the client has no way to meet the need, an Exception to Policy (ETP) may be requested. The request must include a complete explanation of why the ETP is being requested.

2. No exception can be made to the nursing home residence requirement, the six-month time limit or the need for a physician certification, since these requirements are specified in state law or federal regulations.

   NOTE: The six-month time period is consecutive, not cumulative.

3. If the client has no income which can be used for income exemption and has no other way to retain his/her independent living situation, a prepaid discharge allowance may be granted. The allowance may not exceed $180 a month and the total amount, during the short-term stay may not exceed $400 (same as the nursing home discharge allowance).

K. Overpayment.

Eligible clients are required to use the money retained to maintain their existing residence. Failure to do so constitutes a medical assistance overpayment.

1. Social service staff must advise CSO financial staff immediately when eligibility ceases because the client will not leave the nursing home within the six-month time limit.

   NOTE: A change in the client's medical condition during the six-month period which prevents discharge from a nursing home does not cause the income exemption to be considered an overpayment if the income exemption is terminated the first of the month following notification of a change in condition.

2. Social service staff must also advise CSO financial staff of any information indicating the client has not used the income exemption for housing maintenance and the source of the information.

3. Financial will notify the client of the change in participation amount and the existence of any medical assistance overpayment.

46.48 Social Leave and Medical Leave

A. Nursing Home.

SS Manual - 1887
David v.

1. Social leave

   Allowable social leave is a total of 18 days per calendar year.

a. Social leaves in excess of 24 hours will be reported by the facility to the CSO and will be counted in the 18-day total.

b. Social leaves in excess of 36 hours require CSO approval of the patient care plan and will be counted in the 18-day total.

c. A single social leave in excess of seven days at one time requires written approval from the CSO for the provider to be reimbursed for the bed and will be counted in the 18-day total.

d. An Exception to Policy shall be requested if social leave is in excess of 18 days per calendar year.

2. Hospitalization

a. There is no reservation of NH beds for patients admitted to a hospital. While DSHS does not pay for reserved NH beds, relatives may do so if they wish.

b. NH placement authorization is not required for the readmission of a Medicaid eligible patient returning to a Title XIX certified facility from hospitalization. These patients do not require a service worker to tentatively reclassify. DSHS 15-31(X) submitted by the facility will provide notice to financial services and the NCC. Hospital discharge planners will ensure persons requiring SNF care are discharged to dual certified facilities.

c. When a facility is pending decertification, termination, or nonrenewal of contract, readmission is prohibited.

B. Congregate Care/AFH

1. When a client for social reasons is to be absent from the facility for more than 72 hours, Contractor shall enter written justification of such absence in the client's chart. The chart shall be available in the facility for audit purposes. Discharge and readmission of the client shall not be necessary for documented, justified absences not exceeding 14 days at a time. Social leave in excess of 14 days in a row shall require written Department approval.

2. For CCF Regular/MH and AFH clients, discharge and readmission of the client shall not be considered necessary for brief hospitalization not exceeding seven days. Absence shall be documented in the client's chart.

3. For alcohol and drug clients, all leave up to 72 hours is allowable if documented and consistent with the client's treatment plan. Leave in excess of 72 hours, whether for social or medical reasons, shall require written approval from the Bureau of Alcohol and Substance Abuse.

SS Manual - 1888
David v.

SS Manual - 1889
David v.

46.49 Community Nurse

A. Community Nurse Role

1. The community nurses are an addition to casework staff in selected, more populous areas of the state. They are a part of the Region/CSO staff and report as designated by the Regional Office. When appropriate, they function as part of a local client assessment team for adults requesting residential services. Duties focus on preplacement screening through assessment of a client's physical, mental, psychosocial and environmental resources and needs.

2. With the client's consent, assessment information is shared with appropriate agencies and individuals, i.e., physicians and family members as well as CSO and I & A staff involved with the client. determine the appropriate level of care or mix of services if nursing home is not appropriate.

3. The service worker will make the final determination as to the client's service needs and arrange for the appropriate community or residential services to be provided. The community nurse also assesses need of state mental hospital referrals for congregate or adult family home care.

B. Procedures

1. Determination of Client Need

   a. When a community or hospital request is made for nursing home care, or a service worker requests an assessment for other residential services, the CN will assess the client's needs face to face or participate in a face-to-face team assessment. Based on this assessment, the client, the client's family and the CN/I & A/service worker will participate as part of the team in the decision on the appropriate level of care and mix of services.

   b. Final determination of services to be authorized lies with the service worker. However, if the CN has determined that the client does not need nursing home care, the service worker must arrange some other combination of services. If this is impossible due to a lack of needed resources, a staffing will be arranged with the supervisor to determine the most appropriate action. Persons not requiring nursing home care shall not be placed in nursing homes.

2. Use of Comprehensive Adult Assessment Form

   The CNs will use the DSHS 14-192(X), Comprehensive Adult Assessment form, as the basic assessment tool. The CN will retain a copy and will forward the remaining copies to the adult services worker for use in completing the placement/service planning. The client will be given a copy of the DSHS 14-192(X) unless it has been determined that providing a copy would be detrimental to the client.

46.51 Case Recording

Use of DSHS 14-192(X) and and 14-192A(X), DSHS 9-571D(X) and E, and DSHS 9-73B(X) should be noted on the DSHS 2-305, Service Episode Record, for assessment, annual review and contract monitoring contacts. It is not necessary to transfer information from these forms onto the SER. Enter on SER - "See (form number) of (date) .

46.52 Alcoholism Referrals

A. The service worker will determine eligibility for Title XX-SSBG services on a DSHS 14-139(X) provided by the Community Alcoholism Counselor, and authorize services on the DSHS 14-154(X) or 14-159. No DSHS 14-192(X) is required.

B. The CAC will evaluate the client's need for treatment, and

1. Enroll the client in an outpatient treatment program at the CAC; or

2. Refer the client to an appropriate residential treatment facility; or

3. Assist in placing the client in a detoxification facility;

4. Provide a letter substantiating the need for CCF alcoholism treatment to the CSO service worker.

C. When a client needs/requests financial/medical assistance for detoxification or residential treatment program, the CAC worker will refer the client to financial services for an eligibility determination.

46.53 Drug Abuse Referrals

A. The service worker will determine eligibility for Title XX SSBG services on a DSHS 14-139(X) provided via the Drug Professional and authorize services on the DSHS 14-154(X) or 14-159. No DSHS 14-192(X) is required.

B. The Intake and Referral agency will evaluate the client's need for treatment, and

1. Enroll the client in a certified outpatient drug free treatment program, or

2. Refer the client to a certified residential treatment facility, or

3. Refer the client to a methadone maintenance or detoxification program.

4. Provide DSHS 14-139 and letter substantiating need for those requiring CCF-Drug Treatment.

SS Manual - 1890
David v.

C. When the client needs/requests financial/medical assistance for a methadone or residential treatment program, the service worker will refer the client to financial services for an eligibility determination, providing assistance, if necessary.

46.54 Title XIX Facility Inspection of Care

At the request of BNHA, CSO social worker or service worker with Bachelor's Degree in Social Work will participate as a member of NCC/Social Worker Inspection of Care Team only for inspections in which the NCC has reason to believe the facility is not providing appropriate social services. If indicated, the CSO service worker team member will offer necessary consultation to the Title XIX facility to support the facility's compliance with Title XIX social service responsibilities.

46.55 DSHS 14-154/159, Authorizations for New Nursing Home Clients

A financial eligibility determination must be made prior to social service authorization. If financial services are not able to generate an award letter within three days of placement authorization, the following procedures apply. To allow the DSHS 14-154/159 to be used for nursing home billing purposes, the service worker, after completing the DSHS 14-154/159(X) in the usual manner:

A. Determines the appropriate tiebreaker (Item 28) based on information contained on the financial service SEL and PEL terminal printouts.

B. Obtains the medical (MMIS) match code from Financial Services and enters it in the Special Instructions Section.

C. Enters in the special instructions section, the following information obtained from financial:

"Beginning (date) _____,

Nursing home collects all monthly income except $_____.

Source(s) of income are _____."

D. Enters in special instructions section, the level of care and placement dates:

1. "Level of Care -- SNC or ICC.

2. Placement effective _____ through _____."
(For end date, enter last day of third full month following effective date.)

E. Routes copies of the DSHS 14-154, Social Service Authorization, to the client, financial service and the vendor. For clients not on assistance, a copy is sent to CSO input-edit clerk who will input computer data to establish an interim eligibility file.

F. Financial submits DSHS 7-01, Certification and Computation of Grant, and completes award letter.

G. Nursing home may bill (for a maximum of four billings) attaching the DSHS 14-154(X) until the financial award letter is received.

H. Provider services will honor the DSHS 14-154 as interim award letter for up to four billing periods.

46.56 Referrals from State Mental Hospital

A. Referral of Medicaid clients for nursing home placement assessed by the Bureau of Nursing Home Affairs Nursing Care Consultant:

1. Person requires nursing home care

   a. Mental hospital arranges nursing home admission for persons financially eligible.

   b. Nursing home submits DSHS 15-31(X) to CSO financial and service worker serving the hospital's catchment area and to the nursing care consultant.

   c. Upon receipt of the DSHS 15-31(X), the service worker completes DSHS 15-154/159(X) as per Manual G, 46.55.

2. Person does not require nursing home care, but needs CCF/AFH

   a. Nursing care consultant forwards copy of DSHS 13-02(X), Medical Review Form, to CSO service worker for mental hospital.

   b. CSO service worker completes DSHS 14-192A.

   c. CSO service worker authorizes admission on DSHS 15-154/159(X) if person is eligible and requires CCF/AFH care.

B. Referrals for CCF/AFH - No nursing care consultant assessment:

1. Community nurse interviews client and assesses need using DSHS 14-192(X). See Manual G, 46.31-46.33.

2. If community nurse assesses the person for AFH/CCF and believes nursing home care is required, the community nurse shall consult the nursing care consultant prior to completing the DSHS 14-192(X).

46.57 Special Placement Services for Hard-to-Place Mentally Ill Clients

A. The state mental health institutions have a group of chronically mentally ill clients, usually termed hard-to-place, who have obtained maximum benefit from institutional care but are not accceptable in usual placement resources because of their behavior or special care problems. Because placement is so difficult, these clients usually remain in the institution. Failure to obtain an appropriate placement may be due to any one or a combination of the following factors:

1. The nature of the mental, emotional, and behavioral problems is such that the client is regarded as unacceptable for any of the regular placement alternatives.

2. Physical problems complicate care for the client.

3. Other functional limitations of the client make the client unacceptable for placement in available resources.

B. In an effort to develop placement possibilities for such clients in adult family homes and mental health congregate care facilities, a special fund has been set aside to pay for added, special services which may be necessary.

1. When such clients are being considered for placement, the following procedures are to be followed:

a. In coordination with the placement resource and the client (where possible), the institutional representative (usually a social service staff member) should develop a plan, defining specific special services which will be required.

b. Once the placement plan has been developed, the local Community Services Office (CSO) should be notified and a Contract Processing Action form (CPA) filled out appropriately indicating the contract amendment to be made. It should be indicated that attempts to place the client through regular channels have failed. Documentation regarding the specific placement efforts which have failed should be indicated in the attached exhibit.

c. In addition to identifying data and regular statement-of-work information, the CPA should describe in an attached exhibit the special elements of service to be provided, including justification, and a monthly cost for each of these services, with justification.

d. Special rate amendments to contracts will be awarded for a period of six months. Prior to the end of each contract period, a review of the case is to be conducted by appropriate staff. If contract continuation is justified, such continuance should be requested stipulating any indicated changes or modifications.

2. When the CPA is developed and approved by the CSO, it should be signed and mailed to:

   Administrator
   Adult Residential Programs
   Mental Health Division OB-42F
   Olympia, Washington 98504

   Following appropriate review and approval by the BAAS Adult Family Home Program Manager, Mental Health Division will initiate a contract amendment and assure that appropriate billing and payment procedures are in place.

3. When the amended special rate contract is approved, it will be processed and returned to the contractor. Directions concerning any special billing procedures will be attached. Copies of the final contract will be forwarded to the Mental Health Division and to the Adult Family Home Program Manager, Bureau of Aging and Adult Services, OB-43G, Olympia, WA 98504.

   a. If the placement is successfully implemented, a statement of monthly billing for special services is to be forwarded to Mental Health Program Manager for further processing.

   b. If the additional services or costs become necessary, prior approval from the Mental Health Division is required.

   c. During the placement period, contracts must be amended to reflect any increase or decrease in services and/or service costs.

   d. Mental Health Division shall be promptly notified in writing when such placements terminate, including the reason for termination.

4. Funds are limited as we do not anticipate that a great number of such special rate placements will occur or be approved. In all such instances, it is important that placement attempts through regular channels have been exhausted.

46.97 INTERFACE WITH OTHER DSHS SERVICES

A. In carrying out the plan for residential placement, the CSO or DDD service worker shall confer or coordinate with:

   1. The CSO financial service section responsible for determining financial eligibility prior to placement.

   2. CNs to develop a plan of care appropriate to the client's needs.

   3. Aging Information and Assistance workers when receiving first-time placement requests from persons age 60 or older.

4. DDD/CSO Services when appropriate.

5. The CSO medical consultant when appropriate.

6. BNHA as it relates to NH facilities in negative action, patients requiring discharge or relocation services.

7. Operations Review regarding program audits.

B. In monitoring the Regular and Mental Health CCF Contract, the CSO service worker shall confer or coordinate with:

1. The Community Mental Health Center (CMHC) to verify that the CCF-CMHC contract is signed and utilized by CCFs receiving the special rate for MH clients.

2. The SO CCF program manager(s) regarding special program problems and fiscal issues after obtaining regional clearance.

3. Health Services Division Licensing staff to report evidence of problems of CCF compliance.

C. DDD when placing into SNF or ICF will coordinate with BNHA.

D. The CSO or DDD social service worker will keep licensing staff informed of their observations of the maintenance of licensing requirements and the treatment of persons placed. The licensing staff will maintain this information on the DSHS 10-07(X), Family Home Card, for placement staff use (see Chapter 06).

46.98 INTERFACE WITH NON-DSHS SERVICES

Among other services the CSO service staff shall use as resources in implementing a plan of care are:

A. The local aging network for those services provided by contract through the Area Agency on Aging. These services may include information and assistance, nutrition services (i.e., meals on wheels, congregate meals), health screening, etc. Information and assistance workers should be contacted regarding assessment of first-time referrals if the client is 60 years of age or older.

B. Local hospital discharge workers to facilitate movement of an individual from the hospital to the least restrictive placement.

C. Social Security Administration to assist clients in application/coordination of SSI/SSA.

D. Veterans' Administration for financial, medical and/or rehabilitative services.

E. Public Health Services including but not limited to visiting nurse services, speech therapy, physical therapy and Home Health Aide. The scope of services offered may vary from community to community.

F. Community Alcoholism Center and Drug Abuse professionals for referral purposes.

G. Other community resources for those services not available or funded through public agencies. These may include (but are not limited to) senior citizens centers, Senior Companion Program, Retired Senior Volunteer Program (RSVP), medical community (i.e., doctors, clinics, etc.) transportation services (i.e., ambulance, transportation exchange, etc.), church and service organizations.

46.99 REQUIRED FORMS AND INSTRUCTIONS

A. See Chapter 99, General Forms, for instructions on these generic forms:

DSHS 2-305(X) Service Episode Record (12/79)
DSHS 2-306(X) Communication/Referral (Rev. 9/78)
DSHS 2-306A(X) Communication/Referral Page 2 (Rev. 9/78)
DSHS 7-01(X) Certification and Computation of Grant (Rev. 5/81)
DSHS 14-139(X) Social Services Application (Rev. 12/79)
DSHS 14-154(X) Social Services Authorization (Rev. 3/78)
DSHS 14-159 Change of Service Authorization (Rev. 12/79)

B. The following program specific forms and instructions are included in the remainder of this chapter. Forms used by the CSO/DDD worker and the Information and Assistance worker to assess need for and verify placement; or by AFH, CCF or NH to notify CSO of action regarding a specific client are:

DSHS 9-202(X) Contract Processing Action Request (Rev. 6/80)
DSHS 14-192(X) Comprehensive Adult Assessment (Rev. 2/82)
DSHS 14-192A(X) Annual CCF/AFH Client Reeligibility Review (5/82)
DSHS 15-31(X) Notice of Action - Adult Residential Services (Rev. 5/82)
DSHS 15-134(X) Chore Services Waiver Request (8/81)

C. The following forms are specific to AFHs.

DSHS 9-73(X) Adult Family Home Personal Services Contract (6/80)
DSHS 9-73A(X) Annual AFH Contract Compliance Review (5/82)
DSHS 9-464A(X) Statement of Work-Adult Family Home Sponsor Contract (6/80)
DSHS 9-464B(X) Adult Family Home Special Terms and Conditions (5/81)

SS Manual - 1896
David v.

D. The following forms are specific to CCFs.

DSHS 9-303(X)	Contract/Grant Amendment Modifications or Change Order Form (3/81)
DSHS 9-571(X)	Congregate Care Facility Contract (11/81)
DSHS 9-571A	Statement of Work - Regular CCF (1/82)
DSHS 9-571B	Statement of Work - Mental Health CCF (2/82)
DSHS 9-571C	Statement of Work - Alcohol and Drug Client (8/82)
DSHS 9-571D	Annual Congregate Care Contract Compliance Review - Regular Program (6/82)
DSHS 9-571E	Annual Congregate Care Contract Compliance Review - Mental Health Program (6/82)
DSHS 15-124(X)	CCF - Individual Service Plan (10/78)

E. The following forms are completed by the NCC for nursing home placements and reviews. Copies will be forwarded to the CSO when the client requires relocation or discharge. A copy of each form is included in this chapter for information only.

DSHS 13-336	Client Profile (Rev. 12/78)
DSHS 13-395(X)	Interim Review (3/79)

F. The following forms are specific to COPES:

DSHS 14-225	COPES Individual Plan of Care (6/83)
DSHS 14-227	COPES Provider Agreement (4/83)

SS Manual - 1898
David v.

DSHS 9-73(X) (6/80), ADULT FAMILY HOME-PERSONAL SERVICES CONTRACT - SHORT FORM

Instructions

A licensed facility that wishes to serve adult family home residents who are department clients must have a contract with the department. The contract is the legal basis for the sponsor to be paid by the department. The contract must be completed and signed by the adult family home sponsor and the department's contracting officer before the sponsor provides services to department clients. The contract, entitled Personal Services Contract (Short Form) is the contract form the department uses to obtain family home services for clients. This contract can be effective for up to two years.

The contract consists of four parts:

1. Page one of DSHS 9-73(X) contains ten numbered paragraphs plus signature lines.

2. The "general terms and conditions" of the contract are set forth in pages two through four of DSHS 9-73(X).

3. DSHS 9-464A(X) is the statement of what work the contractor may be called upon to perform.

4. The "special terms and conditions" are in DSHS 9-464B(X).

Instructions for filling out page one of the DSHS 9-73(X) are:

Paragraph 2: Insert the names of the adult family home sponsor in the blank.

Insert the address of the family home sponsor. Insert the sponsor's social security number in the appropriate box. Most sponsors will not have a Washington Tax Registration Number.

Paragraph 3: Insert the following language:

As defined in contract attachments "Statement of Work for Adult Family Home Sponsor Contract" DSHS 9-464A(X) and "Special Terms and Conditions for Adult Family Home Sponsor" DSHS 9-464B(X).

Paragraph 4: The effective date of the agreement is the day the contracting officer signs the contract. This is usually about two weeks after the completed form is forwarded to the contracts management section.

If the program representative needs expedited service in order for a particular contract to be in effect earlier, this should be noted in a cover memo accompanying the contract when sending it to the contracts management section.

DSHS 9-73(X) (6/80), ADULT FAMILY HOME-PERSONAL SERVICES CONTRACT - SHORT FORM (cont.)

Instructions

The second blank should contain the ending date for the contract. This should be the day the parties agree on but never more than 24 months from the effective date of the contract. Note that a new contract can be signed to continue the relationship when this contract ends if the parties wish to do business a second contract period.

Paragraph 5: Insert N/A in blank space.

Paragraph 6: Insert the following language:

"At the rates set forth in the most recent schedule of rates which the contractor shall have filed with the department in accordance with department instructions; EXCEPT, that the rates paid shall not exceed those maxi= mum rates established and published by the department.

Fill in the blank at the end of the sentence directly below the boxed-in section with the total dollar sum you expect to pay the sponsor for services to clients during the period the contract will be in effect.

Make no changes in DSHS 9-73(X) without discussing the change with the Contracts Management Section.

DSHS 9-73(X) (6/80), ADULT FAMILY HOME-PERSONAL SERVICES CONTRACT - SHORT FORM

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

PERSONAL SERVICES CONTRACT
(Short Form)

CONTRACT NO. .....

1. *THIS AGREEMENT made by and between the State of Washington's Department of Social and Health Services, hereinafter referred to as the "Department", and that person(s) whose name(s) appear(s) in item 2. below, hereinafter referred to as the "Contractor".*

2. *CONTRACTOR:*

ADDRESS:

Washington State Tax Registration Number:

Social Security # or IRS Employer ID #

SPECIAL TERMS AND CONDITIONS
IT IS MUTUALLY AGREED THAT:

3. *The Contractor will provide the following services/goods:*

4. *Subject to its other provisions, the period of performance under this contract will be from* _____ *through* _____ *unless sooner terminated as provided herein.*

5. *All rights and obligations of the parties to this contract shall be subject to and governed by those Special Terms and Conditions contained in the text of this contract instrument and the General Terms and Conditions on the reverse hereof except:*

IN CONSIDERATION WHEREOF:

6. *The Department shall pay to the Contractor for those services provided herein as follows:**

Maximum payment to the Contractor for services provided under this contract shall not exceed $

IT IS FURTHER AGREED THAT:

7. *The Contractor shall submit invoices on a timely basis at the intervals prescribed and on forms provided by the Department.*

8. *In the event of an inconsistency in this contract, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence in the following order: (a) Applicable Federal & State Statutes & Regulations, (b) Special Terms and Conditions (including the Statement of Work), (c) General Terms and Conditions and (d) any other provision of the contract whether incorporated by reference or otherwise.*

9. *This agreement contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this agreement shall be deemed to exist or to bind any of the parties hereto:*

10. *This contract shall be subject to the written approval of the Contracting Officer of the Department of Social and Health Services and shall not be binding until so approved. Only the Contracting Officer or his/her delegate by writing (delegation to be made prior to action) shall have the expressed, implied, or apparent authority to alter, amend, modify, or waive any clause or condition of this contract. Furthermore, any alteration, amendment, modification, or waiver of any clause or condition of this contract is not effective or binding unless made in writing and signed by the Contracting Officer.*

IN WITNESS WHEREOF: The Department and the Contractor have signed this agreement.

① ..... *DATE*.... /..../.... *CONTRACTOR*

② ..... *DATE*.... /..../.... *CONTRACTING OFFICER*
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

③ *This contract has been approved as to form by the Attorney General.*

**If insufficient space, attach sheet.*

DSHS 9-73 (X) Rev. 6 80
(All previous editions are obsolete and shall not be used)

DSHS 9-73(X) (6/80), ADULT FAMILY HOME-PERSONAL SERVICES CONTRACT - SHORT FORM (CONT.)

GENERAL TERMS AND CONDITIONS

DEFINITIONS—As used throughout this contract, the following terms shall have the meanings set forth below:

(a) "Client" shall mean any agency, firm, organization, individual or other entity applying for or receiving services under this contract.

(b) "Contractor" shall mean that agency, firm, provider, organization, individual or other entity performing services under this contract. It shall include any subcontractor retained by the prime contractor as permitted under the terms of this agreement.

(c) "Contracting Officer" shall mean the Supervisor of the Contracts Management Section of the department and his/her delegates within that section.

(d) "Department" shall mean the Department of Social and Health Services (DSHS) of the State of Washington, any division, section, office, unit or other entity of the department, or any of the officers or other officials lawfully representing that department.

(e) "Subcontractor" shall mean one not in the employment of the contractor, who is performing all or part of those services under this contract under a separate contract with the contractor. The terms "subcontractor" and "subcontractors" mean subcontractor(s) in any tier.

CONTRACTOR NOT EMPLOYEE OF DEPARTMENT—The contractor, his or her employees or agents performing under this agreement are not employees or agents of the department. The contractor will not hold himself/herself out as nor claim to be an officer or employee of the department or of the State of Washington by reason hereof, nor will he or she make any claim of right, privilege or benefit which would accrue to a civil service employee under Chapter 41.06 RCW.

NONDISCRIMINATION—During the performance of this agreement, the contractor shall comply with the department's nondiscrimination plan and the federal and state laws upon which it is based. Requirements of the nondiscrimination plan are hereby incorporated by reference, but are not limited to:

(a) **Nondiscrimination in employment:** The contractor shall not discriminate against any employee or applicant for employment because of race, color, sex, religion, national origin, creed, marital status, age, or the presence of any sensory, mental or physical handicap. This requirement does not apply, however, to a religious corporation, association, educational institution or society with respect to the employment of individuals of a particular religion to perform work connected with the carrying on by such corporation, association, educational institution or society of its activities.

The contractor shall take affirmative action to ensure that employees are employed and treated during employment without discrimination because of their race, color, religion, sex, national origin, creed, marital status, age or the presence of any sensory, mental or physical handicap. Such action shall include, but not be limited to, the following: Employment, upgrading, demotion, or transfer; recruitment or recruitment selection for training, including apprenticeships and volunteers.

(b) **Nondiscrimination in Client Services:** The contractor shall not, on grounds of race, color, sex, religion, national origin, creed, marital status, age or the presence of any sensory, mental or physical handicap,

(1) Deny an individual any services or other benefits provided under this agreement.

(2) Provide any service(s) or other benefits to an individual which are different, or are provided in a different manner from those provided to others under this agreement.

(3) Subject an individual to segregation or separate treatment in any manner related to the receipt of any service(s) or other benefits provided under this agreement.

(4) Deny any individual an opportunity to participate in any program provided by this agreement through the provision of services or otherwise, or afford an opportunity to do so which is different from that afforded others under this agreement. The contractor, in determining (1) the types of services or other benefits to be provided or (2) the class of individuals to whom, or the situation in which, such services or other benefits will be provided, or (3) the class of individuals to be afforded an opportunity to participate in any services or other benefits, will not utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, sex, religion, national origin, creed, marital status, age or the presence of any sensory, mental or physical handicap.

NONCOMPLIANCE WITH NONDISCRIMINATION PLAN—In the event of the contractor's noncompliance or refusal to comply with the nondiscrimination plan, this contract may be rescinded, cancelled or terminated in whole or in part, and the contractor may be declared ineligible for further contracts with the department. The contractor shall, however, be given a reasonable time in which to cure this noncompliance. Any dispute may be resolved in accordance with the "Disputes" procedure set forth herein.

INDEMNIFICATION—The contractor shall defend, protect and hold harmless the State of Washington, the department, or any employees thereof, from and against all claims, suits or actions arising from any negligent act or omission of the contractor or subcontractor, or agents of either, while performing under the terms of this contract. Claims shall include, but not be limited to, assertions that the use or transfer of any software, book, document, report, film, tape or sound reproduction or material of any kind, delivered hereunder, constitutes an infringement of any copyright, patent, trademark, tradename, or otherwise results in an unfair trade practice.

COVENANT AGAINST CONTINGENT FEES—The contractor warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established commercial or selling agency maintained by the contractor for the purpose of securing business. The department shall have the right, in the event of breach of this clause by the contractor, to annul this contract without liability or, in its discretion, to deduct from the contract price or consideration or otherwise recover the full amount of such commission, percentage, brokerage or contingent fee.

CONFLICT OF INTEREST—The department may, by written notice to the contractor:

(a) Terminate the right of the contractor to proceed under this contract if it is found, after due notice and examination by the Contracting Officer that gratuities in the form of entertainment, gifts or otherwise are offered or given by the contractor, or an agent or representative of the contractor, to any officer or employee of the department, with a view towards securing this contract or securing favorable treatment with respect to the awarding or amending or the making of any determinations with respect to this contract.

(b) In the event this contract is terminated as provided in (a) above, the department shall be entitled to pursue the same remedies against the contractor as it could pursue in the event of a breach of the contract by the contractor. The rights and remedies of the department provided for in this clause shall not be inclusive and are in addition to any other rights and remedies provided by law. The existence of facts upon which the Contracting Officer makes any determination under this clause shall be an issue and may be reviewed as provided in the "Disputes" clause of this agreement.

TREATMENT OF ASSETS—

(a) Title to all property furnished by the department shall remain in the department. Title to all property purchased by the contractor, for the cost of which the contractor is entitled to be reimbursed as a direct item of cost under this contract, shall pass to and vest in the department upon delivery of such property by the vendor. Title to other property, the cost of which is reimbursable to the contractor under the contract, shall pass to and vest in the department

DSHS 9-73(X) (6/80), ADULT FAMILY HOME-PERSONAL SERVICES CONTRACT - SHORT FORM (CONT.)

upon (i) issuance for use of such property in the performance of this contract, or (ii) commencement of use of such property in the performance of this contract, or (iii) reimbursement of the cost thereof by the department in whole or in part, whichever first occurs.

(b) Any property of the department furnished to the contractor shall, unless otherwise provided herein, or approved by the Contracting Officer, be used only for the performance of this contract

(c) The contractor shall be responsible for any loss or damage to property of the department which results from the negligence of the contractor or which results from the failure on the part of the contractor to maintain and administer that property in accordance with sound management practices.

(d) Upon the happening of loss or destruction of, or damage to, any department property, the contractor shall notify the Contracting Officer thereof and shall take all reasonable steps to protect that property from further damage.

(e) The contractor shall surrender to the department all property of the department prior to settlement upon completion, termination or cancellation of this agreement.

(f) All reference to the contractor under this clause shall include any of his/her employees or agents or subcontractors.

NONASSIGNABILITY OF CLAIMS—No claim arising under this contract shall be transferred or assigned by the contractor.

RECORDS, DOCUMENTS, AND REPORTS—The contractor shall maintain books, records, documents and other evidence of accounting procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this agreement. These records shall be subject at all reasonable times to inspection, review, or audit by personnel duly authorized by the department, the Office of the State Auditor, and federal officials so authorized by law, rule, regulation, or contract. The contractor will retain all books, records, documents, and other material relevant to this agreement for five years after settlement, and make them available for inspection by persons authorized under this provision

SAFEGUARDING OF CLIENT INFORMATION—The use or disclosure by any party of any information concerning a client for any purpose not directly connected with the administration of the department's or the contractor's responsibilities with respect to services provided under this agreement is prohibited except by written consent of the recipient or client, his/her attorney, or his/her responsible parent or guardian.

RIGHTS IN DATA—Unless otherwise provided, data which originates from this contract shall be "works for hire" as defined by the U.S Copyright Act of 1976 and shall be owned by the department Data shall include, but not be limited to, reports, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes, and/or sound reproductions. Ownership includes the right to copyright, patent, register and the ability to transfer these rights.

Data which is delivered under the contract, but which does not originate therefrom, shall be transferred to the department with a nonexclusive, royalty-free, irrevocable license to publish, translate, reproduce, deliver, perform, dispose of, and to authorize others to do so: *Provided*, that such license shall be limited to the extent which the contractor has a right to grant such a license. The contractor shall exert all reasonable effort to advise the department, at the time of delivery of data furnished under this agreement, of all known or potential invasions of privacy contained therein and of any portion of such document which was not produced in the performance of this agreement. The department shall receive prompt written notice of each notice or claim or copyright infringement received by the contractor with respect to any data delivered under this agreement. The department shall have the right to modify or remove any restrictive markings placed upon the data by the contractor.

SUBCONTRACTING—The contractor shall not enter into subcontracts for any of the work contemplated under this agreement without obtaining prior written approval of the Contracting Officer and/or his/her delegate.

LICENSING AND ACCREDITATION STANDARDS—The contractor shall comply with all applicable, local, state, and federal licensing and accrediting requirements/standards, necessary in the performance of this contract. (See RCW 19.02 for state licensing requirements/definitions)

RIGHT OF INSPECTION—The contractor shall provide right of access to its facilities to the department, or any of its officers, or to any other authorized agent or official of the State of Washington or the federal government at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this contract.

ADVANCE PAYMENTS PROHIBITED—No payment in advance or in anticipation of services or supplies to be provided under this agreement shall be made by the department

SAVINGS—In the event funding from state, federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this contract and prior to normal completion, the department may terminate the contract under the "Termination for Convenience" clause, subject to renegotiation under those new funding limitations and conditions

WAIVER OF DEFAULT—Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of the contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the agreement unless stated to be such in writing, signed by the Contracting Officer of the department, and attached to the original contract

CHANGES AND MODIFICATIONS—The Contracting Officer may, at any time, by written notification to the contractor, and without notice to any known guarantor or surety, make changes within the general scope of the services to be performed under the contract. If any such change causes an increase or decrease in the cost of, or the time required for the performance of this contract, an equitable adjustment may be made in the contract price, or period of performance, or both, and the contract shall be modified in writing accordingly. Any claim by the contractor for adjustment under this clause must be asserted within 30 days from the date of receipt by the contractor of the notice of such change, *Provided*, however, that the Contracting Officer may, if he/she decides that the facts justify such action, receive and act upon any such claim asserted at any time prior to final payment under this contract Failure to agree to any adjustment shall be a dispute concerning a question of fact within the meaning of the clause of this contract entitled "Disputes." However, nothing in this clause shall excuse the contractor from proceeding with the contract as changed

DISPUTES—Except as otherwise provided in this contract, when a bona fide dispute arises between the department and the contractor and it cannot be resolved, either party may request a dispute hearing with the Contracts Management Section of DSHS. Either party's request for a dispute hearing must

1. be in writing, and
2. state the disputed issues, and
3. state the relative positions of the parties, and
4. state the contractor's name, address, and his/her department contract number, and
5. be mailed to the DSHS Contracts Management Section, Olympia, Washington 98504, within fifteen (15) days after either party receives notice of the issue(s) which he/she now disputes. The parties agree that this dispute process shall precede any action in a judicial or quasi-judicial tribunal.

DSHS 9-73(X) (6/80), ADULT FAMILY HOME-PERSONAL SERVICES CONTRACT - SHORT FORM (CONT.)

TERMINATION FOR DEFAULT—The Contracting Officer may, by written notice, terminate the contract in whole or in part, for failure of the contractor to perform any of the provisions hereof. In such event the contractor shall be liable for damages as authorized by law, including, but not limited to, any cost difference between the original contract and the replacement or cover contract and all administrative cost directly related to the replacement contract, i.e., cost of the competitive bidding, mailing, advertising and staff time. *Provided*, that if (i) it is determined for any reason the contractor was not in default, or (ii) the contractor's failure to perform is without his/her and/or his/her subcontractor's control, fault or negligence, the termination shall be deemed to be a Termination for Convenience.

TERMINATION FOR CONVENIENCE—Except as otherwise provided in this contract, the Contracting Officer may, by fourteen (14) days written notice, beginning on the second day after the mailing, terminate this contract in whole or in part when it is in the best interests of the department. If this contract is so terminated, the department shall be liable only for payment in accordance with the terms of this contract for services rendered prior to the effective date of termination.

TERMINATION PROCEDURE—Upon termination of this agreement the department, in addition to any other rights provided in this agreement, may require the contractor to deliver to the department any property specifically produced or acquired for the performance of such part of this agreement as has been terminated. The provisions of the "Treatment of Assets" clause shall apply in such property transfer.

The department shall pay to the contractor the agreed upon price, if separately stated, for completed work and services accepted by the department, and the amount agreed upon by the contractor and the Contracting Officer for (a) completed work and services for which no separate price is stated, (b) partially completed work and services, (c) other property or services which are accepted by the department, and (d) the protection and preservation of property, unless the termination is for default, in which case the Contracting Officer shall determine the extent of the liability of the department. Failure to agree with such determination shall be a dispute within the meaning of the "Disputes" clause of this agreement. The department may withhold from any amounts due the contractor for such completed work or services such sum as the Contracting Officer determines to be necessary to protect the department against potential loss or liability.

The rights and remedies of the department provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this agreement.

After receipt of a notice of termination, and except as otherwise directed by the Contracting Officer, the contractor shall:

1. Stop work under the agreement on the date, and to the extent specified, in the notice;
2. Place no further orders or subcontracts for materials, services, or facilities except as may be necessary for completion of such portion of the work under the agreement as is not terminated;
3. Assign to the department, in the manner, at the times, and to the extent directed by the Contracting Officer, all of the rights, titles, and interest of the contractor under the orders and subcontracts so terminated, in which case the department has the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
4. Settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, with the approval or ratification of the Contracting Officer to the extent he/she may require, which approval or ratification shall be final for all the purposes of this clause;
5. Transfer title to the department and deliver in the manner, at the times, and to the extent, if any, as directed by the Contracting Officer, any property which, if the agreement had been completed, would have been required to be furnished to the department;
6. Complete performance of such part of the work as shall not have been terminated by the Contracting Officer; and,
7. Take such action as may be necessary, or as the Contracting Officer may direct, for the protection and preservation of the property related to this agreement which is in the possession of the contractor and in which the department has or may acquire an interest.

GOVERNING LAW—This contract shall be governed by the laws of the State of Washington.

SEVERABILITY—If any provision of this agreement or any provision of any document incorporated by reference shall be held invalid, such invalidity shall not affect the other provisions of this agreement which can be given effect without the invalid provision, and to this end the provisions of this agreement are declared to be severable.

DSHS 9-73A(X) (5/82), ANNUAL AFH CONTRACT COMPLIANCE REVIEW

Instructions

These forms are used at least annually to monitor the contractor compliance with the terms and conditions of the contract. The form should be used at any time there is reason to believe the contractor is not in compliance.

- Service worker reviews each contract term. If the contractor is in compliance, put an "X" in "yes" box. If not, list the evidence in the "no" section.

- The contractor enters his/her corrective action plan in the box pro= vided.

- The service worker enters the compliance due date agreed upon in the box provided. The service worker will use professional judgment as well as contractor input as to a reasonable/safe time-frame for com= pliance.

- The service worker and contractor sign the completed form.

- Forms are distributed as indicated on the form. CSO copy is filed in the appropriate section of the facility file.

- Form is again completed when corrective action due date occurs.

DSHS 9-73A(X) (5/82), ANNUAL AFH CONTRACT COMPLIANCE REVIEW

ANNUAL ADULT FAMILY HOME CONTRACT COMPLIANCE REVIEW

CONTRACT TERMS AND CONDITIONS	COMPLIANCE			CONTRACTOR'S CORRECTIVE ACTION PLAN	COMPLIANCE DUE DATE
	Yes	No	List Evidence		
1. Special Terms and Conditions (Contractor's responsibilities):					
A. Compliance with licensing requirements and standards					
B. Approved type and number of clients					
C. Client Records					
D Additional remuneration					
E. Client refunds					
F Notification of change					

DSHS 9 73A (5-82) —402—

DSHS 9-73A(X) (5/82), ANNUAL AFH CONTRACT COMPLIANCE REVIEW (CONT.)

CONTRACT TERMS AND CONDITIONS	COMPLIANCE			CONTRACTOR'S CORRECTIVE ACTION PLAN	COMPLIANCE DUE DATE
	Yes	No	List Evidence		
G. Billing					
H Client Property					
I Privacy					
2. Consideration					
3. Approval					
4 Contractor/Employer/ Agent Not Employees					
5 Nondiscrimination					

DSHS 9-73A (5-82) 407-

DSHS 9-73A(X) (5/82), ANNUAL AFH CONTRACT COMPLIANCE REVIEW (CONT.)

CONTRACT TERMS AND CONDITIONS	COMPLIANCE			CONTRACTOR'S CORRECTIVE ACTION PLAN	COMPLIANCE DUE DATE
	Yes	No	List Evidence		
6. Indemnification					
7. Covenant Against Contingent Fees					
8. Conflict of Interest					
9. Subcontracting					
10. Licensing and Accreditation Standards					
11. Rights of Inspection					
12. Statement of Work					

SS Manual - 1907
David v.

DSHS 9-73A(X) (5/82), ANNUAL AFH CONTRACT COMPLIANCE REVIEW (CONT.)

CONTRACT TERMS AND CONDITIONS	COMPLIANCE			CONTRACTOR'S CORRECTIVE ACTION PLAN	COMPLIANCE DUE DATE
	Yes	No	List Evidence		
A. Basic Services					
B. Activities of Daily Living					
C. Health Related Services					

DISTRIBUTION:
CSO Contract File — White
Contractor — Canary
Adult Family Home Program Manager — Pink

CSO Service Worker Signature _____ Date _____

Contractor's Signature _____ Date _____

DSHS 9-73A (5-82) 402-

SS Manual - 1908
David v.

DSHS 9-202(X) (Rev. 6/80), CONTRACT PROCESSING ACTION REQUEST

CONTRACT PROCESSING ACTION REQUEST

(1) CONTRACT PERIOD ___/___/ 19__ / ___/___

(2) CONTRACT MANAGEMENT SECTION USE ONLY
CONTRACT NUMBER

(3) SUBMITTING PROGRAM

(4) PROGRAM CONTACT PERSON CONCERNING THIS CONTRACT PROCESSING ACTION REQUEST

NAME	TITLE	PHONE	ADDRESS	REGION NO.

(5) PERSON EVALUATING CONTRACTOR PERFORMANCE

NAME	TITLE	PHONE	ADDRESS

(6) LEGAL NAME OF CONTRACTOR

(7) CONTRACTOR DOING BUSINESS AS (DBA)

(8) MAILING ADDRESS OF CONTRACTOR

STREET	CITY	STATE	ZIP

(9) WASHINGTON TAX REGISTRATION NUMBER

FEDERAL EMPLOYER IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER

(10) PERSON(S) HAVING CONTROLLING INTEREST IN THE BUSINESS

NAME	TITLE	NAME	TITLE
(1)		(4)	
(2)		(5)	
(3)		(6)	

(11) CHECK APPLICABLE BOX(S)
CONTRACTOR IS. ☐ MINORITY FIRM ☐ WOMEN OWNED FIRM ☐ SMALL BUSINESS FIRM

(12) IF ANY PERSON NAMED IN ITEM 10 IS A PAST OR PRESENT WASHINGTON STATE EMPLOYEE COMPLETE ITEM 13

(13) NAME	AGENCY LAST EMPLOYED	POSITION	TERMINATION DATE
			/ /

(14) DESCRIBE THE SERVICE AND/OR GOODS TO BE PROVIDED BY THE CONTRACTOR

(15) DOES CONTRACT REQUIRE A FINAL REPORT ☐ YES ☐ NO

(16) CONTRACTOR EMPLOYEES TO BE TRAINED ☐ YES ☐ NO

(17) ACCOUNT CODE TO BE CHARGED ON EXPENDITURE DOCUMENTS

FUND	APPROP.	PROGRAM	OBJECT	ALLOC.	ORG. UNIT	LOC.	M/S		AMOUNT
								TOTAL -->	

(18) EXPLAIN WHY THIS SERVICE CANNOT BE PERFORMED BY PERSONNEL OF DSHS OR PERSONNEL OF ANOTHER WASHINGTON STATE GOVERNMENT AGENCY.

(19) LIST NAMES OF COMPETING CONTRACTORS (IF NONE EXPLAIN WHY)

(20) OFFICE OF INFORMATION SYSTEMS REVIEW ☐ APPROVED ☐ REJECTED

NAME (TYPE/PRINT)	SIGNATURE	TITLE
ADDRESS	PHONE	DATE

(21) ANALYSIS & INFORMATION SERVICES DIVISION REVIEW ☐ APPROVED ☐ REJECTED
DATA PROCESSING ADVISORY COMMITTEE REVIEW ☐ APPROVED ☐ REJECTED

NAME (TYPE/PRINT)	SIGNATURE	TITLE
ADDRESS	PHONE	DATE

(22) EMPLOYEE SERVICES DIVISION REVIEW ☐ APPROVED ☐ REJECTED

NAME (TYPE/PRINT)	SIGNATURE	TITLE
ADDRESS	PHONE	DATE

(23) SUBMITTING PROGRAM CERTIFICATION

I hereby request that the contract referenced herein be executed and certify that the information contained herein (including all pages attached hereto) is true, correct and complete and that funds as described in Item 17 are obligated and available for payment of services rendered and goods purchased under this contract.

NAME (TYPE/PRINT)	SIGNATURE	TITLE
ADDRESS	PHONE	DATE

COPY DISTRIBUTION: WHITE—Forward to CMS CANARY—Program Encumbrance PINK—Program Record

DSHS 9-202(X) (Rev. 6/80)

SS Manual - 1909
David v.

DSHS 9-202(X) (Rev. 6/80), CONTRACT PROCESSING ACTION REQUEST (CONT.)

SPECIFIC INSTRUCTIONS

1. Enter the month, day and year the contract is to begin and the month, day and year the contract is to end. *Example:* 5/11/80 to 11/15/80.
2. Contract Management Section use only. The Contract Management Section will enter the assigned contract number in this space.
3. Type or print the name or designation of the Division, Bureau or Region. *Example:* Division of Adult Corrections.
4. Type or print the name, title, telephone number and mailing address of the program staff person to whom questions concerning the CPAR should be directed and the region number where the services are to be performed.
5. Type or print the name, title, telephone number and mailing address of the program person responsible for evaluating the performance of the contractor
6. Indicate the full and legal name of the sole proprietor, partnership, cooperative, corporation, political subdivision, association, non profit organization, etc., with whom the contract is being entered.
7. Indicate the name the contractor is doing business as.
8. Indicate the street address or post office box number, city, state and zip code to which correspondence concerning this contract should be mailed to the contractor
9. Type or print the Contractor's Washington State Tax Registration Number (obtained by the Contractor from the Department of Revenue) and the Contractor's Federal Employer Identification Number or Social Security Number
10. Type or print the full legal name(s) and title(s) of persons having controlling interest in the business and the principal officers
11. Mark (X) the appropriate response(s) if the Contractor is a minority-owned, women-owned or small business firm See definitions below.

    "Minority," "minorities," or "minority person" means ethnic persons residing in the United States, including American Indians/Native Americans, Asian Pacific Americans, Blacks, and Hispanics.

    "Minority-owned businesses" means a business which is owned and controlled by one or more minority persons For purposes of this definition, the non-minority owner or owners of the minority business enterprise may not be the owner or operator, in whole or in part, of a business engaged in the same or similar type of business activity as the minority business enterprise

    "Women-owned business" means a business which is owned and controlled by one or more women residing in the United States or its territories. For purpose of this definition, the male owner or owners in a women's small business enterprise may not be the owner or operator, in whole or in part, of a business engaged in the same or similar type of business activity as the women's business enterprise

    "Owned and controlled," for purposes of determining whether a business is a minority business enterprise, women's business enterprise, or combination women's and minority business enterprise, means that the minorities, women, or combination of both, as the context requires, shall possess

    1. Ownership of greater than 50 percent of the business, *and*
    2. Control over management, interest in capital, and interest in profit or loss commensurate with the percentage of ownership in which the claim of status is based; *and*
    3. A real and continuing interest in the business

    "Small business" means a corporation, partnership, sole proprietorship, or other legal entity formed for the purpose of making a profit that is independently owned and operated from all other businesses, and has 50 or fewer employees.
12. If any person listed in item 10 is a past or present Washington state employee, complete item 13
13. Type/print the name(s) of all persons identified in item 10 who are past or present Washington state employees, the name of the agency with which they were last employed, the position they held or now hold and the date their employment terminated, if applicable (Attach additional page if necessary.)

    NOTE: The contract must be reviewed and approved as to compliance with Merit System Rules prior to submission to the Contracts Management Section whenever a name is entered in this space See instructions for item 22
14. Briefly describe the service and/or goods to be performed and/or delivered by the contractor under the terms and conditions of the contract.(Attach additional page if necessary.)
15. Mark (X) the appropriate response indicating whether or not a final report is to be prepared by the contractor prior to or upon completion of the contract.
16. Mark (X) the appropriate response indicating whether or not contractor employee training will be paid for as part of the terms and conditions of the contract.
17. Enter account code information and the amount of the contract.
18. Briefly explain why the service being contracted for cannot be performed by DSHS personnel or personnel of another Washington State government agency
19. List the names of the contractors that competed for this contract other than the one receiving the award If competitive bidding is not being utilized, explain why in a memorandum addressed to the Contracting Officer Submit it with the Contract Processing Action Request
20. All contracts for the purchase of data processing equipment and/or services must be reviewed and approved by the Office of Information Systems (OIS) prior to submitting the contract to the Contract Management Section for approval OIS will type/print the name of the OIS person reviewing the contract, his/her title, telephone number and mailing address The OIS person reviewing the contract shall mark (X) the appropriate response indicating approval or rejection, sign and enter the date the determination was made The contract and CPAR will then be returned to the person identified in item 4. If the CPAR is rejected a memo of explanation should accompany the CPAR.
21. Contracts for the purchase of data processing equipment, software, maintenance, or consulting services that are under $10,000 must be approved by the Director, Analysis and Information Services Division (AISD) Contracts over $10,000 must be approved by the Data Processing Advisory Committee (DPAC). The Director, Analysis and Information Services Division will be responsible for reviewing contracts, obtaining DPAC approval or disapproval The DPAC/AISD will type/print the name of the person reviewing the contract, his/her title, telephone number and mailing address The DPAC/AISD person reviewing the contract shall mark (X) the appropriate response indicating approval or rejection, sign and enter the date the determination was made The contract and CPAR will then be returned to the person identified in item 4. If the CPAR is rejected a memo of explanation should accompany the CPAR
22. When persons are identified in item 10 as past or present state employees or when the service being contracted for is of a nature that traditionally has been, is being, or could be performed by state employees, the contract must be reviewed and approved with regard to compliance with Merit System Rules by the Employee Services Division (ESD) The ESD will type/print the name of the Employee Services ESD person reviewing the contract, his/her title, telephone number and mailing address. The ESD person reviewing the contract shall mark (X) the appropriate response indicating approval or rejection, sign and enter the date the determination was made. The contract and CPAR will then be returned to the person identified in item 4. If the CPAR is rejected a memo of explanation should accompany the CPAR
23. Type/print the name, title, address and phone number of the person certifying that programmatic requirements are satisfied including but not limited to
    - The contractor is properly licensed;
    - The information contained in the CPAR (including all attached pages) is accurate and complete;
    - That funds identified in item # 17 above will be obligated and made available for funding the contract or grant and that payment will be made from these funds for services rendered or goods purchased under the terms of the contract Include the certifying person's work title, telephone number, and mailing address

    The person certifying that these requirements have been satisfied should sign and date the signature and date items

MINIMUM LEAD TIME PARAMETERS

The following is a list of the minimum number of days prior to the anticipated contract start date for various types of contracts that the Contract Management Section must receive the contract in order to assure processing before the anticipated start date

I. Non-Competitive Contract	Calendar Days
A Standard fixed fee	30
B Negotiated and prepared solely by Program Management	40
C Negotiated and prepared jointly by Program Management and CMS	45
D Negotiated and prepared solely by CMS	50

II. Competitive Bid Contracts	Calendar Days
A Request for proposal (RFP)	120
B Invitation for bid (IFB)	95
C Request for quotation (RFQ)	60

DSHS 9-303(X) (Rev. 3/81), CONTRACT/GRANT AMENDMENT MODIFICATIONS OR CHANGE ORDER FORM

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

CONTRACT AMENDMENT
PAGE ____ of _____ PAGES

1 NAME AND ADDRESS OF CONTRACTOR	2. CONTRACT AND AMENDMENT NUMBERS CONTRACT NO. AMENDMENT NO.

3. ☐ THIS ITEM APPLIES ONLY TO BILATERAL AMENDMENTS.

THE CONTRACT IDENTIFIED HEREIN, INCLUDING ANY PREVIOUS AMENDMENTS THERETO, IS HEREBY AMENDED AS SET FORTH IN ITEM 5 BELOW BY MUTUAL CONSENT OF ALL PARTIES HERETO.

4 ☐ THIS ITEM APPLIES ONLY TO UNILATERAL AMENDMENTS.

THE CONTRACT IDENTIFIED HEREIN, INCLUDING ANY PREVIOUS AMENDMENTS THERETO, IS HEREBY UNILATERALLY AMENDED AS SET FORTH IN ITEM 5 BELOW PURSUANT TO THAT CHANGES AND MODIFICATIONS CLAUSE AS CONTAINED THEREIN.

5. DESCRIPTION OF AMENDMENT.

6. ALL OTHER TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT AND ANY PREVIOUS AMENDMENTS THERETO REMAIN IN FULL FORCE AND EFFECT.

7. ☐ THIS IS A UNILATERAL AMENDMENT SIGNATURE OF CONTRACTOR IS NOT REQUIRED BELOW ☐ CONTRACTOR HEREBY ACKNOWLEDGES AND ACCEPTS THE TERMS AND CONDITIONS OF THIS AMENDMENT. SIGNATURE IS REQUIRED BELOW	8. THIS DOCUMENT HAS BEEN APPROVED AS TO FORM BY THE ASSISTANT ATTORNEY GENERAL
9. FOR THE CONTRACTOR, (SIGNATURE) DATE / /	10. FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES DSHS CONTRACTING OFFICER (SIGNATURE) DATE / /

DSHS 9-303(X) (REV 3/81) - 87 -

DSHS 9-464A (Rev. 10/82), STATEMENT OF WORK FOR ADULT FAMILY HOME SPONSOR CONTRACT

Instructions

DSHS 9-464A(X) (10/82), Statement of Work for Adult Family Home Sponsor Contract, shall be an attachment to each DSHS 9-73(X) (Rev. 6/80), Adult Family Homes Personal Services Contract.

A. Services listed in Part A must be provided to all AFH clients.

B. Services listed in Part B: 1) Activities of Daily Living Services and 2) Health-Related Services may be provided, if authorized, to clients by sponsors who have successfully completed the required sponsor training.

Draw a line through each service that the sponsor is not authorized to provide. The sponsor shall indicate his/her understanding that the lined out services shall not be provided by initialing the lined out items.

When an AFH sponsor has successfully completed the required training, DSHS 9-464A(X) (Rev. 10/82), Statement of Work for Adult Family Home Sponsor Contract, shall be revised to indicate additional services the sponsor may provide, if authorized.

Make no changes in DSHS 9-464A(X) without discussing the changes with the Bureau of Aging and Adult Services and the Contract Section.

DSHS 9-464A (Rev. 10/82), STATEMENT OF WORK FOR ADULT FAMILY HOME SPONSOR CONTRACT

Statement of Work
for
ADULT FAMILY HOME SPONSOR CONTRACT

From among the adult family home services listed below, the Contractor shall provide the service(s) for the Department client(s) for the period stated on the DSHS 14-154(X) (Rev.9/1/80), Social Services Authorization, for which the Department shall give to the Contractor.

A. Services the Department requires for each client:

Room, board, laundry, and such personal and social services as the client requires.

B. Services that the Department may require:

1. Activities of Daily Living Services

Communication
Community Resources
Eating/Dining
Clothing Care
Household Management
Health Care
Survival Skills
Behavior Supervision
Social Skills
Community Mobility
Personal Hygiene, Grooming
Money Management

2. Health Related Services

Incontinence/Bowel and Bladder Training
Ambulation
Behavior
Medication Management
Injections
Catheter/Colostomy Care
Dressings
Range of Motion Exercises

DSHS 9-464B (Rev. 9/82), SPECIAL TERMS AND CONDITIONS FOR ADULT FAMILY HOME SPONSOR

SPECIAL TERMS AND CONDITIONS
for
ADULT FAMILY HOME SPONSOR

1. Contractor Responsibilities

A. The Contractor shall maintain a current adult family home license and shall comply with all other applicable standards pertaining to adult family home programs and facilities housing adult family home programs as issued by the Department. The Department shall make available to the Contractor written statement(s) of all such Departmental standards.

B. The Contractor shall care for only the number of clients for which the Contractor is licensed, but not to exceed four (4) at any time. If the Contractor is qualified to provide health-related services, no more than two (2) of the clients may be provided that additional service at any one time.

C. The Contractor shall maintain a record of each client, including the full name, birthdate, and telephone number of his/her physician, family members, and person(s) to notify in an emergency, and to advise the Department's Community Services Office (CSO) of any significant changes in the client's /clients' condition. The record shall also include date of admission and discharge, and days of social and/or medical leave authorized by the Department.

D. The Contractor shall impose no fees on individual clients for services performed pursuant to this contract; except for the sum stated in the Notification of Eligibility for Adult Family Home.

E. The Contractor shall refund to the client(s) the amount prepaid for care of the client(s) on a prorata basis, in the event that the client(s) move out of the home before the end of the month.

F. The Contractor shall notify the Department when a client does not adapt to the home or requires more care than the Contractor can provide. The Contractor shall notify the Department when a client moves into the home or leaves without previous planning.

G. The Contractor shall render to the Department, monthly in arrears, vouchers (DSHS Form A-19) for services rendered in the manner prescribed by the Department. The vouchers shall be submitted in triplicate.

H. The Contractor shall maintain individual financial records for all clients who request the facility in writing to retain or spend money on their behalf. Such accounts shall be kept current and in detail and contain supporting verification, consents, and receipts for all monies received and disposed of. Funds in excess of those reasonably needed to meet client cash needs shall be deposited in a bank account, separate and apart from other bank accounts of the facility. Contractor shall maintain receipts signed by the client where client funds are delivered to the client in a lump sum. The client shall have the right to make other arrangements for the management of funds at any time. Problems of financial mismanagement in individual cases, which cannot be resolved by advice and counseling, shall be referred to the Department for resolution.

SS Manual - 1914
David v.

DSHS 9-464B (Rev. 9/82), SPECIAL TERMS AND CONDITIONS FOR ADULT FAMILY HOME SPONSOR (BACK)

I. Privacy - The Contractor shall respect the client's right to privacy, including visits, personal mail and other communications.

2. Department Responsibilities

A. The Department shall evaluate the home on a regular basis, at least annually, to ensure compliance with contractual and license requirements.

B. The Department has continuing basic responsibility for the determination of the Department of Social and Health Services client's eligibility for services. Payment to the Contractor shall be authorized on the basis of this determination.

DSHS Bureau of Aging
OB-43G
Olympia, WA 98504

SS Manual - 1915
David v.

SS Manual - 1916
David v.

DSHS 9-571(X) (11/81), CONGREGATE CARE FACILITY CONTRACT

Instructions

A licensed boarding home that wishes to provide congregate care services for residents who are department clients must have a contract with the department. The contract is the legal basis for the congregate care facility to be paid by the department. The contract must be completed and signed by the facility owner or authorized representative and the department's contracting officer before the facility provides services to department clients. The Congregate Care Facility Contract is the contract form the department uses to obtain congregate care services for clients.

The contract consists of three parts:

1. Page one of DSHS 9-571(X) contains eight (8) paragraphs plus signature lines.

2. The "general terms and conditions" of the contract are set forth in pages two through four of DSHS 9-571(X).

3. DSHS 9-571A is the statement of work the contractor shall be required to perform for Regular Congregate Care Program. DSHS 9-571B(X) is the statement of work the contractor shall be required to perform for Mental Health Congregate Care program.

Instructions for completing page one of DSHS 9-571(X) are:

1. "Contract No" is left blank.

2. Insert the assumed business name of the facility in the blank after "Contractor."

3. Insert the physical address in the blank after "address of facility."

4. Insert the boarding home license number in the blank after "Facility License No."

5. Insert the I.R.S. employer ID number in the appropriate blank.

6. The period of performance can be negotiated for periods not to exceed 24 months. The effective date of the agreement is the day the contracting officer signs the contract. This is usually about two weeks after the completed form is forwarded to the Contracts Management Section. This effective date should be inserted in the blank after "From." The ending date should be the day the parties agree on but never more than 24 months from the effective date.

7. Insert the word "Regular" or "Mental Health" as appropriate in the blank after ". . . and social care to adult."

8. Insert the appropriate daily rate for the type of clients to be served in the blank after ". . . shall pay the contractor" (see 46.16 for rates). Insert the maximum number of clients contracted for in the blank after "for a maximum of."

DSHS 9-571(X) (11/81), CONGREGATE CARE FACILITY CONTRACT (CONT.)

Instructions (cont.)

9. Attach the appropriate statement of work:

   a. DSHS 9-571A for regular Congregate Care Program.

   b. DSHS 9-571B for Mental Health congregate care program.

   NOTE: A separate contract must be negotiated for each Congregate Care program, i.e., regular program or Mental Health program.

10. Contract renewals and routine changes can be accommodated by utilizing DSHS 9-303, Contract/Grant Amendment Modifications or Change Order Form. Contract renewals should be negotiated and forwarded to the Contracts Management Section 60 days prior to expiration.

DSHS 9-571(X) (11/81), CONGREGATE CARE FACILITY CONTRACT

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

CONGREGATE CARE FACILITY CONTRACT

CONTRACT NO. — _____

CONTRACTOR — _____

ADDRESS OF FACILITY — _____

FACILITY LICENSE NO. — _____ IRS NO. — _____

TERM — FROM _____ TO _____

PURPOSE—Contractor shall furnish necessary services, engage sufficient staff, and otherwise do all things necessary for or incidental to the provision of residential personal and social care to adult _____ clients placed by the Department in the CCF and to the performance of the General Terms and Conditions and the Statement of Work, attached hereto and incorporated herein.

CONSIDERATION—In consideration for such performance, the Department shall pay the Contractor $_____ per day for each client approved by the Department, for a maximum of _____ clients at any time, less client participation. Contractor shall submit invoices on a timely basis at intervals prescribed and on forms provided by the Department. No payment in advance or in anticipation of services to be provided under this contract shall be made by the Department.

APPROVAL—This contract and any amendment thereto shall be subject to the written approval of the Contracting Officer of the Department or his delegate by writing and shall not be binding until so approved. No other person shall have express, implied, or apparent authority to enter into this contract or to alter, amend, modify, or waive any provision or condition hereof.

CONTRACTOR NOT EMPLOYEE OF THE DEPARTMENT—Contractor and his employees or agents performing under this contract are not employees or agents of the Department. Contractor and his employees shall not hold themselves out as or claim to be officers or employees of the Department or of the State of Washington by reason hereof and shall not make any claim of right, privilege, or benefit which would accrue to a civil service employee under Chapter 41.06 RCW.

CLIENT STATUS—Contractor shall immediately notify the Department in the event of death, discharge, unauthorized leave or other change in status of any client, on the form provided by the Department.

Contractor	Date	Contracting Officer Department of Social and Health Services	Date

This contract has been approved as to form by the Attorney General.

DSHS 9-571 (X) (11/81) OX A-33

DSHS 9-571(X) (11/81), CONGREGATE CARE FACILITY CONTRACT (CONT.)

GENERAL TERMS AND CONDITIONS

DEFINITIONS—As used throughout this contract, the following terms shall have the meanings set forth below:

1. "CCF" shall mean a congregate care facility as defined in Washington Administrative Code.
2. "Client Participation" shall mean only the actual amounts received by a client during the time he is residing in the CCF which, by law, are required to be paid by a client for necessary services under this contract.
3. "Contractor" shall mean the individual or other entity performing services under this contract. It shall include any subcontractor retained by the prime contractor as permitted under the terms of this contract.
4. "Contracting Officer" shall mean the Supervisor of the Office of Contracts Management of the Department and his delegates within that office.
5. "Department" shall mean the Department of Social and Health Services (DSHS) of the State of Washington, any division, section, office, unit, or other entity of the Department, or any of the officers or other officials lawfully representing the Department.

NONDISCRIMINATION—During the performance of this contract, Contractor shall comply with federal and state nondiscrimination laws, including, but not limited to, the following:

1. Nondiscrimination in Employment—Contractor shall not discriminate against any employee, and shall take affirmative action to ensure that employees are employed and treated during employment without discrimination because of race, color, sex, religion, national origin, creed, marital status, age, or the presence of any sensory, mental or physical handicap. This requirement does not apply, however, to a religious corporation, association, educational institution or society with respect to the employment of individuals of such religion to perform work connected with the carrying on of its activities.

   Nondiscrimination shall include, but not be limited to, the following: Employment, upgrading, demotion, transfer, and selection for training, including apprenticeships and volunteers.

2. Nondiscrimination in Client Services—Subject to program requirements, Contractor shall not, on the grounds of race, color, sex, religion, national origin, creed, marital status, age or the presence of any sensory, mental, or physical handicap:

   (a) Deny an individual any services or other benefits provided under this contract.

   (b) Provide any services or other benefits to an individual which are different, or are provided in a different manner, from those provided to others under this contract.

   (c) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service or other benefit provided under this contract.

NONCOMPLIANCE WITH NONDISCRIMINATION PLAN—In the event of Contractor's failure or refusal to comply with nondiscrimination law, this contract may be terminated in whole or in part and Contractor may be declared ineligible for further contracts with the Department. Contractor shall, however, be given a reasonable time in which to cure such noncompliance.

INDEMNIFICATION—Contractor shall defend, protect, and hold harmless the State of Washington, the Department, and any employees thereof, from and against all claims, suits and actions arising from any negligent act or omission of Contractor or any subcontractor, or any employees or agents of either, while performing under the terms of this contract.

COVENANT AGAINST CONTINGENT FEES—Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or a bona fide established commercial or selling agency maintained by Contractor for the purpose of securing business. The Department will have the right, in the event of breach of this clause by Contractor, to terminate this contract without liability or, in its discretion, to deduct from the contract price or otherwise recover the full amount of such fee.

CONFLICT OF INTEREST—The Department may, by written notice to Contractor, terminate this contract if it is found after due notice and examination by the Contracting Officer that gratuities in the form of entertainment, gifts, or otherwise are offered or given by Contractor, or an agent or representative of Contractor, to any officer or employee of the Department with a view towards securing this contract or securing favorable treatment with respect to the awarding or amending or the making of any determination with respect to this contract.

SEVERABILITY—If any provision of this contract or the application thereof to any person or circumstances shall be held invalid, such invalidity shall not affect the provisions or application of this contract which can be given effect without the invalid provisions or application, and to this end the provisions of this contract are declared to be severable.

WAIVER OF DEFAULT—Waiver of any breach shall not be deemed to be a waiver of a subsequent breach and shall not be construed to be a modification of the terms of this contract.

DSHS 9-571(X) (11/81), CONGREGATE CARE FACILITY CONTRACT (CONT.)

CHANGES AND MODIFICATIONS—The Contracting Officer may, at any time upon written notification to Contractor, and without notice to any known guarantor or surety, make changes within the general scope of the services to be performed under this contract. If any such change causes an increase or decrease in the cost, or the time required for the performance, of this contract, an equitable adjustment may be made in the contract price or period of performance, or both, and the contract shall be modified in writing accordingly. Any claims by Contractor for adjustment under this clause must be asserted within 30 days from the date of receipt by Contractor of the notice of such change, provided that the Contracting Officer may, in his sole discretion, act upon any such claim asserted prior to final payment under this contract. Nothing in this provision shall excuse Contractor from proceeding with the contract as changed.

DISPUTES—Except as otherwise provided in this contract, when a dispute arises between the Department and Contractor, a party shall request a dispute hearing with the Department's Office of Contracts Management. Such request for a hearing must:

1. be in writing,
2. state the disputed issues,
3. state the grounds upon which the party's claim is based,
4. state Contractor's name, address, and contract number, and
5. be sent by certified mail or personally delivered to the DSHS Office of Contracts Management, Olympia, Washington 98504, within fifteen (15) days after the party receives notice of the issues in dispute.

GOVERNING LAW—Contractor shall abide by all applicable statutes, rules, and regulations, though not specifically cited herein. This contract shall be governed by the laws of the State of Washington. Rights and remedies of the Department provided by this contract shall not be exclusive but shall be in addition to any other rights and remedies provided by law.

CONTRACT PRECEDENCE—Unless otherwise provided herein, in the event of an inconsistency in this contract the inconsistency shall be resolved by giving precedence in the following order: (1) Applicable Federal and State Statutes and Regulations, (2) General Terms and Conditions, (3) The Statement of Work.

Subject to the preceding paragraph, this contract contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of the contract shall be deemed to exist or to bind any of the parties hereto.

NONASSIGNABILITY OF CLAIMS—No claim arising under this contract shall be transferred or assigned by Contractor.

RECORDS, DOCUMENTS, AND REPORTS—Contractor shall maintain books, records, and documents which sufficiently and properly reflect all direct and indirect costs expended in the performance of this contract. These records shall be subject at all reasonable times to inspection, review, or audit by personnel duly authorized by the Department, the Office of the State Auditor, or authorized federal officials. Contractor shall retain all books, records, and documents material to this contract for five years after termination, and make them available for inspection by persons authorized under this provision. Contractor shall prepare and submit to the Department, upon request, such fiscal and expenditure reports as may be required for determining contractor costs related to performance of services under this contract.

PRIVACY—The use or disclosure by any party of any information concerning a client for any purpose not directly connected with the administration of the Department's or Contractor's responsibilities under this contract is prohibited except by written consent of the client, his attorney, or his responsible parent or guardian. Contractor shall respect the client's right to privacy, including personal mail and other communications.

SUBCONTRACTING—Contractor shall not enter into subcontracts for any of the work contemplated under the Statement of Work without obtaining prior written approval of the Department.

LICENSING AND ACCREDITATION STANDARDS—Contractor shall comply with applicable WAC requirements for boarding homes and private establishments and with all other applicable local, state, and federal licensing and accrediting requirements and standards required in the performance of this contract.

RIGHT OF INSPECTION—Contractor shall provide right of access to its facilities to the Department, its officers, or any other authorized agent or official of the State of Washington or the federal government at all reasonable times, in order to monitor and evaluate performance, compliance, and quality assurance under this contract.

OVERPAYMENTS—In the event Contractor (1) bills for clients not served, (2) bills in excess of the contractual limitation, (3) does not meet the performance criteria set forth herein, (4) bills for clients in excess of licensed capacity, or (5) fails to provide proper documentation for a billing, including a proper record of the presence of a client in the CCF, the Department shall be entitled to notify Contractor that an overpayment has been made and recover such overpayment.

The Department shall pay interest at the rate of one percent per month, but at least one dollar per month, on amounts due Contractor on underpayment or late payments, as provided by and subject to the conditions of Session Laws, Chap. 78, Laws of 1981. Contractor shall pay interest at the rate of one percent per month, commencing thirty days from the date of payment by the Department, on amounts due the Department for overpayments, provided that such interest shall not accrue, in the event of a good faith dispute, between the time of request for a dispute hearing and a final determination by the Department.

DSHS 9-571(X) (11/81), CONGREGATE CARE FACILITY CONTRACT (CONT.)

ADDITIONAL REMUNERATION PROHIBITED—Contractor shall not charge or accept additional remuneration from any client or relative, friend, payee, guardian, or attorney of the client, or any other person, for service provided under this contract other than those specifically authorized by the Department. In the event Contractor charges or accepts prohibited remuneration, the Department shall have the right to assert a claim against Contractor on behalf of the client, for double the amount charged. Any violation of this provision shall be deemed a material breach of this contract.

Contractor shall not be precluded from making reasonable additional charges for personal items and services, which have been approved in writing by the Department. Purchase of these services or items from Contractor must be optional and must be agreed to in writing by the client or his representative and the agreement filed in the resident's record maintained by Contractor.

CLIENT PROPERTY—Contractor shall maintain individual financial records for all clients who request the facility in writing to retain or spend money on their behalf. Such accounts shall be kept current and in detail and contain supporting verification, consents, and receipts for all monies received and disposed of. Funds in excess of those reasonably needed to meet client cash needs shall be deposited in a bank account, separate and apart from other bank accounts of the facility. Contractor shall maintain receipts signed by the client where client funds are delivered to the client in a lump sum. The client shall have the right to make other arrangements for the management of funds at any time. Problems of financial mismanagement in individual cases, which cannot be resolved by advice and counseling, shall be referred to the Department for resolution.

Subject to written conditions provided by the Department, the contractor shall allow the client unrestricted use and custody of clothing, personal items, incidentals allowance and all exempt funds possessed.

ASSIGNMENT—Contractor shall not assign this contract, and shall provide written notice to the Contracting Officer of any change of name of Contractor.

TRANSPORTATION—Contractor shall provide or arrange the provision of transportation of clients for emergency medical care and, subject to program requirements, to day treatment and training programs outside the CCF. Clients shall not be required to use personal and incidental funds for such purpose, unless the client has earnings from a paid workshop program, which have been approved in writing for such use by the Department.

PLACEMENT—Immediately upon arranging with Contractor for placement of a client, the Department shall forward to Contractor the Social Services Authorization, including notice of award, client assessment, and the name, address and telephone number of the client's physician. Upon placement of a client, Contractor shall prepare a client file, which shall be the property of the Department, and which shall contain the above documents together with other documents required by this contract or by program standards.

TERMINATION OF CARE—The Department may terminate care of a client or revoke eligibility for services under this contract by notification to the CCF in writing. Such termination shall be effective 1) immediately upon relocation by the Department of such client in another facility, or 2) thirty days from the date of such notice, if the notice states that the Department will not relocate such client.

Contractor shall have the right to request, by written notice to the Department, permission to discharge a client from Contractor's facility when (1) the client's needs are in excess of services stipulated under the terms of this contract (2) discharge of the client would be in the best interest of the client or in the best interest of other clients, (3) the client has failed to make proper payment, as permitted by the Department, for services rendered, or (4) the client needs nursing care in excess of that permitted by boarding home licensure. Upon approval by the Department of such discharge, Contractor shall immediately notify the client in writing of such decision, and the Department shall commence action for removal or termination of the client, which shall occur within thirty days. Nothing herein shall prohibit the immediate discharge of a client by Contractor in an emergency, after notification to and approval of the Department.

TERMINATION OF CONTRACT—The Contracting Officer may, by written notice, terminate the contract in whole or in part as follows:

1. Failure of Contractor to perform any of the provisions hereof. In such event Contractor shall be liable for damages as authorized by law, including, but not limited to, any cost difference between the original contract and a replacement contract with a third party, including all administrative costs related to such replacement contract. The Department may withhold from any amounts due Contractor for completed work or services such sum as the Contracting Officer determines to be necessary to protect the Department against potential loss or liability.

2. At any time when, in the sole discretion of the Contracting Officer, it is in the best interest of the Department, upon thirty days written notice beginning on the second day after mailing. If this contract is so terminated, the Department shall be liable only for payment in accordance with the terms of this contract for services rendered prior to the effective date of termination.

3. In the event funding from state, federal, or other sources is withdrawn, reduced, or limited in any way prior to normal completion of the contract, the Department may terminate this contract by thirty days written notice, beginning the second day after mailing, subject to renegotiation under new funding limitations and conditions.

4. By mutual agreement of the parties.

Upon termination under this clause, the Department shall continue to pay for clients remaining in the CCF, for a maximum of 30 days from the effective date of termination. Terms of this contract which are applicable shall remain in effect during such period.

DSHS 9-571A (1/82), REGULAR CLIENT STATEMENT OF WORK

Congregate Care Facility Contract

WASHINGTON STATE DEPARTMENT OF SOCIAL & HEALTH SERVICES

REGULAR CLIENT STATEMENT OF WORK

OBJECTIVES—The objectives of the regular client congregate care program are to 1) prevent or reduce inappropriate institutional care, 2) develop independent living skills, and, where possible, assist clients in moving to less restrictive care, 3) maintain clients in the least restrictive setting possible, 4) provide for health and safety and 5) prevent abuse, neglect, or exploitation.

ELIGIBILITY—To be eligible as a regular client, a person shall 1) be at least 18 years of age, 2) be a beneficiary of supplemental social security and state supplementation or continuing general assistance, 3) be unable to maintain safe independent living environment or require personal care and supervision, assistance with daily activities, or health-related services, and 4) not require: nursing care in excess of that allowed by boarding home licensure; developmental disabilities specialized services as described in WAC 275-38 unless there is a plan of care developed to provide for these specialized services apart from regular CCF services provided by the congregate care facility; mental health CCF program as described in WAC 288-15-562(2)(e) unless there is a plan of care developed to provide for mental health specialized services apart from the regular congregate care services provided by the CCF facility; and, alcoholism and/or drug treatment as described in WAC 388-15-562(3).

INDIVIDUAL SERVICE PLAN—Contractor shall develop and maintain an individual service plan, revised annually, for those clients assessed by Department staff as requiring such services to improve level of functioning. The Individual Service Plan, if required, shall be completed by CCF staff with client participation and must be filed in the client's chart.

The individual service plan shall describe the specific problems the resident may have and outline a plan of care, be updated with progress notes, and be reviewed, modified, or terminated as the client's needs change or stabilize.

ACTIVITIES—Contractor shall offer clients who do not participate in sheltered workshops, other employment, or other approved programs a minimum of 14 hours per week of varied and appropriate supervised activities in which each client is encouraged to participate. An activity schedule shall be posted and current, and shall be subject to approval by the Department.

DISCHARGE—Contractor shall notify the Department of the discharge or death of a client within 24 hours, or the next business day following a weekend or holiday.

When a client for social reasons is to be absent from the facility for more than 72 hours, Contractor shall enter written justification of such absence in the client's chart. The chart shall be available in the facility for audit purposes. Discharge and readmission of the client shall not be necessary for documented, justified absences not exceeding 14 days. Social leave in excess of 14 days shall require written Department approval.

Discharge and readmission of the client shall not be considered necessary for brief hospitalization not exceeding 7 days. Absence shall be documented in the client's chart.

DSHS 9-571A 1/82 OX A-46