Medicaid State Plan
Personal Care Services
Service Chapter 535-05

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Medicaid State Plan - Personal Care Service 535-05

Authority Reference 535-05-01

(NEW 7/1/07 ML #3088)

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1. Section 50-24.1-18, 50-24.1-18.1 (North Dakota Century Code)
2. Section 75-02-02 (North Dakota Administrative Code)

Purpose 535-05-05

(NEW 7/1/07 ML #3088)

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Personal care services assist an individual with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), so that the individual is able to live at home. Personal care services are provided so as to assist the eligible individual with as many activities of daily living and instrumental activities of daily living as needed and as permitted in order to maintain independence and self-reliance to the greatest degree possible. Personal care services are appropriate when service activities are essential either on an intermittent or ongoing basis and the need for personal care services is expected to continue for an extended period of time in excess of 30 days.

Personal care services must be the primary need of the individual and are not intended to bring about improvement of an acute medical condition nor are they primarily intended to provide homemaker services to the individual. Personal care services are not appropriate for individuals whose needs fall within normal stages of development.

The individual should direct the care provided, if and when possible, and should be involved in training and monitoring the personal care service provider as much as possible and when appropriate.

Personal care services are generally provided in an individual's residence, however, services may also be delivered in other settings, such as a place of employment, if providing personal care services assists the individual in remaining as independent as possible and avoiding institutionalization. Personal care services may not be provided to an individual who is in a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.

The informal network, especially family members, should be explored as potential informal providers of care before formal care is provided under the provisions of this chapter. Care provided by the informal network

should not be replaced by formal/paid care unless this is necessary for the individual to receive such care.

Definitions 535-05-10

(Revised 1/1/10 ML #3215)

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1. ”Activities of Daily Living (ADLs)” means physical activities routinely performed on a daily basis by an individual and generally includes bathing, dressing, eating, toileting, transferring, maintaining continence, and mobility.
2. “Authorizing agent” means a home and community based service case manager employed by a county social service board or a developmental disabilities employed by a regional human service center.
3. “Basic care assistance provider” means an entity that is licensed as a basic care facility; is not owned or administered by state government; does not specifically provide services for individuals with traumatic brain injury or Alzheimer’s disease or related dementia; and is enrolled with the Department as such.
4. “Instrumental Activities of Daily Living (IADLs)” means complex life activities routinely performed by an individual such as housework, laundry, meal preparation, taking medications, shopping, outside mobility, management of money, personal hygiene, and use of telephone.
5. “Level A personal care services” means the level of care for an individual meeting the minimum eligibility criteria for personal care services.
6. “Level B personal care services” means the level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to the minimum eligibility criteria for personal care services.
7. “Level C personal care services” means the level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to having an impairment in 5 ADLS.
8. "Long term care need" means the need for the services available under the SPED Program, ExSPED Program, Medicaid Waiver Program, or the Medicaid State Plan Personal Care Option that is anticipated to exceed 30 days.
9. “Personal care service provider” means a qualified service provider or a basic care assistance provider.

10. ”Personal care services” means services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands on assistance or cuing so that the individual can perform a task without direct assistance.
11. Qualified service provider” means a county social service board, agency, or independent contractor that agrees to meet standards for service and operations established by the North Dakota Department of Human Services pursuant to NDCC 50-06.2-02(6) and NDAC 75-03-23.
12. “Unit” means either a 15-minute increment or a day.

Personal Care Eligibility Requirements 535-05-15

(Revised 2/1/17 ML #3489)

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To qualify for coverage of personal care services, an individual must have applied for and been found eligible for Medicaid benefits

And

1. Eligibility criteria for **Level A (up to 480 units per month), or Daily Rate care, or Basic Care** includes:

    a. Be impaired in at least one of the following ADLS of:

        i. Bathing
        ii. Dressing
        iii. Eating
        iv. Toileting
        v. Continence
        vi. Transferring
        vii. Inside Mobility

    Or

    b. Be impaired in at least THREE of the following IADLs:

        i. Meal Preparation
        ii. Housework
        iii. Laundry
        iv. Taking medications

2. Eligibility for **Level B (up to 960 units per month)** includes:

    a. Be impaired in at least one of the following ADLS of:

        i. Bathing
        ii. Dressing

iii. Eating
iv. Toileting
v. Continence
vi. Transferring
vii. Inside Mobility

Or

b. Be impaired in at least THREE of the following IADLs:

i. Meal Preparation
ii. Housework
iii. Laundry
iv. Taking medications

AND

c. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

3. Eligibility for Level C (up to 1200 units per month) includes:

a. Be impaired in at least five of the following ADLS of:

i. Bathing
ii. Dressing
iii. Eating
iv. Toileting
v. Continence
vi. Transferring
vii. Inside Mobility

AND

b. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

AND

c. None of the 300 hours (1200 units) approved for personal care services can be allocated to the tasks of laundry, shopping, or housekeeping.

AND

d. Have written prior approval for this service from a HCBS Program Administrator, Aging Services Division, Department of Human Services. The approval must be updated every three months.

After completing a comprehensive needs assessment the individual's case manager shall complete Section II of Personal Care Services Plan, SFN 662, to determine if the individual qualifies for personal care services. Section II allows the case manager to determine the level of impairment an individual is experiencing, based on specific medical, emotional and cognitive status. An individual must be impaired (have a score of at least 2) for any 1 ADL, or impaired (a score of at least 1) in 3 of the 4 IADLs meal preparation, housework, laundry, or taking medications. See the Instructions for Completing the Functional Assessment on scoring ADLs and IADLs.

The assessment measures the degree to which an individual can perform various tasks that are essential to independent living. Information on each of the ADLs or IADLs can be collected by observation, by direct questioning of the individual, or by interview with a significant other. The case manager shall maintain documentation supporting the level of impairment and shall include the following information if applicable:

1. Reason for inability to complete the activity or task
2. Kind of aid the individual uses (e.g., a grab bar or stool for bathing)
3. Kind of help the individual requires (e.g., preparing the bath, washing back and feet, complete bed bath) and the frequency of the need to have the help (e.g. units of services needed)
4. Who provides the help
5. Reasons for inability of a spouse or parent of a minor child to perform the activity or task for the individual
6. The individual's health, safety and welfare needs that need to be addressed
7. Document the anticipated outcome as a result of service provision
8. Other pertinent information

A comprehensive assessment must be completed initially before any personal care services can be authorized and annually thereafter. A review of the individual's needs must be completed every six months or when there is a significant change in the individual's needs.

Personal Care Service Tasks 535-05-20

(NEW 7/1/07 ML #3088)

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An individual who is eligible for personal care service may receive assistance with the tasks identified in this section when supported by a documented need identified through a needs assessment and authorized by a case manager. Reasons for the need to receive personal care services because of an inability of a spouse or parent of a minor child to perform the service must be documented in the needs assessment and the personal care services must be authorized by a case manager.

The following activities and tasks, as defined on SFN 663, may be authorized to be performed by a personal care service provider:

1. Bathing
2. Dressing/Undressing
3. Feeding
4. Toileting
5. Continence/Incontinence Care
6. Transferring, Turning, Positioning
7. Mobility
8. Meal Preparation
9. Housework
10. Laundry
11. Shopping
12. Medication Assistance
13. Eye Care
14. Nail Care
15. Skin Care
16. Hair Care
17. Teeth, Mouth, Denture Care
18. Money Management
19. Communication
20. Exercises
21. Indwelling Bladder Catheter Care
22. Medical gases assistance
23. Suppository assistance

24. Temperature, Blood Pressure, Pulse, Respiration Rate
25. Prosthesis/Orthotics assistance
26. Hoyer Lift/Mechanized Bath Chairs assistance
27. Ted Socks assistance
28. Ostomy Care
29. Postural/Bronchial Drainage
30. Jobst Stockings assistance
31. Ric Bed Care (Speciality Bed)

Limitations and Non-covered Services 535-05-25

(Revised 2/1/17 ML #3489)

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IM 5425
Second Amended IM 5322
Amended IM 5322
IM 5322

1. Personal care services may not include skilled services performed by persons with professional training.
2. An individual receiving personal care services may not be an inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental disease.
3. Personal care services may not include home delivered meals; services performed primarily as housekeeping tasks; transportation; social activities; or services or tasks not directly related to the needs of the individual such as doing laundry for family members, cleaning of areas not occupied by the individual, or shopping for items not used by the individual.
4. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housework tasks when provided must be incidental to the provision of other personal care tasks and cannot exceed 30% of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.
5. Services provided by a spouse, parent of a minor child, or legal guardian are not covered.
6. Payment for the tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication cannot be made to a provider who lives with the client and is a relative listed under the definition of family home care under subsection 4 of North Dakota Century Code section 50-06.2-02 or is a former spouse.

7. Care needs of the individual that are outside the scope of personal care services are not covered.
8. Services provided in excess of the services or hours authorized by the case manager in the individual's approved service plan are not covered.
9. Authorized personal care services may not exceed 120 hours (480 units) per month for Level A Personal Care Services or 240 hours (960 units) per month for Level B Personal Care Services, and 300 hours (1200 units) per month for Level C Personal Care Services.
10. Personal care services may only be provided when the needs of the eligible individual exceed the abilities of a spouse or parent(s) of a minor child to provide such services. Personal care services may not be substituted when a spouse or parent(s) of a minor child refuses or chooses not to perform the service. Personal care services may be provided during periods when a spouse or parent(s) of a minor child is gainfully employed if such services cannot be delayed until the spouse or parent(s) is able to perform them.
11. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.
12. The combination of personal care services and hospice service requires prior approval from the Department.

Prior Authorization 535-05-30

(Revised 2/1/17 ML #3489)

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Prior authorization by a case manager is required for all personal care tasks provided to an individual who meets the qualifying criteria for personal care services. The case manager must complete Personal Care Services Plan SFN 662 (PCSP) authorizing the services and hours that may be provided per month. Services and hours may be authorized for a period not to exceed 6 months.

The case manager must submit SFN 662 and supporting SFN 663(s) to either Aging Services or the Developmental Disabilities Division within three (3) working days of the date of completion of an assessment. Payment for personal care services may not be made without a prior authorization. With the exception of the authorization of Personal Care Services to be provided in a basic care facility, Personal Care Services may not be authorized prior to the date of the assessment. Authorization of Personal Care Services in a basic care facility may be authorized or up to 10 working days prior to the date of the assessment.

In addition, prior authorization from a State HCBS or DD Program Administrator is required to authorize units for meal prep, laundry, shopping, and housekeeping when performed by a live in provider or for a client who lives with other capable persons. Authorizations must be renewed annually.

Case Management 535-05-35

(Revised 2/1/17 ML #3489)

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IM 5404
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Case management for an individual applying for or receiving personal care services shall be the responsibility of a county social service board HCBS case manager except when the individual is also receiving a service(s) through the developmental disabilities division. Case management for personal care services for an individual receiving a service(s) through the DD division shall be the responsibility of a DD case manager. If the individual is not receiving service(s) through the DD Waiver, they have the right to choose the provider of case management services.

The case manager is responsible for assessing an individual's needs for personal care services, developing a comprehensive care plan that includes identification of tasks and times required to perform tasks, assisting the individual with obtaining a personal care service provider, monitoring and reassessing needs on a periodic basis, and terminating services when appropriate.

Decisions regarding personal care services for an incapacitated client are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

The case manager must schedule an appointment for an initial assessment no later than 5 working days after receiving a request for personal care

services and must complete an initial comprehensive assessment no later than 10 working days after receiving a request for personal care services. All contacts with an individual must be documented in the case file.

An application for services must include a complete functional assessment that was conducted with the individual in the home where the individual resides by an HCBS Case Manager. A comprehensive assessment must be completed initially and annually thereafter for the individual or if there has been a significant change in personal care needs. The comprehensive assessment must include information on the individual's physical health, cognitive and emotional functioning, ability to perform activities of daily living or instrumental activities of daily living, informal supports, need for 24 hour supervision, social participation, physical environment, financial resources, and any other pertinent information about the individual or his/her environment.

Individuals must actively participate in the functional assessment to the best of their ability. Case Managers must document in the client narrative if there is a medical reason why the client cannot participate in the assessment or answer questions directly. If a third party (including family) reports that the client cannot participate in the assessment but the case manager questions if this information is accurate you may request medical documentation to confirm that the client is not capable of participating before you can establish eligibility. It is the responsibility of the client to provide all information necessary to establish eligibility per NDAC 75-03-23-15. Proof of blindness, disability and functional limitation may include but is not limited to complying with all requests for medical records or an evaluation from PT, OT, Speech, neuro-psych evaluation etc. that would assist the case manager in completing a determination for HCBS services.

After completing the comprehensive assessment, the case manager and individual work together to develop a plan for the individual's care based on the individual's needs, situations, and problems identified in the assessment. The individual and case manager work together to develop a comprehensive plan of care that is recorded in the individual's case file, authorized on the Authorization to Provide Personal Care Services SFN 663, and summarized on the Personal Care Services Plan SFN 662. The plan must include:

1. All problems identified, including those that will not be addressed through the provision of personal care services.
2. Desired outcome(s) for each problem must be documented in the comprehensive assessment for which units of personal care services have been authorized.
3. The type(s) of help needed to achieve each desired outcome.
4. Services and providers that can supply the need for help.
5. Provider(s) the individual selects.
6. The amount of personal care service to be provided and the specific time-period.
7. Documentation of the medical necessity to monitor vital signs and identify who is to be notified of an individual's vital signs readings.

The case manager shall identify personal care service providers available to provide the service required by the individual and provide the following information to the individual:

1. Name, address and telephone number of available personal care service providers.
2. Identify whether a provider is an agency or individual QSP or a basic care assistance provider.
3. Any limitations applicable to the available providers.
4. If applicable, any global or individual specific endorsements for specialized cares that available providers are qualified to perform.

The individual must select the personal care service provider(s) they want to deliver the service to meet their care needs. The case manager must then complete an Authorization to Provide Personal Care Services, SFN 663, for each provider selected and finalize the Personal Care Services Plan, SFN 662.

The case manager must monitor and document that the individual is receiving the personal care services authorized on SFN 663. The case manager must review the quality and quantity of services provided. A reassessment of the individual's needs and care plan must be completed at a minimum of six-month intervals. The case manager shall visit with an individual in his/her place of residence every six months and review and update the assessment and the individual's care plan as necessary.

The case manager is responsible for following Department established protocols when abuse, neglect or exploitation of an individual is suspected.

Standards for Targeted Case Management (TCM) for persons in need of Long term Care.

- The service shall be performed by a social worker or agency who employs individuals licensed to practice social work in North Dakota and who has met all the requirements to be enrolled as either an Individual or Agency Qualified Service Provider (QSP) or an Indian Tribe/Indian Tribal Organization who has met State Plan requirements and requirements to be enrolled as a QSP or Developmental Disabilities Program Manager (DDPM) who is a Qualified Developmental Disability Professional (QDDP) or has one year experience as a DDPM with the Department.

The following enrolled provider types are eligible to receive payment for TCM:

- Case Managers employed by a County Social Service Agency who have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.
- Developmental Disabilities Program Manager (DDPM) who is a Qualified Developmental Disability Professional (QDDP) or has one year experience as a DDPM with the Department.
- An Individual Case Manager or Agency Case Manager that has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.
- Indian Tribe or Indian Tribal Organization who has met the provider qualifications outlined in the North Dakota State Plan Amendment

The following enrolled provider types are eligible to receive payment for TCM and Authorize MSP-PC Service:

- Case Managers employed by a County Social Service Agency (also eligible to approve services under SPED and EXSPED See Chapter 525-05-25).
- Developmental Disabilities Program Managers (DDPM)

- If the client is a recipient of services funded by the SPED, Expanded SPED Programs, or MSP-PC the one case file will contain documentation of eligibility for TCM as well as for the service(s)

The following enrolled provider types are eligible to receive payment for single event TCM:

- County HCBS Case Managers, DDPMs, enrolled Individual or Agency Case Managers and enrolled Indian Tribe or Indian Tribal Organizations.
  - If the client requests a contact more than once every six months the Case Manager needs to obtain prior approval from a HCBS Program Administrator.
  - Indian Tribe or Indian Tribal Organizations are limited to providing TCM Services to enrolled tribal members.

Targeted Case Management (TCM)

The individual receiving TCM will meet the following criteria:

1. Medicaid recipient.
2. Not a recipient of HCBS (1915c Waiver) services.
3. Not currently be covered under any other case management/targeted case management system or payment does not duplicate payments made under other program's authorities for the same purpose
4. Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or reside in a nursing facility if it is anticipated that a discharge to alternative care is within six months.
5. Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the ages of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.
6. Has "long-term care need." Document the required "long-term care need" on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.

7. The applicant or referred individual must agree to a home visit and provide information in order for the process to be completed.

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Care Plan Development

3-Referral and Related Activities

4-Monitoring and Follow-up Activities

- The focus or purpose of TCM is to identify what the person needs to remain in their home or community and be linked to those services and programs.
- An assessment must be completed and a Care Plan developed. The client's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS Web Based System or the THERAP System/MSP-PC Functional Assessment.
- Targeted case management is considered a "medical need" and thus included as a health care cost. Use of Medicaid funding for targeted case management may result in the recipient paying for/toward the cost of their case management. The client must be informed of that fact by noting Case Management Service and cost on the Individual Care Plan. Clients must also check and sign acknowledgment that if they are on Medicaid they may have a recipient liability. Payments from the Medicaid Program made on behalf of recipients 55 years or older are subject to estate recovery including for Targeted Case Management.

- The case record must include a HCBS Comprehensive Assessment and narrative which includes:

    - Name of the individual
    - Dates of case management service
    - Name of the case management provider/staff
    - Nature, content , units of case management service received, and whether goals specified in the plan are achieved

- Whether the individual has declined services in the care plan
- Coordination with other case managers
- Timeline of obtaining services
- Timeline for reevaluation of the plan

Limits:

Case management does not include direct delivery of services such as counseling, companionships, provision of medical care or service, transportation, escort, personal care, homemaker services, meal preparation, shopping or assisting with completion of applications and forms (this is not an all-inclusive list).

Case file documentation must be maintained:

1. In a secure setting
2. On each individual in separate case files

If case management is not provided under any waivered service, Targeted Case Management must be identified on the Personal Care Services Plan, SFN 662.

An individual must be given annually a "Your Rights and Responsibilities" brochure, DN 46 (available through Office Services), and verification of receipt of the brochure must be noted on SFN 1047, Application for Services, or in the documentation of the assessment.

Rural Differential Rates 535-05-38

(Revised 2/1/17 ML #3489)

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Purpose

The purpose of the rural differential rate is to create greater access to home and community based services for clients who reside in rural areas of North Dakota by offering a higher rate to QSPs who are willing to travel to provide services. QSPs that are willing to travel at least 21 miles round trip to provide care to authorized individuals in rural areas will be reimbursed at a higher rate for those cares. QSPs are not paid for the time they drive to or from the client's home; the rural differential rate may only be used for the time spent actually providing services.

Standards for Providers

Enrolled agency or individual QSPs, authorized to provide Medicaid State Plan Personal Care Services.

All individual QSPs and agency employees that are authorized to bill using the rural differential rate will be required to submit proof of address upon request to Medical Services Home and Community Based Services. The only proof of address that will be accepted for North Dakota residents will be a valid North Dakota driver's license. Once the driver's license is received the Department will verify that the address is current with the Department of Transportation.

If the QSP or agency employee resides in another State, the Department will accept another form of address verification i.e. current utility bill etc. If out of State residents submit other forms of identification the decision to accept it for purposes of being eligible to receive the rural differential rate will be made on a case by case basis.

Service Activities, Authorized

The rural differential rate must be identified on the Personal Care Service Plan, SFN 662 and the Authorization to Provide Personal Care Services, SFN 663. The SFN 662 and SFN 663 must be sent to the HCBS State office for all cases where the rural differential has been authorized. The SFN 663 must also include the clients physical address (PO Box is not acceptable). A printed copy of the map quest results must be maintained in the clients file, and send into the HCBS State office. If more than one provider is authorized and not all have Rural Differential Rate or different Rural Differential Rates a separate SFN 663 must be completed for each rate.

Service Eligibility, Criteria for

An HCBS client receiving services paid at the rural differential rates will meet the following criteria:

1. Must be eligible for Medicaid State Plan personal Care (MSP-PC).
2. Reside outside the city limits of Fargo, Bismarck, Grand Forks, Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston.

    - Situations where there is a discrepancy in what is considered city limits must be prior approved by the Rural Differential Coordinator. The HCBS Case Manager must send a written request for verification to the HCBS Program Administer responsible for program oversight.

3. Needs personal care and does not have access to a QSP of their choice, within 21 miles of their residence that is willing to provide care.

Service Delivery

The rural differential rate is based on the number of miles (round trip) a QSP travels from their home base to provide services at the home of an authorized HCBS recipient.

• Home base is either the individual QSPs physical address, or the Agencies home office, satellite office, or employees physical address (if they are not required to report to the home office each day because of distance) whichever is closer.

• If an agency employee is not required to report to the home office each day because of distance and they live 21 or more miles (round trip) from the client's home the rural differential rate may be used. If the employee lives less than 21 miles (round trip) from the client's home than the rural differential may not be used.

• Rural differential rates are based on the distance it takes to travel to each individual client's home even if the QSPs serve more than one recipient in the community or in the same home.

Addresses:

Case Managers must use the physical address (PO BOX is not acceptable) listed on the QSP list when determining which rural differential rate to use for individual QSPs and Agency providers. A QSP list including the provider's physical addresses will be provided to the HCBS Case Managers monthly.

Agency employees who are not required to report to their agency each day because of distance must make their address available to the HCBS office for verification. This address must be entered on the SFN 663 under QSP physical address. If a QSP states that the physical address on the QSP list is incorrect they must contact the HCBS office to change it before an authorization can be provided that includes a rural differential rate. It is not sufficient to notify the case manager.

If the QSP's address changes, the provider must notify HCBS and their Case Manager within 14 days. Once the Case Manager receives a notification of address change, they must recalculate a Map Quest to determine if there are any changes to Rural Differential eligibility for the QSP.

If the QSP's new address does not change the tier they have previously been approved for, the Case Manager must only make corrections to the authorization and Map Quest. A copy of the unchanged care plan, updated authorization and Map Quest must be forwarded to the Department. In addition, a copy of the revised authorization must be forwarded to the QSP.

If the address change does affect the tier previously authorized, the Case Manager must make corrections to the care plan, authorization and Map Quest and send to the Department. A copy of the revised authorization must also be forwarded to the QSP.

If the QSP no longer qualifies for an RD rate, the Case Manager must update the SFN 662 and SFN 663 by putting the DATE RD Removed on both forms and submit the SFN 662 and 663 with the state. The updated SFN 663 must be sent to the QSP.

Payment for Services 535-05-40

(Revised 1/1/10 ML #3215)

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A personal care service provider enrolled as a qualified service provider shall be paid based on 15 minute increments using a provider specific 15 minute unit rate, which may not exceed the maximum 15 minute unit rate established by the department.

A personal care service provider enrolled as a qualified service provider, who resides with an individual eligible to receive personal care services, may elect to be paid a daily rate for each day personal care services are provided for at least 15 minutes. The daily rate may not exceed the maximum per day rate established by the department and may be paid to no more than one QSP.

A personal care service provider enrolled as a basic care assistance provider shall be paid a daily rate if personal care services are needed and provided every day. The daily rate is an average per day rate that is provider specific and may not exceed the maximum per day rate established by the department. The daily rate is applicable to all eligible individuals needing and receiving daily personal care services from the basic care assistance provider and does not vary based on the amount of services provided daily. If personal care services are provided intermittently to an individual, the basic care assistance provider shall be paid based on the maximum agency 15 minute unit rate for the services provided to that individual.

Case management activities must be documented in the case file before payment for case management can be requested. The authorizing agent may be paid for targeted case management (TCM) for a Medicaid eligible individual in need of long term care services only if the individual is not receiving case management under any HCBS waiver or other targeted case management provisions. No claim may be made for TCM when a change in funding source for case management occurs or if an individual is not eligible for Medicaid. When accessing Targeted Case Management

payment, documentation must support that the individual is at risk of requiring long-term care services this can be narrated on the SFN 1047, Application for Services.

Provider Billing Procedures 535-05-45

(Revised 2/1/17 ML #3489)

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The personal care service provider is responsible for keeping written records documenting the delivery of care to each individual. The written record must include the date, the tasks performed, and the time required to perform the tasks.

The approved services on SFN 662 and SFN 663 must identify the procedure code the provider is to use to bill for services provided.

A personal care service provider who is enrolled as a QSP must use the Turnaround Document for Home and Community Based Care for the Elderly/Disabled (TAD), SFN 925, or the QSP online billing option to bill for services. A personal care service provider enrolled as a basic care assistance provider must bill using the Basic Care Assistance Turnaround Document. Only one (1) procedure code per individual may be entered in any one section on the TAD. Procedure code T1019 must be used be used to bill on a 15-minute increment basis. Billing is limited to the time in performance of the authorized tasks provided. The provider must bill in 15-minute increments on a daily basis. Each 15-minute increment is one (1) unit and the number of units of service provided on each day of care must be shown on the billing document. Procedure code T1020 must be used to bill a daily rate for a provider authorized to bill a daily rate. Only 1 unit per client may be billed per day for procedure code T1020. The provider may be paid the daily rate only for days on which personal care services were provided. The daily rate may not be paid for any days on which the individual was in the hospital or a health-care facility or on leave from the residence, except payment is allowed for the day the individual returns to the provider's care. Payment may be claimed when personal care services are provided on the day of death.

Case Managers should determine units in each of the categories of ADLs, Medication Assistance, Meal Preparation, Laundry/shopping/housekeeping, and Other. Some flexibility is anticipated in the provision of tasks amongst

the categories of ADL, Other, and Medication Assistance and the provider is allowed to bill up to the total units approved; however, the provider may not bill for units in excess of the units authorized in the category of laundry, shopping and housekeeping and Meal Preparation.

Reductions, Denials, and Terminations 535-05-50

(Revised 2/1/17 ML #3489)

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An individual dissatisfied with a decision made regarding personal care services may appeal that decision to the Department of Human Services under the fair hearing rules set forth in N.D.A.C. 75-01-03-03. An individual must be informed of the right to appeal any actions by the case manager or the department that result in denial, suspension, reduction, discontinuance, or termination of personal care services. Refer to Service Chapter 449-08 for more information with regard to Hearings and Appeals.

Denial/Termination/Reduction

The applicant/client must be informed in writing of the reason(s) for the denial/termination/reduction.

The Notice of Denial/Termination/Reduction form (SFN 1647) is dated the date of the mailing. Contact the HCBS Program Administrator to obtain the legal reference required at "as set forth . . . ." The legal reference must be based on federal law, state law and/or administrative code; and may include a policy and procedures manual reference(s). The citation used to complete the SFN 1647 must be obtained from a HCBS Program Administrator or the HCBS Unit Supervisor of Aging Services.

The client must be notified in writing at least 10 days (it may be more) prior to the date of terminating or denying services **(UNLESS** it is for one of the reasons stated in this section that does not require a 10-day notice). The date entered on the line, the effective date field, is 10 calendar days from the date of mailing the Notice (SFN 1647) or the next working day if it is a Saturday, Sunday, or legal holiday.

1. **Termination** of a service is discontinuing the service. The client must be informed in writing of the Termination by providing the client with a completed SFN 1647 or the client may provide a written statement indicating they no longer want the service.

2. **Denial** of a service may include denying the service to a new applicant or denying the number of units a current client requests.

    - When denying units the client has requested, the client must be informed in writing of the Denial by providing the client a completed SFN 1647.
    - When a client contacts the HCBS Case Manager or DD Case Manager per phone for general information about the service, the applicant must be made aware that a formal determination of eligibility for the service cannot be made by phone. The client must be offered the option to complete an Application for Services SFN 1047. Upon receipt of the completed SFN 1047 a home visit would be scheduled to determine eligibility.

        - After the SFN 1047 is received and a formal assessment is completed the client must be informed in writing of the Denial by providing the client with a completed SFN 1647 or the client may provide a written statement indicating they do not want the service.

    - When a home visit is completed to assess or inform an applicant about services, an application for service is implied by the client and a completed SFN 1647 must be provided informing the client of the Denial or the client can provide a written statement indicating they do not want the service.

3. **Reduction** in services may include reducing the number of units or reducing the tasks in a specific category. A written reduction notice is required (the client agreeing with the reduction is not sufficient).

    If the service is reduced the client must be informed in writing of the reason(s) for the reduction in service on the SFN 662, the effective date of the reduction must be no sooner than 11 days after the client signs the SFN 662 and the client must be given a copy of the appeal rights printed on back of the SFN 662.

Any of the reasons below do not require a 10-day notice:

1. The client enters a nursing home.
2. The county or Human Service Center has received in writing the client's decision to terminate services.
3. Client's whereabouts are unknown and attempt to contact the client are supported by documentation in the client's file.
4. State or federal government initiates a mass change which uniformly and similarly affects all similarly situated applicants, recipients, and households.
5. Case Management has factual information confirming the death of the client.

Termination of a Personal Care Service Plan (A Termination notice, SFN 1647, is required or the client can provide a written statement indicating they no longer want the service.)

Personal Care Service has not been used in 60 days:

The authorization for personal care service may be terminated if the service is not used within 60 days, or if services lapse for at least 60 days, after the issuance of the authorization to provide personal care services.

Health Welfare and Safety:

The department may deny or terminate personal care services when service to the client presents an immediate threat to the health or safety of the client, the provider of the service, or others, or when the services that are available are not adequate to prevent a threat to the health or safety of the client, the provider of services, or others.

The client is no longer eligible for Medicaid:

The Case Manager must send a letter informing the client that eligibility for MSP-PC is dependent on eligibility for Medicaid (the right to appeal the closure of the Medicaid benefit is sent to the client by Economic Assistance).

Provider Qualifications 535-05-55

(Revised 1/1/10 ML #3215)

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To provide personal care services, an individual or agency must be enrolled with the Medical Services Division as a qualified service provider. A residential care provider must be licensed and enrolled as a basic care provider. Agency providers must ensure that each employee meets the required standards for a QSP before an employee can provide personal care services. Residential providers must ensure that each employee meets the required standards in the Basic Care Licensing Standard outlined by the North Dakota Department of Health.

A QSP must be at least 18 years of age and must provide evidence that he or she meets the general QSP standards included at NDAC 75-03-23-07. Competency of meeting standards required to provide personal care services for which a global or client specific endorsement is required can be verified by a health care professional or applicable certifications or licensure.

The provider agreement with a personal care service provider shall be terminated for cause under the provisions of NDAC 75-03-23-08.

Critical Incident Reporting 535-05-57

(Revised 7/1/21 ML# 3633)

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Critical Incident

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of any client individual receiving HCBS.

In order to assure the necessary safeguards are in place to protect the health, safety, welfare of all individuals receiving HCBS, all critical incidents (as defined in this chapter) must be reported and reviewed (as described in this chapter). The goal of the incident management system is to proactively respond to incidents and implement actions that reduce the risk of likelihood of future incidents.

This chapter includes all individuals receiving personal care service, including those that receive MSP-PC in a Basic Care setting.

Reportable Incidents

1. Abuse (physical, emotional, sexual), neglect, or exploitation
2. Rights violations through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation, or policy
3. Serious injury or medical emergency, which requires care that would not be routinely provided by a primary care provider
4. Wandering or elopement
5. Restraint violations
6. Death of any HCBS individual who has an open case, regardless of where the death occurred or if it was witnessed by the provider. A Report of an individual's death must include and the cause (including death by suicide)
7. Medication errors or omissions

- Medication errors that occur in a setting other than a basic care facility include all medication errors and omissions
- Medication errors in a basic care facility are defined to align with the reporting requirements of the Department of Health. A reportable medication error for the purposes of this chapter is defined as "a medication error by facility staff member which results in a negative outcome to a resident or a pattern of medication errors"

8. Any event that has the potential to jeopardize the individual's health, safety or security if left uncorrected.
9. Changes in health or behavior that may jeopardize continued services.
10. Illnesses or injuries that resulted from unsafe or unsanitary conditions.

HCBS Case Manager will follow up with all reported critical incidents.

If HCBS Case Manager has first-hand knowledge of a critical incident, follow incident reporting requirements.

Apart from a critical incident that occurs within a basic care facility, if the case involves abuse, neglect or exploitation, a formal VAPS (Vulnerable Adult Protective Services) referral will be initiated according to ND Century Code 50-25.2-03(4). VAPS will be responsible for independent review and follow up.

If the incident involves a provider, the complaint protocol will be followed to determine the next steps, which may include involving law enforcement.

Incident reporting requirements

Any paid provider or paid family member who is with an individual, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident. If the incident is a death an incident report must be completed even if the death is not witnessed by the paid provider or paid family member.

Note: A General Event Report (GER) in the Therap case management system is the same as a Critical Incident Report (CIR) referenced in this policy.

As soon as a paid provider or paid family member learns of a critical incident involving an individual, the incident must be:

1. Reported to the HCBS Case Manager and
2. A Critical Incident Report (CIR) must be completed and submitted to the HCBS Case Manager within 24 hours of the incident. The CIR must be submitted using a General Event Report (GER) offline form.

    a. The GER offline form can be accessed here: https://help.therapservices.net/app/answers/detail/a_id/2039/related/1#OfflineForms-GER
    b. The GER Event Report along with the GER Event Type form (e.g. medication error, injury, etc.) must be completed and submitted together.
    c. The program administrator will then enter the GER Event Report and Event Type into Therap.

<u>Examples</u>

Example 1: If an individual falls while the QSP is in the room but the individual didn't sustain injury or require medical attention, a critical incident report is not required.

Example 2: If a family member informs the case manager or the facility that an individual is in the hospital due to a stroke, a critical incident report is not required because the case manager nor the facility staff witnessed or responded to the event. If the individual dies while in the hospital an incident report must be submitted if the individual's HCBS case is still open.

Example 3: If an employee in the facility comes to an individual's room and the individual is found on the floor and the staff member calls 911 so the individual may receive medical attention, a critical incident report is required because the individual required medical attention AND the staff member responded to the event (fall).

Example 4: If an individual was not given a dose of digoxin and developed heartbeat irregularity a critical incident report is required because the medication error resulted in a negative outcome.

Department Responsibilities

Within 24 hours or 1 business day of receiving the report from the HCBS case manager, the department will submit a medical case incident report for high level incident reports into the ND Risk Management Incident Reporting system.

The program administrator will also enter GER offline reports into Therap within 24 hours of receiving report or 1 business day.

The department will hold quarterly critical incident team meetings to review all critical incident reports for trends, need for increased training and education, additional services, and to ensure proper protocol has been followed. The team consists of the ND DHS Aging Services Division Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the DHS risk manager.

The Department of Justice (DOJ) agreement coordinator (Aging Services Division Director) is responsible to ensure that critical incidents are reported as described in the settlement agreement to the DOJ and the subject matter expert (SME) within 7 calendar days of the receipt of the critical incident.

Remediation Plan

A remediation plan is required to be developed and implemented for each incident except for death by natural causes as required by the DOJ and the Aging Services Division. The department will be responsible to monitor and follow up as necessary to assure the remediation plan was implemented.

The remediation plan will include corrective actions taken, a plan of future corrective actions, and a timeline to complete the plan if applicable. The HCBS case manager and program administrator are responsible to follow up with the QSP to ensure the remediation plan is acceptable.

Instructions for Completing the Functional Assessment 535-05-60

Activities of Daily Living (ADLs) Scoring 535-05-60-01

(NEW 7/1/07 ML #3088)

View Archives

The scale used to measure independence in ADLs uses ratings from 0 through 3. A score of zero represents complete independence (no impairment), while 3 represents complete dependence (impairment). Each item measures the level of impairment of the individual, regardless of the amount of help they may or may not be receiving at present. Scoring is based on how individual usually performs a task.

Two general concepts govern the manner in which an individual is compared with the assessment criteria. First, the individual is considered as a "whole entity." The Case Manager does not measure physical capacity or cognitive ability or affective state separately, but rather one's functioning as a whole. For example, if one has ample physical strength and skill to complete a task, but also has cognitive limitations that prevent him/her from doing so, that person cannot complete it. Secondly, the Case Manager must measure the individual's level of functioning in the present. What the individual could or could not do in the past is not an issue nor is what the individual, under hypothetical conditions, might be able to do in the future. Each task must be looked at as the sum of its parts. One must be able to complete all of the parts of a task in order to complete the task.

Information regarding ADL impairments can be obtained by observation, interview with family or friends, or by direct self-report of the individual. Narratives must be included in the case file for each ADL identified as an impairment. Narratives must include:

- Reason for inability to complete the task
- The kind of aids (grab bars, bath stool etc) the individual uses
- The kind of help the individual is receiving
- What services and the frequency the individual requires to meet needs

- Outcome anticipated as a result of service provision
- Other relevant information

For each functional impairment identified for which a service has been authorized, a desired outcome and the assistance required to achieve the outcome must be addressed in the notes/narrative section of the comprehensive assessment. An ADL or IADL must be scored impaired before a service or task related to the activity is authorized.

For each ADL or IADL that is scored impaired and no services have been authorized, document how the need is being met.

The scale used to rate each ADL has four basic categories of functioning:

0: Completely Able - Activity completed under ordinary circumstances without modification, and within reasonable time. (A "reasonable time" involves an amount of time the individual feels is acceptable to complete the task and an amount which does not interfere with completing other tasks, as well as the professional judgment of the case manager based on the individual's age, health condition, (e.g. arthritis) and situation.

1: Able with Aids/Difficulty - Activity completed with prior preparation or under special circumstances, or with assistive devices or aids, or beyond a reasonable time.

2: Able with Helper - Activity completed only with help or assistance of another person, or under another person's supervision by cuing. Individual performs at least half the effort to complete the activity.

3: Unable - Individual assists minimally (less than half of effort), or is totally dependent.

Activities of Daily Living (ADLs) Considered in Determining Eligibility for Personal Care Service 535-05-60-05

(NEW 7/1/07 ML #3088)

View Archives

BATHING - Measure the individual's ability to bathe, shower or take sponge baths independently for the purpose of maintaining adequate hygiene. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, frequent nose bleeds, and balance problems. Consider ability to turn faucets, regulate water temperature, wash and dry completely.

0: Able to prepare and take a bath or shower independently within a reasonable time. NOTE: If the only help an individual requires is help with shampooing, score this item "0."

1: Requires the use of equipment (i.e., tub stool, grab bars, or handle bars) to bathe or shower. Small items such as mitten wash cloths, long-handled brushes or non-slip soap dishes are not considered special equipment.

2: Needs another human to assist throughout this activity. This may include cuing. Individual must perform at least half the task.

3: Unable to assist or assists minimally (less than half the effort) or is totally dependent on another human to complete the activity.

DRESSING/UNDRESSING - measure the individual's ability to dress or undress. Consider individual's need of appropriate dress for weather or street attire. Consider ability to get clothes from closets and drawers as well as putting them on. Also include ability to put on prosthesis or assistive devices. Consider fine motor coordination for buttons and zippers,

and strength for undergarments or winter coat. Do not include style or color coordination. Do not include tying shoes.

0: Able to dress independently within a reasonable amount of time.

1: Uses aids such as zipper pulls and specially designed clothing (e.g., velcro fasteners) or requires an inordinate amount of time to do so.

2: Needs another human to assist with dressing and performs at least half the effort or needs human assistance as a reminder to get dressed or for the laying out of clothes.

3: Totally dependent due to physical or cognitive impairment or provides less than half the effort in dressing.

EATING – measure the individual's ability to feed him/herself including cutting meat and buttering bread. Consider individual's ability to cut food into manageable size pieces, chew and swallow hot and cold foods, and swallow beverages. Do not include meal preparation.

0: Able to eat independently within a reasonable amount of time.

1: Uses special grip utensils or plates or takes an inordinate amount of time to eat.

2: Performs at least half the effort required to eat, but receives some assistance from another human.

3: Performs less than half the effort.

TOILETING – measure the individual's ability to use bathroom, commode, bedpan, or urinal, transfer on or off the toilet, flush, cleanse, adjust clothes, and manage ostomy or catheter. Consider frequency of need and need for reminders.

0: Able to complete activity independently or uses a urinal, bedpan or commode at night only and manages without assistance (including emptying the device).

1: Uses grab bars, raised toilet set or transfer board or takes an inordinate amount of time.

2: Requires human assistance in completing the activity but performs half the effort.

3: Performs less than half the effort.

CONTINENCE/INCONTINENCE – measure the individual's ability to control bladder and bowel. Incontinence may have one of several different causes, including specific disease processes, side-effects of medications, and functional difficulty (i.e., inability to reach the bathroom in time to avoid accidents - usually due to poor mobility.)

0: Complete voluntary control of the bladder/bowel; never incontinent.

1: Individual has catheter or other urinary drainage device including absorbent pads. Individual is able to empty, clean, and manage the use of the device without human assistance. Individual has no accidents. Requires stool softeners, suppositories, laxatives, or enema, but does not require human assistance, or has colostomy, but can manage device without human assistance. Individual has no accidents.

2: Individual needs human assistance with a device, medications, enemas, or has occasional accidents (with or without a device).

3: Cannot control urinary flow or control of bowels, despite aids or assistance.

TRANSFERRING IN AND OUT OF BED OR CHAIR – measure the level of assistance the individual needs to move to or from bed, chair, wheelchair or standing position. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc.; the ability to adjust the bed or place/remove handrails, if applicable and necessary. Do not include transferring to toilet.

0: Able to transfer independently within a reasonable amount of time.

1: Special equipment, such as lifts, hospital beds, sliding boards, "trapezes" or pulleys, is used or individual takes an inordinate amount of time to transfer.

2: Is supported by human help to transfer or performs half the effort.

3: Must be lifted in/out of bed/chair.

MOBILITY - measure individual's ability to move about inside the home. Do not consider transferring in and out of bed or chair.

0: Able to get around inside independently within a reasonable amount of time.

1: Uses aid such as walker, wheelchair, cane, crutches, or furniture to get around.

2: Needs human assistance to get around.

3: Individual is bedbound.

Instrumental Activities of Daily Living (IADLs) Scoring 535-05-60-10

(NEW 7/1/07 ML #3088)

View Archives

Instrumental activities of daily living (IADLs) measures an individual's ability to carry out tasks that may not need to be done daily like ADLs, but which nevertheless are important for living independently. Intervention may be required to help an individual adapt to difficulties experienced in performing IADLs. Performance of IADLs requires mental as well as physical capacity. The IADL scale measures the functional impact of emotional, cognitive, and physical impairments. Only four IADLs are used when determining if an individual is eligible to receive personal care service. If an individual is eligible for personal care services, he/she may receive assistance with IADLs that are not considered when determining the eligibility for personal care services, but have been scored a 1 or 2.

IADLs are scored based on what an individual can do rather than what he/she is doing. IADLs should be scored based on how an individual usually performs a task. Individuals who have occasional difficulty should be coded based on their usual performance, noting the occasional difficulty in the narrative. Not all individuals have the opportunity to perform IADL tasks. For example, an individual who lives with a relative or spouse might not prepare meals simply because another person routinely does this task. Similarly, some individuals do not manage their own money because a spouse does it. However, the IADL scale is designed to measure an individual's ability both physical and cognitive to perform these tasks, regardless of the individual's opportunity to perform them.

In IADL scoring it is essential to look at each task as the sum of its parts. Doing the laundry, for example, includes requirements of the physical ability to carry laundry to the washing machine, the cognitive ability to operate the washing machine including the measuring of soap and setting of controls, the physical ability to move laundry from washer to dryer, the cognitive ability to operate the dryer, the skill to fold and physical ability to carry the clean laundry back from the machine. If one can operate the

washer and dryer, but cannot carry the laundry to or from the machines, this individual would rate a 1, “With Help."

Obtain information regarding IADL impairments by observation, interview with family or friends, or by direct self-report of the individual. Narratives must be included in the case file for each IADL identified as an impairment. Narratives must include:

- Reason for inability to complete the task.
- The kind of aids (grab bars, bath stool etc) the individual uses
- The kind of help the individual is receiving and frequency of assistance
- What services and the frequency the individual requires to meet needs
- Outcome anticipated as a result of service provision
- Other relevant information

The scale used to rate each IADL task has three basic categories of functioning:

0: Without help. Individual is able to perform task independently, without reminder or assistance.

1: With help. Individual is able to perform task only with assistance, reminder, or cuing.

2: Can't do at all. Individual is not able to perform task at all, even with assistance.

Instrumental Activities of Daily Living (IADLs) Considered in Determining Eligibility for Personal Care Services 535-05-60-15

(NEW 7/1/07 ML #3088)

View Archives

MEAL PREPARATION – Measure the individual's ability to prepare hot and/or cold meals that are nutritionally able to sustain the individual or therapeutic, as necessary. Consider individual's cognitive ability, such as ability to remember to prepare meals, individual's ability to prepare foodstuffs, to open containers, to properly store and maintain foodstuffs, and to use kitchen appliances. Do not consider clean up. Do not include canning of produce or baking of such items as cookies, cakes, and bread.

0: Able to prepare and cook meals or individual does not usually cook but is able to.

1: Needs some assistance from another person, i.e., individual is unable to prepare a meal but is able to reheat a prepared meal.

2: Unable to prepare or cook meals.

HOUSEWORK – Measure the individual's ability, not the actual performance, to do routine housework. Routine housework does not include cleaning of basement, attic, windows, shampoo carpet, or moving furniture. Consider minimum hygienic conditions required for the individual's health and safety. Do not include laundry. Do not include refusal to do tasks if refusal is unrelated to the impairment.

0: Completely able.

1: Able to do some but not all housework.

2: Unable to do any housework.

LAUNDRY - Measure the individual's ability to do laundry. Consider the individual's cognitive ability to sort, carry, load and unload, fold and put away clothes. Consider the need to use coins for pay machines. Consider the individual's physical and cognitive ability to complete these tasks even if individual lives with others who do the laundry for the individual. Score 0 if the only problem is that laundry facilities are located outside the home.

0: Completely able to do laundry.

1: Requires some human assistance (i.e., facility is in the basement and a family member carries the laundry up the basement stairs).

2: Unable to do any laundry.

TAKING MEDICATION – Measure the individual’s ability to take medicine by oneself. Consider the ability to remember to take medicine, get the medicine from the place it is kept within the home, measure proper amounts, actually swallow the medicine, apply ointment; or give injections (including the filling of syringes). Score 0 for an individual who has no medication needs. Score according to individual's ability to perform the task even if commonly done by others. Score need for service monitoring of medications due to possibility of overdose as a 2. Do not consider obtaining of medication from pharmacy.

0: Completely able to take medication, including giving injections.

1: Requires some human assistance.

2: Unable to take medication.

Instrumental Activities of Daily Living (IADLs) Not Considered in Determining Eligibility for Personal Care Services 535-05-60-20

(NEW 7/1/07 ML #3088)

View Archives

SHOPPING - This item considers the individual's ability to shop for groceries and other essentials assuming transportation or delivery is available. If the individual needs assistance or is unable to shop, the task may be approved. Consider ability to make shopping lists, to function within the store, to locate and select items, to reach and carry purchases, to handle shopping carts, to communicate with store clerks, and to put purchases away when determining the level of assistance needed. Do not consider banking, posting mail, monetary exchanges, or availability of transportation to determine individual's shopping abilities.

0: Able to shop but needs help with transportation.

1: Needs human assistance (i.e., carrying bundles).

2: Unable to shop.

GET AROUND OUTSIDE - This item considers the individual's ability to move around outside, to walk or get around by some other means (i.e., wheelchair), and to do so without assistance. Consideration should be given to the ability to negotiate stairs, streets, porches, sidewalks, and entrances and exits of residence and destination. An individual who requires an escort to push a wheelchair, hold arm for stability or to assist in event of disorientation or who is completely unable to go outdoors due to physical or mental disability may be authorized for personal care tasks related to getting around.

0: Completely able to get around outside (even if he/she uses a wheelchair/walker).

1: Requires an escort to push a wheelchair, hold his/her arm for stability or to assist in event of disorientation.

2: Completely unable to go outdoors due to physical or mental disability.

MANAGEMENT OF MONEY - This item considers the individual's ability to handle money and pay bills. Consideration is given to the individual's ability to plan, budget, write checks or money orders, and exchange currency and coins. Include the ability to count and to open and post mail. Do not consider insufficient funds. An individual who cannot write checks and pay bills without help, but makes day to day purchases and handles cash or who has a legal guardian or conservator or is unable to manage money may be considered for assistance with this task.

0: Able to manage his/her money independently.

1: Cannot write checks and pay bills without help, but makes day to day purchases and handles cash.

2: Has a legal guardian or conservator or client is unable to manage money.

COMMUNICATION/TELEPHONE USE - This item considers the individual's ability to use the telephone. Include getting telephone numbers and placing calls independently. The individual must be able to reach and use the telephone, answer the telephone, dial, articulate and comprehend. If the individual uses special adaptive telephone equipment, consider the individual's performance based on the ability to perform this activity with that equipment. If the individual has no telephone, ask about his/her ability to use a telephone elsewhere, such as at a neighbor's home. The use of an

emergency response system devise may not be considered when determining telephone use.

Special equipment in common use includes:

- amplifiers for people with speech and hearing impairments
- enlarged dials or number stickers for the visually impaired
- modified telephones for those with hearing aids
- telephones hooked up to teletypewriters for those with speech impairments
- signals (tone ringers, loud bells or lights) to indicate that the telephone is ringing
- speaker telephones and head sets for persons who cannot hold receivers

The tasks of routine writing or reading also fall within the scope of the IADL of communication/telephone use because each is a basic and common means of communication. If the individual needs a routine regimen of assistance with routine writing or reading of correspondence, this functional impairment may be documented within the scope of the IADL of communication/telephone use.

Time associated with routine assistance with communication/telephone use should always be very minuscule (likely not lasting more than 1 or 2-15 minutes units) and occur not more than twice in any given month under most circumstances.

An individual who requires human assistance to perform the task or is unable to answer the telephone or dial the operator may be considered for personal care tasks related to communication.

0: Completely able.

1: Requires human assistance (i.e., someone else must dial).

2: Cannot answer the telephone or dial the operator.

Other IADLs 535-05-60-25

(NEW 7/1/07 ML #3088)

View Archives

The need for the following tasks must be included in the individual's assessment before the tasks can be authorized. These IADL tasks do not need to be scored based on a level of impairment. The assessment must however, include the need, frequency and outcome for each authorized task.

- Apnea Monitor
- Exercises
- Eye Care
- Fingernail care
- Haircare/shaving
- Hoyer lift
- Indwelling bladder catheter
- Jobst stockings
- Ostomy care
- Oxygen
- Postural/bronchial drainage
- Prosthesis/orthotics
- Skin Care
- Specialty Bed
- Suppository/bowel program
- Ted Socks
- Teeth, mouth, denture care
- Vital signs

Notes and Narratives 535-05-65

(Revised 4/1/12 ML #3326)

View Archives

Include all information relevant to the client obtained during the assessment process that was not entered in a comment or note field for ADLs or IADLs. A signed and dated hard copy of the assessment including the narrative must be kept in the client file.

All contacts relating to a client must be noted in the narrative section of the comprehensive assessment. Notes maintained in any other format are not considered valid. When applicable, notes/narrative should include the following:

- Date
- Reason for contact (i.e. initial, annual, six month, collateral, returned call, received call)
- Location of visit (i.e. home visit, care conference, hospital visit, office visit, telephone contact, letter sent)
- A description of the exchange between the case manager and the client or the collateral contact
- A listing of identified needs
- Service delivery options
- Summary of care plan
- Client satisfaction and follow-up plan
- Initial’s of Case Manager completing the note or narrative

HCBS Case Managers Record Management System

- The HCBS Comprehensive Assessment is a web-based product of Synergy Technologies. The HCBS Comprehensive Assessment enables the HCBS case manager to record the applicant's/client's functional impairment level and correlate that to the need for in-home and community-based services.

DD Case Managers Record Management System

- The DD Case Managers comprehensive assessment consists of three components;

    1. Case Plan in THERAP that identifies the desires outcomes and all services the individual is receiving.
    2. Progress Assessment Review (PAR) in THERAP that includes information regarding diagnoses, medications, behavioral issues, psychiatric, legal and support needs. The PAR and Case Action Form also serve as the ICF/MR level of care screening.
    3. Personal Care Eligibility and Needs Assessment for DD that determines whether the specific eligibility for Personal Care Services are met.

Forms 535-05-70

Instructions for Completing Personal Care Services Plan, SFN 662 535-05-70-01

(Revised 2/1/17 ML #3489)

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IM 5434

The Personal Care Services Plan (PCSP) SFN 662 documents the eligibility for personal care services and the amount of personal care services that will be provided to an eligible individual and the provider(s) selected by the individual to perform the services. The PCSP is required for all individuals assessed or receiving personal care services and is the outcome of the initial comprehensive assessment, annual assessment, or six-month review of the individual's needs. No payment may be made to any provider until the PCSP is filed with the state office. A copy of all Authorizations to Provide Personal Cares Services SFN 663 must accompany the PCSP filed with the state office.

The PCSP is to be revised or updated as an individual's needs require. At a minimum it must be reviewed with the individual six months following an initial or annual assessment. The PCSP must be revised every time the individual's service needs change or when a change in service provider(s) occurs.

The individual's case manager must complete the PCSP in conjunction with the individual or his/her legal representative. The signature of the individual or the legal representative on the PCSP is required before services can be authorized for payment. If the individual or legal representative refuses to sign the PCSP, the reason for the refusal must be noted in the case file. Any changes or revisions to a PCSP require the signature of the client with the exception of a change in provider. When a change in service provider occurs between case management contacts -- the client or legal representative may contact the case manager requesting the change in provider. The contact and approval for the change in provider must be verified in the case manager's documentation and noted

on the PCSP which is sent to the Department. A copy of the updated care plan must be sent to the client or legal representative. However, changes in services, which include tasks, or the amount of service, which includes amount of units authorized for each task, must be signed by the client or legal representative and approved.

Section I – Client Information

Enter the individual's name, address, Medicaid number, county of residence, and the date the comprehensive assessment is completed and the date the LOC was determined.

A LOC determination approval must be obtained before level B or Level C is authorized and whenever an individual has not had a LOC determination approved within 12 months of the start of a care plan period. If the individual does not meet NF or ICF/MR level of care then check PCS-A. The date of the next LOC determination is the responsibility of the case manager and needs to be scheduled to allow sufficient time in which to give the client a ten working day notice should personal care services be reduced because the individual no longer meets the criteria for LOC.

Instructions For Obtaining ICF/MR Level Of Care (LOC) Determination (for use by DD case managers)

An individual in need of Level B or Level C personal care services must have an ICF/MR LOC determination done prior to authorizing Level B or Level C and whenever a comprehensive needs assessment is completed.

Individuals eligible to meet the ICF/MR level of care include individuals with a diagnosis of mental retardation as defined in NDAC 75-04-06 or persons with related conditions as defined in 42 CFR 435.1009.

The developmental disabilities case manager must complete a comprehensive needs assessment to determine whether the individual meets the minimum criteria for the ICF/MR level of care. The application of the Guidelines for ICF/MR level of care screening serve as the basis as to whether the individual qualifies for Level B of Level C personal care services.

Instructions For Obtaining Nursing Facility (NF) Level Of Care Determination

An individual in need of Level B or C personal care services who does not meet ICF/MR level of care criteria must have a NF level of care determination approved prior to authorizing Level B or Level C and within 12 months of the start of any personal care service plan. The date of the next NF level of care determination is the responsibility of the case manager and needs to be scheduled to allow sufficient time in which to give the client a ten working day notice should personal care services be reduced or terminated.

The case manager shall use the existing and established procedures for requesting a NF level of care determination from Dual Diagnosis Management (DDM). The information needed for submission of information to DDM is usually obtained during the comprehensive needs assessment process.

It is the responsibility of the case manager to trigger the screening by submitting information to DDM. The basis of the information submitted is verified and documented in the completion of the materials identified in items 1 and 2 below. Item 2 below is the ONLY document that needs to be submitted to DDM.

1. The comprehensive needs assessment
2. ND LEVEL OF CARE/Continued Stay Review Determination Form

You are encouraged to submit by web based method; however you may fax the information.

Following are the screen types listed on the LOC Determination Form.

- MSP-PC
- HCBS Waiver/MSP-PC (check only if eligible for both)

DDM will send written confirmation of NF level of care determination to the case manager for filing in the client's record.

If you are unable to resolve NF determination issues with DDM, contact the Administrator of Long Term Care Projects at 328-2321.

Section II – Eligibility for Personal Care Service

Score the individual's needs in accordance with the instructions for scoring ADLs and IADLs to determine if the individual qualifies for personal care services. Narratives in the individual's file must verify the rationale for each score, and the determination for eligibility. Client must be scored impaired in the ADL or IADL before it can be authorized.

Choose the level of personal care needed based on the eligibility criteria outlined in Personal Care Eligibility Requirements 535-05-15.

Determine the type of provider that will be providing services based on the individual's choice.

Check/complete the appropriate box:

PCS-A

PCS-B

PCS-C

Daily

Basic Care

If the individual chooses to receive services on a daily rate (T1020), the "Daily" check box must be checked. To determine the Daily rate send a completed SFN 662 and 663 to Aging Services and the rate will be calculated by Aging Services. The provider and case manager will receive a copy of a profile that documents the rate. The daily rate needs to be recalculated whenever there is an increase or decrease in units of service approved for a client.

The developmental disabilities case manager must complete a comprehensive needs assessment to determine whether the individual meets the minimum criteria for the ICF/MR level of care. The application of

the Guidelines for ICF/MR level of care screening serve as the basis as to whether the individual qualifies for Level B personal care services.

If any of the QSPs are eligible for Rural Differential Rate check the appropriate RD boxes. When a QSP is no longer receiving rural differential for this client complete Date RD removed and submit the SFN 662 and SFN 663 to Aging Services and the QSP. See Rural Differential Rates 535-05-38.

Section III – Approved Services

For QSPs who will be paid based on 15 minute unit rate basis, enter the personal care service provider name, provider number, the units authorized on SFN 663, the 15-minute (T1019) procedure code, and the billable units (units will be the same as the authorized units) to be provided on a monthly basis. If multiple providers are listed on SFN 663 list all providers and provider numbers but complete only 1 line for authorized units, procedure code, and billable units. The procedure code for services must be T1019. The total number of units of service to be provided per month by all providers based on 15-minute increments must be entered. The total number of units per month for procedure code T1019 may not exceed 480 units if PCS – A is checked or 960 units if PCS – B is checked or 1200 units if PCS-C is checked.

For a QSP who elects to be paid a daily rate, enter the personal care service provider name, provider number, the authorized units from SFN 663, the per day (T1020) procedure code, and 31 in the billable units/day column. The procedure code for personal care services provided on a daily basis must be T1020. When the care plan is filed with the state, the daily rate will be calculated by the state office and the provider will be notified of the daily rate. In no case may a daily rate exceed the daily rate limit set forth in the state plan.

If personal care services are to be provided by a basic care assistance provider, enter the provider name, and provider number.

- If the basic care assistance provider is to be paid based on a daily rate, enter the units authorized on SFN 663 in the authorized units column, enter 4 in the procedure code column, and 31 in the billable

units/days column. Eligibility for daily rate requires the client receives a daily services in at least one of the Task Categories listed on the SFN 663 of ADL, Meal Prep, Med Assistance or Other on a daily basis.

- If the basic care assistance provider is to be paid based on a 15 minute increment rate enter the units authorized on SFN 663 in the authorized units column, T1019 in the procedure code column, and the authorized units in billable units/days column (units will be the same as the authorized units) to be provided on a monthly basis.

Section IV - Other Services

Record services which are not authorized as personal care services but are being provided or arranged for the individual. This section should include services such as home health, home delivered or congregate meals, transportation, SPED, EXSPED, waivered services, or family support services.

Section V – Signatures

The instructions for the completion of a reduction is outlined in Denials, Terminations, and Reductions 535-05-50

If the care plan for personal care services expires or services are terminated and a new care plan is not going to be issued, you must follow the policy for Termination. Complete the date of case closure and reason for case closure and submit to the client and Department and a copy of the canceled authorization SFN 663 to the client provider, and Department. If a care plan for personal care services is being terminated prior to the end of the effective date of the plan and a new care plan is being issued send a copy of the canceled care plan SFN 662 to the client and Department and a copy of the canceled authorization SFN 663 to the client, provider, and Department. The instructions for the completion of a Termination is outlined in Denials, Terminations, and Reductions 535-05-50.

If the individual was determined not to qualify for personal care services in Section II, then the individual must be informed of their rights. The instructions for the completion of a Denial is outlined in Denials, Terminations, and Reductions 535-05-50.

If the client is not in agreement with the PCSP, they should enter their initials indicating they are not in agreement with the plan of care. The Case Manager must provide the client with a completed SFN 1647, (Reduction, Denial, or Termination Form).

The individual (or the individual's legal representative) and the case manager both must sign to signify agreement with the PCSP. If the individual refuses to sign the PCSP, the case manager must provide the client with a completed SFN 1647 and a copy of the unsigned plan must be forwarded to the state office.

If a care plan changed due to a change such as; a change in provider, or change in units approved, or other change prior to the end of an existing care plan period, check the reason for the change and describe if appropriate. Then send a copy of the canceled and updated care plan SFN 662 to the client and Department and send copy of the canceled and updated SFN 663 to client, provider, and Department.

The case manager should check the appropriate identification of the program case management, DDCM for Developmental Disabilities Case Manager or HCBS for Home and Community Based Waiver Case Manager.

Section VI – Six-Month Review and Continuation of Plan with No Changes

The case manager may complete this section only if no change in the individual's status, authorized units, and provider(s) occurs at the six-month review or 3 month review for Level C Personal Care. The case manager must enter the new effective date continuing the plan for the next period that may not exceed 6 months or 3 month review for Level C Personal Care. The case manager and the individual both must sign for the continuation of the plan.

Distribution

The original PCSP and any changed PCSP is filed in the individual's case file. One copy is mailed or given to the individual or the legal representative when completed. A copy of SFN 662 and a copy of SFN 663(s) must be mailed within 3 days of completion to the respective state

office (Developmental Disabilities or Aging Services). The SFN 662 is available from Office Services and an electronic copy is available through the state e-forms.

Instructions for Completing the Authorization to Provide Personal Care Services, SFN 663 535-05-70-05

(Revised 2/1/17 ML #3489)

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The Authorization to Provide Personal Care Services SFN 663 is used to grant authority to a qualified service provider or basic care assistance provider for the provision of agreed upon service tasks to an eligible individual.

The Authorization to Provide Personal Care Services is completed when arrangements are being made for the delivery of personal care as agreed to in the individual's Personal Care Services Plan. The individual must have an identified need for the services in order to be authorized to receive the services. For example, if an individual is not identified on the PCSP as being impaired in bathing, no authorization can be given for a provider to assist the individual with bathing.

The case manager must complete an Authorization to Provide Personal Care Services for all providers, including basic care assistance providers, selected by the individual to perform personal care services. If personal care services are to be provided by multiple providers, without specific identification of authorized services to each provider, only one SFN 663 is completed and each provider must receive a copy of the SFN 663. The use of one form for multiple providers may only be used if all providers are authorized to perform the same tasks. The case manager must determine that the provider(s) the individual has selected is available and when service(s) will begin.

Enter the name, Medicaid provider number of the personal care service provider(s), and Physical Address in the "Qualified Service Provider(s) Name and Number" block. If the provider is a basic care provider enter the date the individual was admitted or is anticipated to be admitted to the facility in the "Date of Admit to Basic Care" block.

Enter the client's name, Medicaid ID number, physical address, and telephone number, in the applicable blocks.

"Authorization Period" - Identify the period of time the authorization is in effect. The authorization period MAY NOT exceed six (6) months or 3 months for Level C Personal Care, except for an initial authorization which can include a partial month in excess of 6 months. Renewal of the authorization should coincide with the 6-month Review or Annual Reassessment. The authorization period should begin on the first of a month, except if this is an initial authorization for personal care services for an individual or if a change in status or provider occurs, and must end on the last day of a month.

"Six Month Review Authorization Period" - this section is to be completed at the six month or 3 month for Level C Personal Care review only if there is no change from the existing authorization in the amount of units, tasks, or providers. Identify the additional period of time the existing authorization is to be in effect. The additional authorization period MAY NOT exceed six (6) months or (3) month for Level C Personal Care.

"Total Authorized Units" – enter the total units authorized to be provided, this includes the total of the units approved in the Authorized Units per Task Category behind the correct procedure code. If the procedure code is T1020 (Daily Rate) complete the per day rate/cost.

"Authorized Units per Task Category" - enter the total authorized units of service based on 15-minute increments for each personal care services tasks authorized under ADL - activities of daily living, Meal Prep -meal preparation, Med Assist – medication assistance, Ldry/Shp/Hskp - laundry, shopping, housekeeping, and Other. Total of the five subgroups must equal total authorized units. NOTE: Total authorized housekeeping, laundry, and shopping units of service may not exceed 30% of the total units of all personal care services authorized for the client. Authorized units must be supported by documentation in the individual's case file.

- Some flexibility is anticipated in the provision of tasks amongst the categories of ADL, Other, and Med Assist and the provider is allowed

to bill up to the total units approved in these 3 categories; however, the provider may not bill for units in excess of the units authorized in the category of Ldry/Shp/Hskp and meal preparation.

- A written, signed recommendation for the task of vital signs provided by a nurse or higher credentialed medical provider must be on file that outlines the requirements for monitoring, the reason the task is required and frequency. When the tasks of Temp/Pulse/Respiration/Blood Pressure are authorized, the individual to be contacted for readings must be listed on the SFN 633.

- For the task/activity of exercise a written recommendation and outlined plan by a therapist for exercise must be on file. Exercise is limited to maintain or improve physical functioning that was lost or decreased due to an injury or a chronic disabling condition (i.e., multiple sclerosis, Parkinson's, stroke etc.). Exercise does not include physical activity that generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.).

- For individuals receiving Personal Care Services in a Basic Care setting, enter ADL, Meal Prep and Medication Assist to verify the daily rate. Do not need to identify units for laundry, shopping and housekeeping.

In addition, prior authorization from a State HCBS or DD Program Administrator is required to authorize units for meal prep, laundry, shopping, and housekeeping when performed by a live in provider or for a client who lives with other capable persons. Prior authorization must be renewed annually.

"Personal care services tasks authorized" - check the specific service tasks to be completed by the personal care service provider(s). The explanation of tasks found on the back of the Authorization to Provide Personal Care Services should be referenced in defining the parameters of the service tasks. Include the amount of units that are authorized for each task. If use of a daily rate is authorized, 1 or more of the tasks of dressing/undressing, feeding, incontinence, inside mobility, toileting,

transferring/turning/positioning, meal preparation, and medication assistance must be needed and provided on a daily basis.

The activities and tasks identified as global endorsements may be provided only by a personal care service provider who has demonstrated competency and carries a global endorsement. Review the QSP list to determine which global endorsements the provider is approved to provide.

Activities and tasks authorized as a client specific endorsement may be provided only by a personal care service provider who has demonstrated competency and carries a client specific endorsement to provide the required care within the identified limitations. The case manager must obtain from the QSP, a completed SFN 830, Request for Client Specific Endorsement. A copy of SFN 830 must be included in the individual's file, and a copy sent to Aging Services.

Check the appropriate Rural Differential Rate if applicable. Include the unit rate that is authorized. Note: If more than one provider is authorized and not all have Rural Differential Rate or different Rural Differential Rates a separate SFN 663 must be completed for each rate.

When a QSP is no longer receiving rural differential for this client complete Date RD removed and submit the SFN 662 and SFN 663 to Aging Services and the QSP. See Rural Differential Rates 535-05-38.

The case manager must sign and date the form to officially authorize, reauthorize, or cancel the personal care services. The only time a authorization to provide service is not canceled is when the service period expires.

Distribution

The original and any changed Authorization to Provide Personal Care Services is given to each personal care service provider(s) and a copy of the form is filed in the individual's case record, and a copy is provided to the individual or legal representative, and a copy is sent to the appropriate State Office.

The SFN 663 is available from Office Services and an electronic copy is available through the state e-forms.

Instructions for Completing HCBS Notice of Reduction, Denial or Termination, SFN 1647 535-05-70-10

(1/1/09 ML #3172)

View Archives

Purpose: The applicant must be informed in writing of the reason(s) for a denial or termination of service.

The case manager may send a cover letter with the Notice identifying other public and/or private service providers or agencies that may be able to meet the applicant's needs.

When the client is no longer eligible or ineligible for the Medicaid State Plan Personal Care Service Option, the case manager must terminate or deny services and inform in writing of the reason(s) for a reduction, denial, or termination of service. The case manager must also cancel any current "Authorization to Provide Personal Care Services," SFN 663, issued to the client's providers. Even if services continue under another funding source, the client must be informed in writing of the reasons he/she is no longer eligible for the program.

If a client initials or checks the check box on the SFN 662 indicating that they are not in agreement with the plan and/or before providing a 10-day closure notice, you must send an email to the HCBS Program Administrator responsible to provide citations for MSP-PC.

The email must include the clients name, funding source (i.e. MSP-PC), and the reason you are reducing, closing, or terminating services. You do not need to send a copy of the completed SFN 1647 to the State office.

Date: Record the date of completion;

Denial, Termination, or Reduction, Checkbox: Check the appropriate box whether it is a denial of a requested service or program; or termination of an existing service or program; or reduction of an existing service.

Client Name, Client ID: Record the individual's first and last name and the identification number (if applicable);

Case Manager Name, County or Human Service Center Name, Title of Employee: Self Explanatory;

"It has been determined . . . program or service": Indicate the service(s) or program(s) being denied, terminated, or reduced.

"Reason": Record the reason why the individual is being terminated for service or program or the reason for denial or the reason for a reduction in existing services.

"As Set Forth": Record the state or federal legal reference supporting the reason for denial, termination, or reduction in service that you received from the Program Administrator.

Date This Denial . . . is Effective: The client must be notified in writing at least 10 days prior to the date of termination, denial, or reduction of a service or program. The date entered on the line is 10-calendar days from the date of mailing the Notice or the next working day if it is a Saturday, Sunday, or legal holiday.

If you disagree with this decision, please contact the following: If Case Management other than County enter your supervisor's name.

And to request a conference with the County Director or designee, contact the following: If Case Management other than County, enter your supervisor's name.

If a Medicaid appeal is received before the date of termination above is effective, services can continue until a hearing decision has been made. If the department's decision is upheld, the individual will be required to reimburse for services provided after the termination date.

This form is not available through the State Office. It is available through the State e-form system. Click here to view and/or print this form.

HCBS Case Closure/Transfer Notice or Request for HCBS NF Determination, SFN 474 535-05-70-13

(Revised 2/1/17 ML #3489)

View Archives

Purpose: To notify Aging Services/HCBS an MSP-Personal Care case was transferred to another county.

When prepared:

This form is to be completed for transfers related to MSP-Personal Cares. Do not submit to close a MSP-Personal Case.

Steps of Completion:

In the first section, always complete the County name and Case Manager Section. Also complete the Client Name: Record the first and last name

ID Number: Record the Medicaid recipient identification number.

Indicate on the form that this is a MSP-Personal Care case.

Transfer Case to Another County Section: Print the client's last, first, and middle (initial) name; record the applicable ND identification number, the receiving county name, and the client's new address (if known).Enter the date client is leaving current county and date client is entering new county.

The new HCBS Case Closure/Transfer Notice is due to Aging Services/HCBS within 3 working days from the date the County is made aware that the case is transferring to another County.

This form is not available from the state office. It is electronically available through the state's e-forms.

Application for Service, SFN 1047 535-05-70-15

(10/1/09 ML #3199)

View Archives

Purpose: For individuals to formally request Home and Community Based Services and Medicaid State Plan Personal Care Service.

Prior to conducting a comprehensive assessment, an applicant (or legal representative) must complete the application form.

- Date – date of application;
- Agency – County Social Service Board of applicant's physical county;
- Name – print the name of the applicant (one SFN 1047 per applicant);
- I apply for services to assist me with – the applicant indicates what services or programs for which the applicant is requesting assistance;
- FOR YOUR INFORMATION – applicant must read this section prior to signing;
- The applicant must check to acknowledge the receipt of the "Your Rights and Responsibilities" brochure. (The Brochure # is DN46;
- Signature section – the applicant and/or the legal representative must sign and date the application form.