

**CONSUMER DIRECTED OPTION
STANDARD OPERATING AND REIMBURSEMENT PROCEDURES MANUAL**

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Chapter 1:

General Overview of the Consumer Directed Option

CONSUMER DIRECTED OPTION STANDARD OPERATING AND REIMBURSEMENT PROCEDURES MANUAL

Introduction

The Consumer Directed Option (CDO) allows persons eligible for services through the Acquired Brain Injury (ABI), Home and Community Based waiver (HCB), the Supports for Community Living waiver (SCL) and the Michelle P. Waiver (MPW) to choose their own providers for non-medical waiver services. This choice gives members flexibility in the delivery and type of services they receive by placing the waiver participant in charge of directing services and managing a monthly budget based on their authorized service care needs. CDO also allows participants to use their flexible allowances to purchase goods and services that are necessary to help them continue to live independently in their home and community. CDO is a Medicaid funded program; therefore, adherence to both federal and state program rules is required. This Standard Operating and Reimbursement Procedure (SORP) Manual provides instruction for the operationalization and reimbursement procedures of the CDO model.

The regulatory language associated with the facilitation of CDO services for each waiver may be found in the following Kentucky Administrative Regulations (KAR):

907 KAR 1:145	Supports for Community Living Services for an Individual with Mental Retardation or a Developmental Disability;
907 KAR 1:155	Payments for Supports for Community Living Services for an Individual with Mental Retardation or a Developmental Disability;
907 KAR 1:160	Home and Community Based Waiver Services;
907 KAR 1:170	Reimbursement for Home and Community Based Waiver Services;
907 KAR 1:835	Michelle P. waiver services and reimbursement;
907 KAR 3:090	Acquired Brain Injury Services;
907 KAR 3:100	Payments for Acquired Brain Injury Services; and
907 KAR 3:210	Acquired Brain Injury Long Term Care Waiver Services and Reimbursement.

The language outlined in the Kentucky Administrative Regulations supersedes the language outlined in the CDO Standard Operating and Reimbursement Procedures Manual. To ensure the current version of the regulation is being followed, it is imperative that the support brokerage and financial management staff check the following Kentucky Legislative (LRC) website and follow the current regulation language for each waiver program:

<http://www.lrc.ky.gov/kar/TITLE907.HTM>

Effective July 1, 2008 Community Mental Health Centers (CMHC) assumed the responsibility of providing support brokerage to those members eligible for SCL and ABI who are choosing CDO. CDO participants currently receiving a SCL or ABI service with an Area Agency on Aging and Independent Living (AAAIL) have the option of remaining with the AAAIL for continued services. All new CDO members for SCL or ABI must be under the services of the CMHC agency for their county of residence if the CMHC has elected to provide these waiver services.

Effective August 1, 2008, CMHC also assumed responsibility for providing support brokerage to those members eligible for the MPW and choosing to direct the services through CDO. Current CDO participants receiving HCB waiver with the AAAIL who are eligible for and choosing MPW have the option of continuing to receive their CDO services with the AAAIL. All new MPW members must be under the services of the CMHC agency for their county of residence if the CMHC has elected to provide these waiver services.

Consumer Directed Option Overview

CDO differs from traditional waiver approaches in that the participant is in charge of determining available services, scheduling, employing, budgeting, and evaluating the usefulness of the services, rather than a traditional waiver case manager. CDO is not for everyone because not everyone is willing or able to manage all of the requirements or otherwise have a trusted representative to manage all the tasks for them. The goal of the CDO model is to offer participants the ability to direct services that most appropriately meet their needs, using person centered planning principles, in order to remain living in the community. The following CDO and person centered planning principles are essential to the model:

Consumer Directed Option:

- Reflects the belief that individuals, when given the opportunity to choose the service they will receive and to direct some or all of them, will exercise their choice in ways that maximize their quality of life.
- Includes person centered planning principles to ensure the participant is making personal choices for the spending of the budget based on his or her own needs and goals.
- Provides one option among several service delivery models and it must be available for all participants who choose the option.
- Requires a flexible, individualized budget that the participant may spend on services that assist the individual to meet their community support needs and enhance their ability to live in the community by:
 - ✓ Allowing the participant to use the individualized budget to choose and directly hire workers to provide the services;
 - ✓ Allowing the participant to use the individualized budget to purchase goods, supplies, or other items to meet community support needs;
 - ✓ Providing the participant with significant choice in the allocation of their funds between hiring workers and making other purchases.
- Allows participants to designate a representative to help them with making decisions and managing their services.
- Provides a system of supports to assist the participant in developing and managing his or her spending plan; fulfill the responsibilities of an employer, including managing payroll for workers he or she hires directly; and obtain and pay for other services and goods.

- Obtains feedback from participants, representatives, and family members (when appropriate) as well as data from support service providers to continuously improve the program.

Person Centered Planning Principles:

Person centered planning principles are the cornerstone of quality service provision and shall be used to guide interactions and supports for CDO participants.

Person centered planning supports for individuals with disabilities will:

- Ensure dignity and respect for each person as a valued individual.
- Be entitled to the rights, privileges, opportunities, and responsibilities of community membership.
- Be supported and encouraged to develop personal relationships, learning opportunities, work and income options, and worship opportunities as full participants in community life.
- Be based on individually determined goals, choices, and priorities.
- Be easily accessed and provided regardless of the intensity of individual need.
- Be afforded the opportunity to direct the planning, selection, implementation and evaluation of their services
- Require that funding be flexible and cost effective and make use of natural, generic and specialized resources.
- Be the primary decision makers in their own lives.
- Be evaluated based on outcomes for individuals.

The work we do and the way we work will:

- Ensure that all persons have dignity and value, and are worthy of respect.
- Provide safeguards to ensure personal security, safety, and protection of legal and human rights.
- Be coordinated on person-centered and family-centered principles, focusing on individual needs, strengths, and choices.
- Support that all people have strengths and abilities and are the primary decision-makers in their lives.
- Provide information and supports that promote informed decision-making.
- Be accessible and culturally responsible.
- Access informal and generic community resources whenever possible in the most integrated community setting appropriate to the person.
- Be based on best practice and utilize state-of-the-art skills and information.
- Be directed toward the achievement of interdependence, contribution, and meaningful participation in the community.
- Distribute resources in an equitable manner according to the individual need and comply with requirements governing public funds administered by the system.

Organizational and Structural Administration

The Department for Medicaid Services (DMS) has authorized the Department for Aging and Independent Living (DAIL) to administer CDO. While DAIL is responsible for the day-to-day operation of CDO, additional roles associated with the model are fulfilled as follows:

- A. **CDO Advisory Board.** The Advisory Board consists of waiver participants, family members of participants, advocates, provider agencies and state department representatives to provide guidance and recommendations regarding the implementation and operation of CDO. The CDO Advisory Board meets periodically to provide oversight and management assistance and make policy recommendations to DMS.
- B. **Area Agencies on Aging and Independent Living (AAAIL).** DAIL contracts with AAAILs to provide Support Broker services to participants choosing CDO.
- C. **Area Development District (ADD).** DAIL contracts with ADDs to provide the financial management components of the CDO service delivery system.
- D. **Community Mental Health Center (CMHC).** The Department for Medicaid Services contracts with the CMHCs to provide support broker and financial management services to participants choosing CDO through the Supports for Community Living, Acquired Brain Injury, Acquired Brain Injury Long Term Care and Michelle P. waiver programs.
- E. A **Participant** is an individual who meets the eligibility and financial requirements of one of the 1915c waiver programs (ABI, ABI-LTC, HCB, MP, and SCL). The individual must have the ability to self-direct their own care and understand the rights, responsibilities, roles, and risks of managing their own care or, if the individual is unable to make his/her decisions independently, he/she can designate a representative to do so for him/her.
- F. A **Designated Representative** exists if the participant is unable to make decisions independently. In this case, the participant may designate a representative to make decisions for him/her. The participant, the support broker, DAIL or DMS may request a designated representative. A state guardian may serve as a designated representative but is not required to serve in this capacity.

The designated representative:

- must be willing to serve in this capacity and understand the rights, roles and responsibilities of managing the care of the participant with an individual benefit total;
- shall not be monetarily compensated for serving as a representative;

- shall have no vested interest in any agency that may provide waiver services; shall not provide any CDO service;
- must be at least twenty-one (21) years of age;
- agree to pre-determined frequency of contact with the participant;
- be willing to comply with all criteria and responsibilities of the consumer;
- agree to assist the participant with managing the benefit total based on the participant's plan of care and support spending plan; and
- Obtain approval from the participant or family to serve in this capacity.

G. **Medicaid Agency Providers** have permission from Medicaid to provide Medicaid funded services. A list of Medicaid providers specific to the aforementioned waivers include:

1. Adult Day Healthcare Centers
2. Community Mental Health Centers
3. Home Health Agencies
4. SCL Traditional Providers
5. Area Agencies on Aging and Independent Living (CDO Only)

H. **Quality Improvement Organization.** The state Medicaid agency contracts with a Quality Improvement Organization (QIO) to determine level of care and approve and prior authorize services requested on the plan of care of the Participant.

Relationship between Traditional Option and CDO

Under the traditional service option, the case manager is responsible for facilitation of the development of a plan of care to meet the needs of the waiver participant. Under CDO, the support broker is responsible for facilitating the person centered planning process to develop a plan of care and support spending plan that addresses the participant's needs. This includes arranging for services from a variety of resources such as state funds, private funds, and natural supports.

A waiver participant can also choose to use blended services. CDO blended services is defined as a non-duplicative combination of an authorized waiver service provided pursuant to a participant's approved plan of care. When a participant chooses to use blended services, he/she receives some services from the traditional provider while directing other services under the CDO. It should be noted that DMS clarified a participant cannot receive the **same** waiver service from both the traditional provider and through CDO. For example, a participant that has chosen and is approved to receive community living supports through the traditional provider cannot also hire a CDO employee to provide community living supports, even if the service would be provided at different hours on the same day. Additionally, under the blended service option, the support broker is responsible for case management and facilitating the person-centered planning process to develop a plan of care which addresses the participant's needs. This includes arranging for services from a variety of resources such as state funds, private funds, and natural supports.

Support Brokers and Financial Managers

The state provides two distinct support services to assist participants in assuming their management responsibilities: support brokerage and financial management services. Following is a summary of each service:

Support Broker

The support broker will train, provide technical assistance, answer questions, coordinate services and community resources and monitor service provision and assist in developing a person centered plan of care including an emergency back-up plan, support spending plan and budget. The training and technical assistance will help participants to budget correctly and avoid overspending as well as provide guidance on recruiting, hiring, supervising, and firing employees. The benefit total shall be based on need, utilization and existing service limitations. Support brokers at a minimum, shall make a monthly face-to-face home visit with the participant to assure that service delivery is in accordance with the participant's plan of care and support spending plan and is adequate to meet the participant's needs according to regulation. The face-to-face home visit will also ensure the participant's health, safety and welfare.

The support broker must also work closely with the financial management agency to monitor payment for service provisions and ensure they are within the scope of the plan of care, support spending plan and prior authorization limits. Additionally, the support broker will complete or coordinate the review of a previously completed assessment/reassessment process for the participants of whom they are providing support brokerage. Support broker services will be provided through the Regional Area Agencies on Aging and Independent Living via contract established with the Department for Aging and Independent Living. Support broker services will also be provided by the Regional Community Mental Health Centers via a provider agreement with the Department for Medicaid Services.

Although all participating agency employees, including state level CDO staff, are available during most business hours to respond to participant inquiries, the support broker **shall** be the first level of contact with participants. As such, the support broker is required to be available twenty-four (24) hours per day, seven (7) days a week. The support broker must ensure the participant has the needed contact information so that phone calls can be made when needed.

Prior to being offered employment or acting in an employee role, a support broker must submit to a criminal background check and not have been convicted of committing a felony and not have pled guilty or been convicted of committing a sex crime or violent crime as defined in KRS 17.165 (1) through (3). CMHC support broker staff must also adhere to Medicaid provider requirements established by the Department for Medicaid Services. Support brokers shall not be a provider of services or supports other than support broker services to any participant enrolled in CDO. Support brokers cannot serve as the participant's designated representative.

Financial Manager

The financial manager will provide assistance with paying employer and unemployment compensation taxes, appropriate local taxes, processing employment information, reviewing records to ensure correctness, paying providers, paying employees in accordance with the fair labor standards act and local, state and federal employment-related laws.

Financial managers shall not be a provider of services or supports other than financial management services to any participant enrolled in CDO. Financial managers cannot serve as the participant's designated representative. CMHC financial management staff must also adhere to Medicaid provider requirements established by the Department for Medicaid Services.

Assessments

The assessment shall be requested by an individual requesting waiver services, a family member or legal representative of the individual, the individual's physician, a physician assistant or an Advanced Registered Nurse Practitioner (ARNP) if allowed per the appropriate Kentucky Administrative Regulation. An assessment contact or request may begin while the potential waiver participant is in a hospital, nursing facility, their own home or another place of residence; however, the assessment must be completed in the individual's home during a face-to-face home visit.

It is the responsibility of the support broker to ensure an assessment is completed for each individual requesting CDO services. As required by the Department for Medicaid Services under Consumer Directed Option; the support broker must make an initial contact with the consumer within two (2) business days of receiving the referral for waiver services to explain CDO, answer any questions, and make an appointment to complete the assessment. The appointment to complete the assessment must be made within five (5) business days of the initial contact. To total time from receiving the referral and completing the assessment is seven (7) business day.

An assessment shall include a comprehensive summary identifying an individual's needs and services. The assessment is used to evaluate the participant's physical health, mental health, social supports, natural supports and their home environment. The state Medicaid agency contracts with the QIO to approve and prior authorize services requested on the plan of care of the participant. Initial waiver assessment packets must be submitted to and received by the QIO as soon as possible. Initial waiver assessment packets received more than sixty (60) calendar days after the date of the assessment shall be returned without a review and a new assessment shall be completed.

A reassessment service follows the same evaluation criteria as outlined in the assessment service. A reassessment service determines the continuing need for a waiver service and if appropriate a CDO service. A reassessment service shall not be retroactive and must be initiated by an authorized assessment provider or support broker who shall notify the Department for Medicaid Services via the Quality

Improvement Organization (QIO) no more than twenty-one (21) days prior to the expiration of the current level of care certification period to ensure that certification is consecutive. **While the CMHC is the only agency that may provide the assessment or reassessment service for Michele P. Waiver participants, it is the support broker's responsibility to make sure they are completed when warranted.**

Plan of Care/Support Spending Plan

As required for CDO by the Department for Medicaid Services; it is the responsibility of the support broker to make sure a plan of care (MAP-109) is completed for each participant within seven (7) business days from the date of referral. A participant's plan of care (POC) must be individualized to meet the participant's specific needs and include services and supports based upon therapeutic goals. All services or goods must reduce the need for personal care or enhance independence within a participant's home and community. The plan of care must include goals, interventions, and anticipated outcomes in addition to the specific services needed to accomplish goals and outcomes. The identified services will also include the amount, frequency, and duration or length of time the expected services should last. All services and supports whether or not funded through the Medicaid waiver must be reflected on the plan of care. This may include details about natural supports that are used to meet participant's needs. The support spending plan must also reflect the amount of the participant's approved CDO budget after the appropriate employer taxes and if chosen, worker's compensation is deducted. The plan of care will also include the anticipated reassessment date at the twelve (12) month mark. In order to be covered, a CDO service must be included in the plan of care using the assessment form (MAP-351) as a guide. The plan of care and support spending plan is completed on a form called the MAP-109. When completing the support spending plan, the hourly pay rate shall not exceed the fixed upper payment limits for CDO services in conjunction with the corresponding units of service, and may not exceed Medicaid pay rates for traditional service delivery. The fixed upper payment limits are found in the Kentucky Administrative Regulations as follows: 907 KAR 1:155, 1:170; 1:835E and 3:100.

Emergency Back-Up Plan

The emergency back-up plan is also a required component of the participant's plan of care. It identifies who will be used to "back up" the participant's primary employee should that individual become unavailable. It also should include directions on what the participant would like to be done when particular anticipated emergencies arise such as should the participant have a seizure, or a fall, or a behavior that might otherwise be harmful for the participant or another individual. The person who is responsible in the emergency event must be named on the plan of care, must receive the same training as the primary employee and must be physically able to provide the needed services to the participant. This person can be paid or unpaid. Paid emergency back-up employees must submit to and meet the regulatory requirements in order to serve as a back-up employee.

Incident Reporting Requirements

The state has a viable system by which it receives, reviews, and acts upon critical events or incidents. Kentucky Revised Statutes (KRS) 209 requires staff or any other person who has reason to suspect or actual knowledge that a vulnerable child or adult has been abused, neglected, or exploited to report immediately upon discovery to the DCBS Protection and Permanency office.

DAIL staff, Support Brokers, Participants, Representatives, and Provider Agencies are provided training regarding the requirements of KRS 209.

All incidents of abuse, neglect, or exploitation are required to be reported by the Department for Community Based Services (DCBS) to DMS or designated agency for review and analysis. The support broker shall document the report number and who they reported the incident to in their case notes.

Support brokers must make the report within 24 hours of the incident to the DCBS Protection and Permanency Office and to the Guardian (as required by regulation). Within one (1) business day of reporting the incident to DCBS the support broker must report the incident to the assistant director of the Division of Mental Retardation (for SCL participants), the Medicaid ABI Branch Manager (for ABI participants) and for all CDO complaints and investigations the report is made to the Departments for Medicaid Services and Aging and Independent Living.

State staff or the designee shall review and make a determination if further action is necessary to ensure the health, safety, and welfare of the consumer. All incidents shall include a complete written report of the incident investigation and follow-up. All incidents must be filed in a secured centralized location within the Support Brokerage Agency and made available upon request to DMS, DAIL, DMHDDAS and other state and federal entities as appropriate.

CDO Services

“CDO services” are specific non-residential, non-medical services and shall incorporate activities similar to those provided in the traditional waiver option such as adult day training, attendant care services, community living supports, companion care, homemaker services, personal care services, supported employment services and unskilled respite care services. CDO services also include goods and services, support brokerage services, and financial management services.

All services must be provided in the participant’s home or in the community and be based upon therapeutic goals and not be diversional in nature. Per the Kentucky Administrative Regulation, a CDO service cannot be provided to an individual if the same or similar service is being provided to the participant via other services or programs. To be covered, a CDO service shall be specified in a participant’s plan of care and support spending plan. Reimbursement shall not exceed Medicaid’s allowed reimbursement for the same or similar service provided in another program or in a more traditional setting.

Although each waiver program has a specific set of services and corresponding definitions, CDO services are packaged under a global term to provide flexibility with service delivery and service billing. Therefore, each package of services has one global and unique name and the billing code remains the same regardless of the specific service provided. **For direct services available through CDO the global service names are the Home and Community Supports Service and the Community Day Supports Service.** As an example, the Supports for Community Living waiver service options are broken into two packages. "Home and Community Supports Service" where the service package includes: CLS and unskilled respite and the two services are billed under the same code, S5108 and "Community Day Supports Service" where the service package includes: Adult Day Training and Supported Employment and the two services are billed under the same code, T2019.

Acquired Brain Injury

Services available through the Acquired Brain Injury waiver program under CDO include companion care, personal care, and unskilled respite. These services are combined into one flexible CDO service entitled "Home and Community Support Services". Allowed services under the home and community support service include the following:

Companion Care: Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

Companion services include accompanying and assisting an ABI recipient while utilizing transportation services. Companion services shall not be provided to an ABI member who receives community residential services.

Personal Care: Personal care services shall consist of assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the actual cost of the meals. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or that are essential to the health and welfare of the individual, rather than the individual's family.

Unskilled Respite: Unskilled respite care services shall be short term care that is provided to give relief to the participant's primary caregiver. Unskilled respite care services are not to relieve a paid CDO provider (employee). Unskilled respite care services must be provided in the participant's home at a level to appropriately and safely meet the **non-medical** needs of the waiver participant. Unskilled respite care services provided to children shall be required to be of a

skill level beyond normal babysitting. A participant must access respite care services at least once every six (6) months.

Home and Community Based

Services available through the Home and Community Based waiver include: Attendant Care, Homemaking, Personal Care, and Unskilled Respite. Following is a description of each service:

Attendant Care: Attendant care service shall consist of hands-on care that is of a non-medically oriented nature specific to meet the needs of the waiver consumer who is medically stable but functionally dependent and requires care or supervision twenty-four (24) hours per day. Attendant care services under CDO are authorized for non-medical services only.

The waiver participant must have a primary caregiver and the participant's primary caregiver must be employed and unable to provide care during working hours. Attendant care services are authorized only when the primary caregiver is working. The primary caregiver is not required to live in the same residence as the waiver consumer, but the primary caregiver is expected to provide the care during the hours the primary caregiver is not working and attendant care is unavailable. For HCB, the participant shall not receive personal care services, homemaker services and ADHC services when receiving attendant care.

Homemaking: Homemaker services shall consist of general household activities such as meal preparation and routine household care. Homemaker services are provided to waiver consumers who are functionally unable, and would normally perform all appropriate tasks or if the caregiver regularly responsible for homemaker activities is temporarily absent or functionally unable to manage the homemaking activities. Homemaker services are for the participant only and not provided to meet the needs of other family members or household occupants (room-mates).

Personal Care Service: Personal care services shall consist of assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individuals' family.

Unskilled Respite: Unskilled Respite care services shall be short term care which is provided to a waiver consumer due to the absence or need for relief of the primary caregiver. Unskilled respite care services may not be used to relieve a paid CDO provider (employee). Unskilled respite care services must be provided at a level to appropriately and safely meet the unskilled (non-medical) needs of the waiver consumer. Unskilled respite care services provided to

children shall be required to be of a skill level beyond normal babysitting. A consumer must access respite care services at least once every six (6) months.

Supports for Community Living

Supports for Community Living services include community living supports, unskilled respite, adult day training and supportive employment. These services are offered through two flexible service packages, home and community support services and community day supports.

Community Living Supports (CLS) Services: These supports facilitate independence and promote integration into the community for individuals residing in their own home.

The supports are provided one-to-one and include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation, laundry, routine household care and maintenance, activities of daily living such as bathing, eating, dressing, personal hygiene, shopping, money management, reminding, observing, and/or monitoring of medications, and non-medical care not requiring nurse or physician intervention.

These supports also include socialization, relationship building, leisure choice and participation in generic community activities. These supports are based upon therapeutic goals, are not diversional in nature, and are not to replace other work or day activities.

Unskilled Respite: Unskilled Respite care services shall be short term care which is provided to give relief to the participant's primary caregiver. Unskilled respite care services shall be provided to an SCL member unable to independently administer self-care. Unskilled respite care services are not to relieve a paid CDO provider (employee). Unskilled respite care services must be provided at a level to appropriately and safely meet the non-medical needs of the waiver participant. Unskilled respite care services provided to children shall be required to be of a skill level beyond normal babysitting.

Adult Day Training: Adult Day Training (ADT) services are intended to support the participation of consumers in daily, meaningful and valued routines of the community, which for adults may include work-like settings that do not meet the definition of supported employment. ADT services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. The service expectation is to achieve the outcomes (goals) defined by each consumer and, to attain and support participation in less restrictive settings. The training, activities and routines established by the adult day training program shall be meaningful to the consumer and provide an appropriate level of variation and interest. The training objectives are individualized and developed under the direction of the consumer through the person centered planning process and is provided in accordance with the approved plan of care.

ADT services are typically provided on a regularly scheduled basis, for no more than five days per week. The hours must be spent in training and program activities. Support services lead to the acquisition, improvement and/or retention of skills and abilities to prepare the participant for work and/or community participation or transition from school to adult support services. Adult day training services may be provided as an adjunct to other services included on a consumer's support plan. For example: a consumer may receive supported employment or other services for part of a day or week and adult day training services at a different time of the day or week. Adult day training services will only be billable for the time that the consumer actually received the service.

Services provided in a variety of community settings that assist the individual in meeting the personal outcomes reflected in their approved plan of care are included. The supports are provided for the express purpose of providing access to community-based activities that cannot be provided by natural or other unpaid supports, and are defined as activities designed to result in increased ability to access community resources without paid supports.

Any consumer receiving ADT services that are performing productive work that benefits the organization, or would have to be performed by someone else if not performed by the consumer, must be paid. Consumers who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

At least annually, providers will conduct an orientation informing consumers of supported employment and other competitive opportunities in the community.

Supported Employment (off-site): Supported employment services, consists of paid employment for person for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Michelle P. Waiver (MPW)

Michelle P. Waiver is a combination of waiver services provided under the HCB and the SCL waiver including ADT, Attendant Care, CLS, Homemaker Services, Personal Care Services, Supported Employment and Unskilled Respite Services. These services are described above under the HCB and the SCL waiver programs. MPW services cannot be provided if the same or similar service is being provided by non-CDO Michelle P. waiver services. For MP, the participant

shall not receive personal care services, homemaker services, ADHC, ADT, CLS or supported employment when receiving attendant care.

Acquired Brain Injury Long Term Care (ABI-LTC) Waiver

Acquired Brain Injury Long Term Care Waiver is a combination of ABI, SCL and HCB waiver services including ADHC, ADT, CLS, Supported Employment and Unskilled Respite. These services are described above under the aforementioned waiver programs. ABI-LTC services cannot be provided if the same or similar service is being provided by non-CDO ABI services. For ABI-LTC, the participant shall not receive ADHC, ADT, CLS or supported employment when receiving attendant care.

Following is a summary of the CDO home and community supports service package and the CDO community day supports service package:

CDO Home and Community Support Services: These supports facilitate independence and promote integration into the community for individuals residing in their own home and are available only under the Consumer Directed Option

The supports are provided one-to-one and include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation, laundry, routine household care and maintenance, activities of daily living such as bathing, eating, dressing, personal hygiene, shopping, money management, reminding, observing, and/or monitoring of medications, and non-medical care not requiring nurse or physician intervention. These supports also include socialization, relationship building, leisure choice and participation in generic community activities.

CDO Community Day Support Services: These services must be provided in a community setting and be available only under the Consumer Directed Option. The services must be tailored to the individual's specific personal outcomes related to the acquisition, improvement, and retention of skills and abilities to prepare and support the individual for work or community activities, socialization, leisure, or retirement activities.

Home and community supports and community day supports are to be based upon therapeutic goals and not be diversional in nature nor are they to replace other work or daily activities.

CDO Goods and Services

Every waiver participant may request that a portion of their budget be used to purchase goods and services that are individualized and included in the plan of care and support spending plan; however, there are rules and guidelines for how participants can and cannot spend budget dollars. The authorization for goods and services (Appendix N) can reduce the dollar amount potentially available for direct services since

a budget cannot exceed the Medicaid maximum limitation amounts. A participant may purchase goods and services within their budget that directly relate to the goals, interventions, and expected outcomes the participant has helped outline in their individualized plan of care. In order to be covered, any service or goods must be included in the plan of care and support spending plan and be approved by Medicaid (Appendix N). Goods and services must reduce the need for personal care or enhance independence within the home or community. Examples may include, but not be limited to, a grab bar for the shower to reduce the need for shower assistance, a wheelchair ramp to increase accessibility to the home and community. Additional items include environmental and minor home adaptation, appliances (which cannot exceed \$1500 over a 3 year period), personal alarms/life lines (equipment only, no monthly fees), assistive technology or assistive-type goods and services, incontinent supplies, and nutritional supplements. Permanent environmental and minor home adaptations are not permitted for individuals renting their home. However, Medicaid may for example authorize a grab bar that uses suction cups and it not be permanently installed.

Items that may NOT be purchased include but are not limited to services covered by the Medicaid State Plan including the Durable Medical Equipment Program, Medicare, other third parties including education, home-based schooling and vocational services or through any other source. Services, goods, or supports provided to or benefiting persons other than the individual participant, room and board, personal items and services not related to the disability, vacation expenses, vehicle modifications and repairs, health club memberships, community membership dues, recreational activities, creative arts, cell phones, specialized toys, play therapy, hippo-therapy, massage therapy, exercise equipment and educational opportunities not covered by other public health programs. Experimental Goods or Services cannot be purchased nor can chemical or physical restraints. Transportation for medical appointments cannot be consumer directed. Transportation is provided for Medicaid recipients under the state plan and utilization under waiver services is duplicative.

It is the support broker's responsibility to ensure goods and services are purchased within the regulatory guidelines. The support broker should seek consultation from their supervisor who may also in turn, consult with CDO State employees, if any questionable goods or services are requested or purchased by a participant.

The Department for Medicaid Services may terminate the participant from Consumer Directed Option services if it is determined that the participant or a service provider under the supervision of a participant, has not followed the plan of care, support spending plan and approved budget.

Prior Authorization of Services and Billing Codes

The support broker is required to obtain a prior authorization for any waiver service including goods and services (Appendix N), prior to the date of service or expenditure. Medicaid reviews the prior authorization request and issues an authorization or a denial for each category of service. If approved, a prior authorization (PA) letter will be issued. The PA is also available to the support brokerage agency and financial management agency via the Kentucky Health Network System (described in greater detail below). If denied, a letter will be sent to the support broker, and the participant, outlining the appeal process. The financial manager will be responsible for ensuring prior authorization, paying for goods and services, billing Medicaid (EDS), and tracking reimbursements. The structure of the service packages allows the flexibility of shifting the amount of units that have been prior authorized among packaged services as the participant's needs change according to their plan of care. This flexibility is offered without the need for additional prior authorizations as needs change as long as the service shift only involves services within one package. The support broker will be responsible for ensuring the consumer is kept up to date of the monthly expenditures and remaining budget balance each month during the face-to-face home visit.

The Healthcare Common Procedure Coding System (HCPCS) codes are utilized for service billing and reimbursement processes. Following are services, corresponding billing codes, and unit definitions for each waiver program:

Acquired Brain Injury

CDO Waiver Program	Service	Code-Modifier (Modifier if Applicable)	Unit
Acquired Brain Injury (ABI)	Assessment/Reassessment	T1028-SC	1 per unit, for entire assessment process. Reassessment can only be provided once within a 12 month time-frame
	Support Broker Service	T2022-HI	1 per member, per month
	Financial Management Service	T2040	1 per 15 minutes, 8 units maximum per member per month
	Home and Community Support Services	S5108	1 per 15 minutes
	Goods and Services	T1999	1 unit per item

Home and Community Based

CDO Waiver Program	Service	Code-Modifier (Modifier if Applicable)	Unit
Home and Community Based (HCB)	Assessment/Reassessment	T1028-SC	1 per unit, for entire assessment process. Reassessment can only be provided once within a 12 month time-frame
	Support Broker Service	T2022	1 per member, per month
	Financial Management Service	T2040	1 per 15 minutes, 8 units maximum per member per month
	Home and Community Support Services	S5108	1 per 15 minutes
	Goods and Services	T1999	1 unit per item

Supports for Community Living

CDO Waiver Program	Service	Code-Modifier (Modifier if Applicable)	Unit
Supports for Community Living (SCL)	Assessment/Reassessment	T1028-SC	1 per unit, for entire assessment process. Reassessment can only be provided once within a 12 month time-frame
	Support Broker Service	T2022-HI	1 per member, per month
	Financial Management Service	T2040	1 per 15 minutes, 8 units maximum per member per month
	Home and Community Support Services	S5108	1 per 15 minutes
	Community Day Supports Services	T2019	1 per 15 minutes
	Goods and Services	T1999	1 unit per item

Acquired Brain Injury Long Term Care

CDO Waiver Program	Service	Code-Modifier (Modifier if Applicable)	Unit
Acquired Brain Injury Long Term Care (ABI- LTC)	Assessment/Reassessment	T1028-SC	1 per unit, for entire assessment process. Reassessment can only be provided once within a 12 month time-frame
	Support Broker Service	T2022-HI	1 per member, per calendar month
	Financial Management Service	T2040	1 per 15 minutes, 8 units maximum per member per calendar month
	Home and Community Support Services	S5108	1 per 15 minutes
	Community Day Supports Services	T2019	1 per 15 minutes
	Goods and Services	T1999	1 unit per item

Michelle P. Waiver

CDO Waiver Program	Service**	Code-Modifier (Modifier if Applicable)	Unit
Michelle P. Waiver (MPW)	Support Broker Service	T2022-HI	1 per member, per month
	Financial Management Service	T2040	1 per 15 minutes, 8 units maximum per member per month
	Home and Community Support Services	S5108	1 per 15 minutes
	Community Day Supports Services	T2019	1 per 15 minutes
	Goods and Services	T1999	1 unit per item

**Assessments and reassessments are billed directly from CMHC to Medicaid and do not flow through the EDS claims process; therefore, there is no billing code for these services.

Kentucky Health Network System

The Department for Medicaid Services implemented a Medicaid Management Information System (MMIS) which includes the Kentucky Health Network (KYHealth-Net) System. The system provides significant enhancements for providers.

To access the KyHealth-Net, a provider must have a single sign on account. To obtain an account or receive answers to questions, concerns or problems associated with KyHealth-Net support brokers or financial manager should contact the Electronic Data Systems (EDS) Electronic Data Interchange (EDI) helpdesk. Providers with approved access should contact the EDI helpdesk at 1-800-205-4696 or send inquiries via email to KY_EDI_Helpdesk@eds.com.

Note: Providers will be required to change the account password every 30 days.

Services available under the Kentucky Health Network System include:

- **Prior Authorization (PA)**
The KyHealth-Net has a PA link which offers the PA checklist, PA Letters and PA inquiry.
- **Internet Claim Submission**
The KyHealth-Net has a “claims wizard,” which assists providers through the claim submission process. Any claim problems, issues or concerns should first be directed to the provider’s EDS representative. If EDS is unable to provide resolution or assistance then the provider would contact Medicaid at (502) 564-7540 or (502) 564-5560.
- **Immediate Claim Adjudication on Internet Claims**
Claims submitted via KyHealth-Net will be adjudicated immediately, and provide a real-time response. This will allow the opportunity to correct denied claims, and resubmit them immediately.
- **Remittance Advices**
The Remittance Advice statements will be made available via KyHealth-Net. Sample Remittance Advice pages with corresponding explanations are included in the provider billing instructions located at the following Medicaid Internet hyperlink: <http://www.kymm.com/kymm/Provider%20Relations/billingInst.aspx>
- **Claim Status Inquiry**
The KyHealth-Net has a claim inquiry engine where providers can search by member ID, Patient account number, Date Type, Internal Control Number (ICN) or Transaction Control Number (TCN) and Claim Status to view detailed claim information.
- **Member Information**
Includes county, eligibility, card issuance data, waiver, third party liability, spend down, patient liability, presumptive eligibility, copay/coinsurance history, poverty

indicator, KenPAC provider and Lock-In provider information.

- **Service Limitations**
A history of members paid vision, dental, hearing and ultrasound services.
- **KenPAC**
A list of current KenPAC member for which the provider received a management fee payment. Available to KenPAC providers only.
- **Nursing Facilities**
A listing of members assigned to a nursing facility including the certification number and dates along with the eligibility segments. Available to Nursing Facilities only.
- **Pharmacy History**
A listing of prescriptions paid by Medicaid for each member. Does not include prescriptions denied or pending by Medicaid, or prescriptions covered by any other insurance or self pay.
- **Qualifying Income Trust (QIT)**
Listing of members, assigned to a particular provider, meeting the criteria for needing a QIT to maintain Medicaid eligibility.
- **Regional Transportation Broker Listing**
A listing of members assigned to a specific regional transportation broker. Available to regional transportation brokers only.

CDO Budget

The CDO budget is the amount of funds a participant has available over the course of twelve (12) months for direct service delivery and to purchase goods and services that have been authorized by Medicaid. Participants will receive a monthly print-out of how much money has been spent and how much is remaining in the budget. The Department for Medicaid Services establishes a budget based on Kentucky Administrative Regulation criteria for each waiver program. For participants who are currently receiving Medicaid waiver services from a waiver program authorized to provide Consumer Directed Option, the budget is based on the assessment, plan of care and the cost of Medicaid services used in the past (historical costs) to meet their individual personal care needs, minus 5% administrative costs. If a participant has never received Medicaid waiver services their budget is based on an assessment, plan of care, and if applicable the average utilization cost of Medicaid waiver services used by others in the same waiver to meet their care needs, minus 5% administrative costs.

****NOTE:** The following table reflects the maximum Medicaid budget a waiver participant can receive to help maintain placement in their home. In addition to Medicaid funded services, natural supports within the home and community must also be considered. The assessment and plan of care guides the development of the budget.

Waiver Program	Maximum Gross Dollar Amount**	Limitations
ABI	\$67,533.00**	Annually
HCB	\$34,453.00**	Annually
SCL	\$140,000.00**	Annually
MPW	Based on Plan of Care and Regulatory Limits	Annually
ABI-LTC	Per Regulatory Criteria	Annually

Budget Adjustment (Exceptions): Any consumer whose needs exceeds the historical cost, minus five (5) percent or the average utilization costs minus five (5) percent (as appropriate) must work with their support broker to submit a request for a budget exception. Exception budget requests must be submitted on a DAIL-100 form and follow the instructions pertaining to the form. No exception will be granted on budget requests that exceed the nursing facility or intermediate care facility costs for Medicaid recipients as listed above. *These maximum limits are subject to change annually as determined by the Department for Medicaid Services.*

Additional information and established procedures concerning Budget Adjustments or Exception Requests is found in the CDO Standard Operating and Reimbursement Procedures Manual and the appropriate waiver regulation.

Chapter 2:

Standard Operating and Reimbursement Procedures for the Administration of the Consumer Directed Option

Statement of Policy and Purpose

Financial eligibility criteria require all participants who wish to participate in CDO to first meet the income requirements for one of Kentucky’s participating 1915c Medicaid waiver programs (ABI, ABI-LTC, HCB, MP, SCL). Before enrolling in CDO, the appropriate Medicaid eligibility shall be determined by the local Department for Community Based Services (DCBS) Family Support office and the applicant shall be enrolled in a Medicaid Waiver Program. Medicaid coverage must be secured and verified for the purposes of guaranteeing ongoing payment, goods, and supports to effectively serve participants safely in their communities.

Procedure

- A. The Department for Community Based Services’ (DCBS) Family Support Office is responsible for the annual financial determination for all waiver populations (Appendix A - DCBS Regional Contact List). Financial resources must be within Medicaid resource guidelines. The resource limits vary accordingly when the potential participant is married as the spouse’s resources are also considered. The resource limits may be reviewed on the DCBS Eligibility Policy Manual at http://manuals.chfs.ky.gov/dcbs_manuals/DFS/voliva/volivams1860.doc

Following are financial resource limits according to marital status and service options:

Marital Status	Services Being Received	Resource Limit
Single Person	Medicaid Waiver services	\$2,000.00
Married Couple	Both get Medicaid Waiver services	\$4,000.00
Married Couple	One spouse gets Medicaid Waiver services and the other does not	\$22,000.00 or the spousal share + \$2,000.00 (maximum \$101,540.00)

- B. The support broker shall initially verify and continue verifying monthly, the participant’s continued Medicaid eligibility. In order to qualify for waiver services, including CDO, the participant cannot be receiving only *Qualified Medicare Beneficiary* (QMB) benefits and cannot be receiving *Passport Health Plan* benefits. The DCBS office can confirm the type of eligibility if not able to determine via the Kentucky Health Network system.

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1. KyHealth-Net's eligibility screen should be located for each CDO participant, printed monthly, and filed in the participant's case management and financial management case record.
2. Individuals receiving the Qualified Medicaid Beneficiary (QMB) are not receiving the Medicaid eligibility benefits needed for waiver services. The individual or a designated representative must go to the local DCBS office and apply for adult medical (waiver services) benefits AFTER the assessment has been completed and level of care certification AND prior authorization has been approved by the QIO.

The DCBS office receives an automated notice from the QIO once the participant's level of care (LOC) and prior authorization (PA) has been approved. However, any current documentation the participant has available should be provided to the DCBS worker at the time of the Medicaid eligibility application.

The participant may call the local DCBS office to obtain further instructions or information on what is required to complete the application process to determine Medicaid eligibility for waiver services.

- C. This policy shall be reviewed and revised as necessary.

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Statement of Policy and Purpose

In addition to Medicaid financial eligibility, participants who wish to CDO must meet their respective waiver program criteria as outlined in the appropriate administrative regulation. Program eligibility must be secured and verified for the purposes of guaranteeing ongoing payment and supports to serve participants in their home and community as individual functional needs may change in an instant thereby affecting their program eligibility.

Procedure

- A. The support broker shall facilitate the completion of the MAP-10, Waiver Services and Physician’s Recommendation form (Appendix B) to be included with the waiver application packet submitted to Medicaid’s Quality Improvement Organization (QIO) when requesting prior authorization for participation in one of the approved waiver programs. The MAP-10, Waiver Services and Physician Recommendation form (Appendix B) details the statement of need for long-term care services and it shall be signed and dated by the appropriate licensed provider as outlined below and be less than one (1) year old:
 1. Acquired Brain Injury: Signed and dated by a Physician
 2. Home and Community Based: Signed and dated by a Physician, Advanced Registered Nurse Practitioner (ARNP) or Physician’s Assistant (PA).
 3. Supports for Community Living: Signed and dated by a Physician or a Qualified Mental Retardation Professional (QMRP).
 4. Michelle P. Waiver: Completed by a provider as defined in regulation.

- B. Medicaid’s Quality Improvement Organization (QIO) determines level of care patient status in accordance with 907 KAR 1:022. Program eligibility criteria for each waiver (ABI, HCB, SCL and MPW) are outlined below:
 1. **Acquired Brain Injury (ABI) Waiver:**
 Individuals are eligible for the ABI waiver if they:
 - a. Are between the ages of 21 and 65 years;
 - b. Meet nursing facility level of care;

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- c. Have a primary diagnosis of an acquired brain injury;
- d. Exhibit cognitive, behavioral, motor or sensory damage with a potential for rehabilitation and retraining;
- e. Have a rating of a least four (4) on the Rancho Los Amigos Level of Cognitive Function Scale;
- f. Are realistically expected, upon discharge from the program to remain in the community setting with existing community resources;
- g. Are eligible for Medicaid;
- h. Receive Social Security Income or Social Security Disability Income are presumed to be financially eligible; and,
- i. Have income that does not exceed 300% of the Social Security Income standard may also be financially eligible

2. Home and Community Based Waiver:

- a. The individual who is age sixty-five (65) years or older, blind or disabled;
- b. The individual must obtain a written certification by a physician that if Medicaid Waiver services were not available, nursing facility services would be ordered and the individual would be admitted to a nursing facility in the immediate future;
- c. An individual who meets Nursing Facility Level of Care criteria giving consideration to the medical diagnosis, age-related dependencies, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services; and
- d. The individual chooses to be at home and get Waiver services.

3. Supports for Community Living (SCL) Waiver:

- a. To be eligible to receive a service in the SCL program, an individual shall:

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1. Complete and submit the MAP-620, Application for SCL Waiver and ICF/MR Services (Appendix H), and be placed on the SCL waiting list;
2. Receive notification of potential SCL funding;
3. Meet ICF-MR-DD patient status requirements established in 907 KAR 1:022;
4. Meet Medicaid eligibility requirements established in 907 KAR 1:605;
5. Submit an application packet to the Department for Medicaid Services (or designee) which shall contain:
 - aa. The Long Term Care Facilities and Home and Community Based Program Certification Form, MAP-350 (Appendix C);
 - bb. The MAP-351 Assessment Form (Appendix D);
 - cc. The results of a physical examination that was conducted within the last twelve (12) months;
 - dd. A MAP-10 (Appendix B), statement of the need for long-term care services, which shall be signed and dated by a physician or a QMRP and be less than one (1) year old;
 - ee. The results of a psychological examination completed by a licensed psychologist or psychologist with autonomous functioning;
 - ff. A social case history which is less than one (1) year old;
 - gg. A projection of the needed supports and a preliminary MAP-109 plan of care for meeting those needs (Appendix E); and
 - hh. A MAP-24C (Appendix G) documenting an individual's status change; and
 - ii. A copy of the letter notifying the SCL consumer of an SCL funding allocation; and

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6. Receive notification of an admission packet approval from the Department for Medicaid Services (or designee).
- b. To maintain eligibility as an SCL consumer:
1. An individual shall be administered an NC-SNAP assessment by the Department for Mental Health, Developmental Disabilities and Additional Services (DMHDDAS) in accordance with 907 KAR 1:155;
 2. An individual shall maintain Medicaid eligibility requirements established in 907 KAR 1:605;
 3. An ICF-MR-DD level of care determination shall be performed by the Department for Medicaid Services (or designee) at least once every twelve (12) months; and
 4. A case management/support broker provider shall notify the local DCBS Family Support office, Department for Medicaid Services and the Department for Mental Health, Developmental Disabilities and Addiction Services (DMHDDAS) on a MAP-24C form (Appendix F) if an SCL consumer is:
 - aa. Terminated from the SCL waiver program;
 - bb. Admitted to an ICF-MR-DD facility; [or]
 - cc. Admitted to a hospital; or
 - dd. Transferred to another Medicaid waive program.
- c. An SCL waiver service shall not be provided to an SCL consumer who is receiving a service in another Medicaid waiver program or is an inpatient of an ICF-MR-DD or other facility.
- e. The Department for Medicaid Services (or designee) may exclude from receiving an SCL waiver service an individual for whom the aggregate cost of SCL waiver services would reasonably be expected to exceed the cost of ICF-MR-DD services.

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4. **Michelle P. Waiver (MPW):**

- a. A Michelle P. waiver service shall be provided to a Medicaid-eligible Michelle P. Waiver recipient who:
 1. Is determined by the department to meet MPW service level of care criteria in accordance with Section 5 [MPW service level of care criteria below] of the MPW administrative regulation; and
 2. Would, without waiver services, be admitted to an ICF-MR-DD or a nursing facility.
- b. The department shall perform a MPW level of care determination for each Michelle P. waiver recipient at least once every twelve (12) months or more often if necessary.
- c. A Michelle P. waiver service shall not be provided to an individual who:
 1. Does not require a service other than:
 - aa. An environmental and minor home adaptation;
 - bb. Case management; or
 - cc. An environmental and minor home adaptation and case management;
 2. Is an inpatient of:
 - aa. A hospital;
 - bb. A nursing facility; or
 - cc. An ICF-MR-DD;
 3. Is a resident of a licensed personal care home; or
 4. Is receiving services from another Medicaid home and community based services waiver program.

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- d. A Michelle P. waiver provider shall inform a Michelle P. waiver recipient or his or her legal representative of the choice to receive:
 - 1. Michelle P. waiver services; or
 - 2. Institutional services.
- e. An eligible Michelle P. waiver recipient or the recipient's legal representative shall select a participating Michelle P. waiver provider from which the recipient wishes to receive Michelle P. waiver services.
- f. A Michelle P. waiver provider shall use a MAP-24 (Appendix F) to notify the department of a Michelle P. waiver service recipient's:
 - 1. Termination from the Michelle P. waiver program; or
 - 2. a. Admission to an ICF-MR-DD or nursing facility for less than sixty (60) consecutive days;
 - b. Return to the Michelle P. waiver program from an ICF-MR-DD or nursing facility within sixty (60) consecutive days;
 - 3. Admission to a hospital; or
 - 4. Transfer to another waiver program within the department

MPW Services Level of Care Criteria:

- (1). An individual meets MPW services level of care criteria, if the individual:
 - (a) Requires physical or environmental management or rehabilitation and:
 - 1. Has a developmental disability or significantly sub-average intellectual functioning;

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2. Requires a protected environment while overcoming the effects of a developmental disability or sub-average intellectual functioning while:
 - a. Learning fundamental living skills;
 - b. Obtaining educational experiences which will be useful in self-supporting activities; or
 - c. Increasing awareness of his or her environment; or
3. Has a primary psychiatric diagnosis if:
 - a. Possessing care needs listed above in paragraph (a) or (b);
 - b. The individual's mental care needs are adequately handled in an ICF-MR-DD; and
 - c. The individual does not require psychiatric inpatient treatment; or;
- (b) Has a developmental disability and meets the:
 1. High-intensity nursing care patient status criteria pursuant to 907 KAR 1:022, Section 4(2); or
 2. Low-intensity nursing care patient status criteria pursuant to 907 KAR 1:022, Section 4(3).
- (2) An individual who does not require a planned program of active treatment to attain or maintain an optimal level of functioning shall not meet MPW services level of care criteria.
- (3) The department shall not determine that an individual fails to meet MPW services level of care criteria solely due to the individual's age, length of stay in an institution, or history of previous institutionalization if the individual meets the criteria established in subsection (1) of this section.
- C. This policy shall be reviewed and revised as necessary.

Participation Requirements – CDO Participant Self-Direction or Representative Selection	CDO-PR-0120-01
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Statement of Policy and Purpose

Individuals seeking the consumer directed option (CDO) must be able to direct their supports and services or must be able to appoint a representative to assume their responsibilities in order to safeguard the participant's health, safety, welfare and avoid institutional placement while living in their community.

Standard Operating Procedures

Individuals must be able to direct their supports and services utilizing the services of a support broker and financial manager. The individual may appoint a representative to assume their participant responsibilities.

- A. The support broker will provide written information about CDO to participants and their families or caregivers. Videos and brochures are available through the Department for Aging and Independent Living. Support brokerage agencies may further develop and distribute their own informational publications; however, these informational publications must receive the approval of DAAL prior to distribution.
- B. If a participant chooses CDO but is unable to direct their supports and services, they may designate a representative to coordinate their service needs on their behalf.
 - 1. The representative shall make informed and appropriate decisions on behalf of the participant taking into consideration the participant's needs.
 - 2. The representative shall not be paid or reimbursed and shall continue to meet the requirements outlined in the Kentucky Administrative Regulation for the waiver program.
 - 3. The participant shall complete, sign and date the MAP-2000 (Appendix H) designating a representative.
 - 4. The support broker shall ensure the representative was chosen by the participant, without influence or pressure, and meets the regulatory requirements.
- C. This policy shall be reviewed and revised as necessary.

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Statement of Policy and Purpose

Individuals seeking the consumer directed option (CDO) must be able to direct their supports and services by accepting their rights, roles, responsibilities, and the risks involved with self-directing or must be able to appoint a representative to assume their responsibilities in order to safeguard the participant's health, safety, welfare and avoid institutional placement while living in their community. It is the role of the support broker to ensure participants and representatives are informed of and understand rights, roles, responsibilities, and risks of uncertain outcomes to ensure success of the CDO approach for services.

Standard Operating Procedures

The support broker shall review with each participant and each representative their rights, responsibilities, and risks involved with self directing. The CDO Rights, Responsibilities and Risks Statements document (Appendix S) shall be the document used during the review and used to obtain the appropriate signatures. This document ensures that the participant or representative received a copy of the document and had questions answered by the support broker. Following is a detailed summary outline of the rights, roles, responsibilities, and risks as though the participant was reading it. This information can also be found in the CDO Participant Handbook.

Rights

You have the right to:

- Be treated with dignity and respect at all times
- Make informed choices based upon appropriate information provided to you, and to have those choices respected, while respecting the rights of others to disagree with those choices
- Use the services of a representative whom you choose to make choices on your behalf
- Freely choose among approved providers in your locale for Support Broker and Fiscal Intermediary services
- Feel safe and secure in all aspects of life, including health and well being; be free from exploitation, fraud and abuse, but not be overprotected
- Refuse service
- Set home rules
- Change care providers
- Make your own decisions
- Be notified of program changes in a timely manner
- Confidentiality regarding your care

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- Voluntarily withdraw from the program at any time and return to the traditional care model
- Ask questions until you understand
- Manage Personal Care Assistants by:
 - Deciding whom to hire to assist you
 - Deciding what special knowledge or skills the assistant must possess
 - Training each assistant to meet your individual needs
 - Replacing assistants who do not meet your needs
- Request a new assessment if your needs change
- Receive a report of how you have spent your monthly budget
- Voice grievances about care or treatment without fear of discrimination or reprisal
- Appeal issues and decisions to the Department for Medicaid Services

Roles

By choosing CDO, you assume all three (3) of the following roles to assist with addressing your unmet service needs: participant, employer, and custodian. For some participants, a representative will act as an agent. When a representative is involved, the role of the participant becomes the same as the role of the representative with input from the participant when possible.

You as Participant: Your role as participant is to make informed decisions about the best way to meet your needs, receive services, make changes as needed and stay within your budget.

You as Employer: Your role is to find and hire people to work for you. Your support broker is not responsible for doing this for you. You will train your workers about your medical condition and needs and the specific work they will do for you as well as schedule when you want the work to be performed. You will also decide how much to pay your employees within your approved budget and the regulatory guidelines, and fire an employee when or if necessary. Finally, you will authorize paychecks for your employees.

You as Custodian: Your role as custodian of public money is to use your budget responsibly. The Medicaid waiver budget must be used to meet your long-term care needs. You will have the freedom to be creative and you can change your mind along the way; however, you must make purchases based on need and that help you remain at home and in your community and out of a nursing home or other institution. Your experiences and your successes will help decide whether others in Kentucky will have the future opportunity to manage their own services. Therefore, it is important that you use your budget responsibly.

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A Representative on Your Behalf: The representative may make decisions and choices on behalf of you, the participant and the representative may manage all care and financial responsibilities while involving the participant as much as possible in decisions regarding needs, services, budget, and satisfaction with services. When possible, the participant should also be involved in hiring workers and setting their work schedules.

Representatives are required for participants who are unable to make decisions about personal care needs, organize and manage the household or manage employees and employer tasks. If you have a court-appointed guardian or other legal representative acting on your behalf, that same person may serve as your representative.

Representatives must not have a history of abuse, neglect, or exploitation of others, or abuse alcohol or drugs. Representatives must meet regulatory requirements. Representatives may not accept payment for services nor can they be employed by you for any additional service.

Responsibilities

While utilizing CDO, you accept the responsibility to gain the information needed to successfully manage the services to support your independence of living in your own home. Along with your rights come responsibilities. Please read the following sections of this manual to fully understand your responsibilities and remember you have the right to ask questions until you fully understand any issue or requirement.

You have the Responsibility to:

- Manage and maintain your health and to access medical help as needed or to seek assistance in order to do so
- Demonstrate the required skills and abilities needed to self-direct personal care assistants/employees without jeopardizing your health and safety or designate a representative to assist you
- Act as a supervising employer by:
 - Deciding wages, schedules and benefits (if any) of your assistants
 - Completing hiring agreements with each employee
 - Following all employment laws and regulations with the assistance of a financial manager provided by the state.
 - Following all requirements of the support broker/Internal Revenue Services (IRS) tax and labor laws in regards to hiring and paying personal care assistants including: completing all necessary forms, and reviewing time sheets for accuracy and submitting them in a timely manner

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- Treating all employees with dignity and respect
- Keep track of the balance of your monthly budget so you do not over-spend
- Notify your support broker of admission to a hospital, nursing facility, rehabilitation facility, or intermediate care facility
- Ensure a safe working environment
- Develop an emergency back-up plan

Risks

As indicated above, one of the many responsibilities you embrace as a CDO participant is the development of an emergency back-up plan. This requirement is necessary to safeguard against potential risks that may lead to uncertain outcomes. Other risks may include employer liability for on- the-job injuries of employees or potential harm of your well-being of an employee with an abusive past. Although there are numerous scenarios that may contribute to risk you must educate yourself and develop strategies to pro-actively safeguard yourself. Risk is the level of likelihood of a bad or undesirable outcome and risk-taking is the willingness to tolerate the potential of uncertain outcomes. Following are ways to address some, but not all, of the potential risks.

Address Your Liability Risk by:

- Maintaining a safe workplace and timely correct any hazardous conditions in your home
- Exploring liability insurance coverage if an employee is accused of causing injury to a third party as you may be jointly liable
- Exploring the option for the provision or availability of workers' compensation coverage for all of your employees
- Assuring that the support broker has conducted criminal background checks for all of your employees
- Entering into a written employment agreement with each employee that also allows termination of employment at will. This agreement can also include a provision requiring the employee and/or you to provide advance notice of termination even if termination is at will
- Asking questions of your support broker, attending training, and exploring other ways to learning about employment laws
- Using your head rather than just your heart for decision making
- Learning from others in addition to your own experiences

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Statement of Policy and Purpose

It shall be the policy of the Department for Aging and Independent Living (DAIL) to establish lines of authority, channels of communication, and procedures necessary for the effective statewide administration of Consumer Directed Options (CDO).

Standard Operating Procedures

- A. The DAIL organizational chart establishes the lines of authority, responsibility, and channels of communication for the administration of CDO (Department for Aging and Independent Living Organizational Chart, Appendix J).
- B. The Commissioner shall be the chief program officer ultimately responsible for personnel, services, privacy of information, and quality management.
- C. The branch manager with day-to-day direct oversight of the CDO shall develop and revise CDO standards as determined necessary or as requested by the Department for Medicaid Services. These CDO standards shall be outlined in the CDO Standard Operating and Reimbursement Procedures Manual.
- D. The branch manager with day-to-day direct oversight of the CDO shall establish and make available on a statewide basis, policies and procedures essential for fiscal management and support broker operation.
 - 1. DAIL shall provide training and maintain a viable working relationship with the support brokerage agency and the financial management agency through monitoring and technical assistance functions.
 - 2. DAIL shall conduct annual monitoring visits/field review audits of AAAILs and review the participant's record. This review will include administrative, programmatic, clinical, and fiscal aspects.
- E. The branch manager with day-to-day direct oversight of the CDO shall report to the Commissioner or a designee and direct the activities of the program areas as follows:
 - 1. Develop, make available, and revise, as necessary, program and fiscal reporting requirements for CDO.
 - 2. Monitor at least annually, Area Development District and Area Agency on Aging administration of CDO including the provision of any financial management and support brokerage services. DAIL will train the Department for Mental Health, Developmental Disabilities and Addiction Services, when needed and requested by the Department, concerning annual CDO on-site monitoring of the Community Mental Health Centers

Administrative Responsibilities – Department for Aging and Independent Living (DAIL)	CDO-AR-0200-01
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performing CDO Support Brokerage Agency and Financial Management Agency responsibilities.

3. Provide or assist with training and technical assistance in situations where assistance is needed due to problems in coordination with other programs or agencies, difficult consumer situations and complaints.
 4. Provide periodic updates and provider letters for continuing education and support. This will also provide the opportunity to communicate quality improvement initiatives.
 5. Develop reports, CDO information, budget requests, and other information to keep administration, legislators, providers and the public aware of the program needs and performance.
 6. Provide annual reports as follows to the Department for Medicaid Services:
 - a. Support Broker and Fiscal Intermediaries Report that includes at a minimum, the support broker agency name, support broker's Medicaid provider numbers; fiscal intermediary agency name, and the dates that the monitoring review(s) is (are) scheduled to be performed by DAIL CDO staff. This report must be submitted to DMS on or before February 15 of each year.
 - b. Member Satisfaction Survey Report, using data provided by the Support Brokerage Agency, that includes at a minimum, the participant's full legal name, participant's Medicaid Identification Number (MAID), the participant's waiver program (ABI, ABI-LTC, HCB, MP and SCL), participant's county of residence, support broker agency, and the response to each question on survey. This report must be submitted to DMS on or before January 5 of each year.
 7. Develop other protocol, guidelines or CDO requirements, when the need has been identified.
 8. Receive, review and determine appropriate resolution of all support brokerage and financial management agencies concerning CDO complaints or other issues.
- F. This policy shall be reviewed and revised as necessary.

Administrative Responsibilities – DAIL/Quality Management	CDO-AR-0200-02
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Statement of Policy and Purpose

It shall be the policy of the Department for Aging and Independent Living to establish and follow quality management practices including but not limited to strategic planning, program evaluation, monitoring activities, and technical assistance. The purpose of such activities is to ensure adherence to applicable regulations, person centered planning principles, best practices, and fiscal integrity in addition to, safeguarding participant health, safety, and welfare.

Standard Operating Procedures

- A. The branch manager with day-to-day oversight of the CDO shall make recommendations for program improvement through the use of various data sources and processes including but not limited to the following:
1. Desk monitoring and/or on-site monitoring outcomes including administrative, programmatic, clinical, patient liability, remittance advices, consumer account, funds disbursement and other fiscal aspects of CDO provision.
 2. Support broker and Fiscal Intermediaries Reports.
 3. Member Satisfaction Survey Report.
 4. Solicited input from CDO Participants and their families.
 5. At least quarterly, DAIL staff will review expenditure reports submitted by the support broker agency, and the health, safety and welfare status of the participant.
 6. At least annually, DAIL staff will conduct a random sampling of either a face-to-face visit or a telephone contact with the Participant.
- B. The branch manager with day-to-day oversight of the CDO shall ensure all aspects of training requirements are met and followed including, but not limited to, case management, person centered planning, budget development and abuse, neglect or exploitation identification.
- C. The Department for Aging and Independent Living shall impose citations and/or corrective action plans when necessary should Support Brokerage Agencies or Financial Management Agencies not adhere to the CDO standards outlined in the CDO Standard Operating and Reimbursement Procedures Manual, Provider Letters and Regulations.

Administrative Responsibilities – DAIL/Quality Management	CDO-AR-0200-02
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- D. The Department for Medicaid Services may perform second-line reviews or audits and may impose other penalties, including recoupment of monies, as necessary following the second-line review or audit.
- E. This policy shall be reviewed and revised as necessary.

Administrative Responsibilities – Provider Agency/Quality Management	CDO-AR-0210-01
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Statement of Policy and Purpose

It shall be the policy of a provider agency to establish quality management practices including but not limited to clearly defined policies and procedures, written job descriptions and lines of supervision in addition to the establishment of data reporting practices and overall responsibility necessary for the effective administration of Consumer Directed Options (CDO).

Standard Operating Procedures

- A. The provider agency shall be responsible for planning, organizing, and administering a district-wide service delivery system in compliance with statutory and regulatory intent, meeting all requirements of the 1915c Waivers as well as the master agreement, and, is approved by DAIL.
- B. A provider agency shall document evidence that supports each paid staff person has received initial and ongoing training to meet or exceed minimum training standards and possess the required qualifications established for their job duties by:
 - 1. Maintaining a written job description for each job category and for each paid staff person involved in direct service delivery.
 - 2. Maintaining a training log to ensure each paid staff person has completed the minimum training to meet CDO requirements.
 - 3. Developing and maintaining written personnel policies and a wage scale for each job classification.
 - 4. Designating a supervisor to ensure that all staff providing CDO services is appropriately supervised. The designated supervisor must meet the required minimum qualifications of a support broker and have at least one (1) year of support broker experience.
- C. A Support Brokerage Agency shall submit the following required **monthly** reports to the DAIL in a format designated by DAIL **before the 15th** of each month via the Secured MOVEIT File Transfer Protocol (FTP) software at the following link: <https://ftp.chfs.ky.gov/>
 - 1. **Monthly CDO Member Enrollee Report.** The report shall include, at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL),

Administrative Responsibilities – Provider Agency/Quality Management	CDO-AR-0210-01
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county of residence, support broker agency, support broker name, and the date the participant enrolled in CDO.

2. **CDO Member Involuntary Termination Report.** The report shall include, at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, date terminated from CDO, and a detailed reason for the **involuntary** termination.
3. **CDO Member Voluntary Termination Report.** This report shall include at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, date terminated from CDO, a detailed reason for the **voluntary** termination and the traditional waiver case management agency name.
4. **CDO Member Corrective Action Plan (CAP) Report.** This report shall include, at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, detailed reason for necessity of the CAP, indication if participant is following the CAP (yes or no), detailed notes on the participant's progress with the CAP, and the date the participant shall be meeting the requirements of the CAP.
5. **Members referred to Support Brokers for CDO Services Report.** This report shall include at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, date referral received by the support broker, date support broker contacted the participant, date of the initial visit with participant, indication of whether participant enrolled in CDO (yes or no), and date CDO services started (direct services started, **NOT** Support Broker services or Financial Management services).
6. **Members Monthly Continuing Income Amount Report.** This report shall include at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, and monthly amount of continuing income (patient liability).
7. **Member Failing to Pay Continuing Income Report.** This report concerns patient liability and shall include at a minimum, the

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participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, and outstanding balance of continuing income owed by participant. Additionally, the support broker shall document in the participant's file, the reason the participant has given for not paying continuing income (patient liability) and if any corrective action plan has been implemented.

8. **Members CDO Budget Expenditure Report.** This report concerns budgetary information and shall include at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, total to-date expenditures deducted from the original budget, and the net budget balance.
 9. **Monthly Visits with CDO Participant Report.** This report details the required face-to-face monthly visits with a CDO participant and shall include at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, and date(s) of the face-to-face monthly visit(s).
- D. A Support Brokerage Agency shall submit the following required **quarterly** reports to the DAIL in a format designated by DAIL via the Secured MOVEIT FTP software **before** the corresponding quarterly dates provided below:
- The first (1st) quarter (January, February, March) due *before* May 1.
 - The second (2nd) quarter (April, May, June) due *before* August 1.
 - The third (3rd) quarter (July, August, September) due *before* November 1.
 - The fourth (4th) quarter (October, November, December) due *before* February 1.
1. **Failed Criminal Background Check Report.** This report shall include at a minimum, the participant's full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, and first and last name of the participant's potential employee. If NO failed criminal background checks, enter N/A or None under Member's Last

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Name. Also be sure to include SB Agency Name where requested.

2. **Participant’s Person Centered Planning and Abuse, Neglect and Exploitation Training.** This report shall include, at a minimum, the participant’s full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, and date(s) training(s) was/were provided by the support broker.
 3. **In-home Visits with CDO Participants Report.** This report shall include at a minimum, the participant’s full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency, support broker name, date of visit(s), and detailed findings (including, but not limited to, reporting that services are being provided in accordance with the approved plan of care, support spending plan and CDO budget and that the participant is satisfied with CDO services).
- E. Member Satisfaction Survey Report.** The Support Brokerage Agency shall ensure a CDO satisfaction survey, *Kentucky’s DAIL’s Adaptation of Quality of Life Changes* (Pre-CDO “Initial Enrollment”, Appendix K) (Ongoing CDO, Appendix L), will be provided by the support broker to the consumer or the consumer’s designated representative at the initial enrollment into CDO and annually thereafter.

The annual report shall include at a minimum, the participants full legal name, Medicaid Identification Number (MAID), waiver program (ABI, ABI-LTC, HCB, MP and SCL), county of residence, support broker agency and the response to each question on the survey.

The Support Broker will administer the survey face-to-face with the consumer or the consumer’s designated representative and allow time to review, compile and submit the aggregate responses to each question in a report to DAIL. The Member Satisfaction Survey Report shall be submitted to DAIL **annually** following a format designated by DAIL via the Secured MOVEIT FTP software **before** December 20.

Participation in the survey process is voluntary and if the consumer or the consumer’s designated representative does not wish to participate, the Support Brokerage Agency shall document this preference.

- F. This policy shall be reviewed and revised as necessary.

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Statement of Policy and Purpose

It shall be the policy of a support brokerage agency (SBA) to further establish quality management practices including but not limited to adherence to clearly defined support broker qualifications, hiring practices, employee training, and overall responsibility necessary for the effective implementation and ongoing provision of support broker services.

Standard Operating Procedures

A. Support brokers shall meet the following qualifications:

1. A support broker must meet the qualifications outlined in the Kentucky Administrative Regulation for the appropriate waiver program that include an individual who has a bachelor's degree in Social Work, Psychology, Sociology or a field relevant to human services; or a bachelor's degree in nursing with a current Kentucky license; or a Kentucky registered nurse with a current Kentucky license and two (2) years experience in working with the elderly or disabled; or a Licensed practical nurse with a current Kentucky license and three (3) years experience working with the elderly or disabled.
2. Within six (6) months of hire; a support broker shall receive and participate in at least fourteen (14) hours of initial CDO training consisting of training provided by the SBA and training conducted by the State; and sixteen (16) hours of in-service training, consisting of CDO refresher trainings and trainings related to the population served annually thereafter. Other than the CDO trainings conducted by the State and the SBA, other in-service training can be obtained by any qualified agency meeting DAIL's approval. If determined necessary, DAIL shall request a support broker submit to additional hours of training; basing this determination on review of exception requests and onsite monitoring visits.

The support broker training shall include, but not be limited to, the following topics: case management, how to conduct effective home visits, understanding the support broker role and responsibilities, training consumers, providing technical assistance and an adequate level of support, responding to emergency situations and the use of emergency backup plans, monitoring responsibilities, assessing the need for a resolution, prevention and corrective action plan, and assessing risk for abuse, neglect and/or exploitation.

Employee Requirements –Support Broker /Support Brokerage Agency	CDO-ER-0300-01
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- B. Support brokerage agencies (SBA) shall employ a minimum of one (1) full-time equivalent support broker for every forty (40) CDO consumers. Time used to provide agency administration or supervision of other staff shall not be counted toward meeting the full-time equivalency requirement.
- C. The support brokerage agency (SBA) shall not initiate a waiting list for CDO and shall not postpone enrollment into CDO.
- D. The CDO support broker shall be responsible for assisting individuals to access other community resources, natural supports or other supports available through other funding streams if their needs exceed the budget limit.
- E. The Support Broker will provide each consumer a Participant Handbook that describes orientation to the program, the philosophy/guiding principles of CDO, participation requirements, how to manage the individual budget, role and responsibilities, billing and scheduling, how to recruit, hire, supervise and fire employees, training necessary to support the individual while providing direct care, how to deal with quality of care problems, and how to identify and deal with abuse, neglect and exploitation.
- F. Support brokers shall provide, at a minimum, the following services and supports:
 - 1. The support broker shall initially verify, and continue to verify monthly, the consumer's appropriate Medicaid eligibility and applicable waiver eligibility through the Kentucky Health Network System.
 - 2. Provide any needed assistance to a participant with any aspect of CDO or blended services including but not limited to:
 - a. Completing and revising a plan of care and support spending plan using person centered planning principles.
 - b. Recruiting, hiring and managing CDO providers (employees);
 - c. Completing and submitting required forms;
 - d. Coordinating all services, including any services not specifically related to CDO but needed to help maintain the participant in the community;
 - e. Continuously monitoring a consumer's health, safety, and welfare;

Employee Requirements –Support Broker /Support Brokerage Agency	CDO-ER-0300-01
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- f. Providing, at minimum, a monthly home visit;
 - g. Ensuring the completion of an assessment and reassessment as required;
 - h. Being available twenty-four (24) hours per day, seven (7) days per week, including holidays; and
 - i. Complying with all applicable federal and state laws, regulations and requirements.
- G. A Support Brokerage Agency shall monitor each support broker for the provision of appropriate service delivery; monthly home visits, and monitoring of the CDO budget, support spending plan and plan of care for each participant by ensuring:
- 1. Each support broker documents progress or lack of progress in directing services and participant progress or lack of progress towards goals during the required monthly home visit or more frequently as needed.
 - 2. Each support broker performs more than the minimum required contacts with each participant when the participant's needs surpass such minimum requirements.
 - 3. Should the monthly monitoring by the support broker reflect that the consumer's needs are not being met, and/or health and safety are being jeopardized or funds in the consumer's budget are not being utilized according to the Plan of Care, the support broker will work with the consumer or the designated representative to resolve the issue. If the issue cannot be resolved, termination procedures should be followed utilizing the regulation and CDO Standard Operating and Reimbursement Procedures Manual as a guide.
- H. This policy shall be reviewed and revised as necessary.

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Statement of Policy and Purpose

It shall be the policy of a financial management agency (FMA) to further establish quality management practices including but not limited to adherence to clearly defined financial manager roles and qualifications, employee training, and overall responsibility necessary for the effective implementation and ongoing provision of financial management services to assist participants in paying their employees and processing payments for providers (employees) according to state and federal labor and tax laws.

Standard Operating Procedures

- A. Financial Managers shall meet the following qualifications:
1. A financial manager shall be an individual who has a bachelor's degree from an accredited institution in Accounting or its equivalent; or a bachelor's degree from an accredited institution in Business Administration or its equivalent and one year (1) experience working in accounting.
 2. Within six (6) months of hire; a financial manager shall receive and participate in at least fourteen (14) hours of initial CDO training consisting of training provided by the FMA and training conducted by the State; and sixteen (16) hours of in-service training, consisting of CDO refresher trainings and trainings related to the population served annually thereafter. Other than the CDO trainings conducted by the State and the FMA, other in-service training can be obtained by any qualified agency meeting DAIL's approval. .
- B. The financial management agency shall provide a full range fiscal accounting functions including but not limited to bookkeeping services, which includes generating payroll, writing checks, calculating and remitting taxes, withholding of federal, state and local taxes from payment to service providers., reconciling consumer accounts and producing reports (such as expenditure reports) for the consumer and the support broker detailing the use of the budget. *Participants shall not have the option to perform their own bookkeeping duties other than approval/verification of employee timesheets.*
- C. The financial management agency shall provide the support broker the appropriate CDO provider employment packet including necessary tax forms and other required documentation. The FMA shall maintain a copy of the CDO Employee or Provider Agreement on file and ensure it is updated annually.
- D. At least monthly, the FMA will review the number of hours billed for CDO services provided and the total amounts billed for all goods and services

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during the month. The FMA will ensure all billed services follow the prior authorization; do not exceed the dollars allotted for the current month and annually; and do not put a CDO provider (employee) in overtime status during any pay period unless due to a one-time short-term (less than 1 – 2 weeks) extenuating circumstance.

- E. The FMA will ensure that payroll checks will be processed twice a month based on appropriate CDO service provisions and records. Payroll checks shall have, at minimum, the following information: Employee’s Name, Employee’s address (and mailing address if different), number of hours worked and the hourly pay rate.
- F. The Financial Manager using the approved CDO budget shall deduct from the gross annual budget for services amount (after administrative five-percent, 5%, with-hold) any appropriate Federal, State and Local taxes, including any chosen Worker’s Compensation premiums, prior to development of the Support Spending Plan in accordance with KRS 205.5606.
- G. The FMA must have a special FEIN that is used for all the tax returns of the CDO Program, if the financial management agency is a “reporting agent” or a “subagent” for the Participant. Tax returns for the “Employers/Participants” are filed in the aggregate using only the agent’s special FEIN. Also, see IRS form 2678. The IRS form 2678 is a required form that must be completed and placed in the appropriate case file and made available for monitoring purposes.
- H. The FMA will track and collect the Participant’s monthly patient liability once the MAP-2000 has been completed and the support broker begins providing case management services. The patient liability is determined by the Department for Community Based Services at the time Medicaid eligibility is approved. The agency shall collect only the amount with-held by Medicaid from the Support Broker Services reimbursement. If at any time the consumer does not pay his/her required patient liability, the Support Broker will start the process of requesting immediate termination following the procedures outlined in the termination section of this CDO Standard Operating and Reimbursement Procedures Manual. If approved for termination from CDO, the support broker shall transition the Participant back to traditional services. The FMA is responsible for providing written notification to the support brokerage agency within twenty-four (24) hours of not receiving the patient liability payment based on the written policy established by the FMA and approved by DAIL.
- I. This policy shall be reviewed and revised as necessary.

Statement of Policy and Purpose

It shall be the practice of the support broker to provide a timely intake for referrals as defined in the regulation for the purpose of meeting the participant's health, safety, and welfare needs while maintaining their placement in the community. During the intake process an assessment will also be completed for the purpose of adequately evaluating the participant's physical health, mental health, social supports, natural supports and environment in addition to the identification of needs and services that will assist with the development of an adequate plan of care.

Standard Operating Procedures

- A. When a support broker receives a referral they shall respond and document their response as follows:
 - 1. Within two (2) business days, contact the member, explain CDO to the member and schedule an appointment for a home visit with the participant; and
 - 2. Within five (5) business days of the initial contact, conduct the face-to-face home visit with the participant.
 - 3. During the first home visit describe CDO and acquire a signature for the acceptance of the participant's (or their designated representative's) rights, responsibilities, roles, and risks for choosing CDO (Provided in the Consumer Directed Option Participant Handbook and referenced in Appendix S). This initial training should also include details regarding person centered planning and the recognition and reporting of abuse, neglect, fraud and exploitation.

- B. At the time of initial referral, the support broker will also request a copy of a completed assessment that meets the requirements of the regulation for review by a qualified assessment team. Except for MPW, where the CMHC completes the assessment per an administrative contract with Medicaid; if an appropriate assessment is not available from the referral source, the support broker must complete the assessment (as part of the assessment team) and ensure all appropriate signatures are obtained. An assessment must be completed with the participant and any other team members the participant would like to include.

- C. Per Medicaid's requirements concerning CDO, the support broker will identify and/or participate with a qualified assessment team to review an existing assessment or complete an assessment within seven (7) business days of receiving the referral. The assessment must be completed on the Medicaid

assessment form, MAP-351 (Attachment D). The following entities are authorized to conduct an assessment:

- a. Adult Day Healthcare Centers
 - b. Community Mental Health Centers
 - Acquired Brain Injury Provider
 - Supports for Community Living Provider
 - Michelle P. Provider (solely responsible for completing MPW assessments under contract with Medicaid)
 - c. Support Broker
 - d. Traditional Home Health Agencies
- D. The support broker must provide supervision and assurances that CDO services shall not be used to replace the natural support system that already exists in the participant's home and community. It is expected that the natural support system be considered when completing the plan of care for the purpose of meeting regulatory requirements and safeguarding the responsible use of resources and state-funds.
- E. This policy shall be reviewed and revised as necessary.

Statement of Policy and Purpose

Every non-waiver service and waiver service, including services that are arranged and managed by the participant through CDO, must be included in the Participant's Plan of Care/Support Spending Plan and prior authorized by Medicaid's Quality Improvement Organization (QIO). A comprehensive plan of care will be based on the person centered planning principles and reflect the needs identified within the assessment. Collectively, all services, natural supports, blended services and any identified goods and services adequately support the participant to live in their community while safeguarding their health, safety, and welfare.

Goods and Services are included on the CDO budget along with the direct services. Goods and Services will reduce the monies made available for direct services since budgets cannot exceed the maximum Medicaid limitations.

Standard Operating Procedures

- A. The support broker will facilitate the completion of a plan of care and support spending plan utilizing the MAP-109 (Attachment E) to identify each service and corresponding therapeutic goals based on the individual needs of the participant identified in the assessment along with frequency, duration, unit cost, hourly wage and name of provider or employee.
- B. When a participant needs both traditional waiver services and services that can be self directed (also referred to as the need for blended services), the support broker must coordinate with the participant's traditional provider to complete the MAP-109 (Attachment E) to include the appropriate traditional/medical services in compliance with traditional waiver requirements. The support broker shall provide any needed assistance to a participant with any aspect of CDO or blended services. The support broker acts as the case manager for CDO and blended services.
- C. The support broker must facilitate participant access to required services as outlined in the plan of care and support spending plan within sixty (60) consecutive days from the date the plan of care is initiated for both new and existing waiver participants. If a participant and the support broker fail to access the required services for a period greater than sixty (60) days, it shall be up to the participant to provide sufficient documentation of good cause. The support broker will submit to the QIO the good cause documentation. The QIO will work with the Department for Medicaid Services to determine if good cause can be granted and waiver services to continue. If a decision to not allow good cause is determined, the individual will be required to adhere to the appropriate traditional waiver regulation requirements. If the individual

- has been discharged from the waiver program then he or she will be required to start the process over with obtaining Medicaid eligibility (if appropriate); waiver eligibility, waiver services; and obtaining another CDO budget if CDO is chosen.
- D. The plan of care must include an emergency back-up plan identifying arrangements that have been made for the provision of services and/or supplies in the unexpected absence of planned service and supports that are critical for meeting participant needs. Any emergency back-up employee must meet the same qualifications as primary employees and receive the same training. Paid employees must submit to criminal background and central abuse registry checks (Appendices O, P and R) as required by the appropriate waiver regulation. Emergency back-up employees must also be physically able to provide the service.
- E. CDO shall not be used to replace the natural support system. It is expected that the natural support system be considered when completing the plan of care. In determining whether a family member or friend is providing a natural support and should not be paid under CDO, the following process shall be followed:
1. The Support Broker will use the MAP-351 to assess the appropriateness of each service;
 2. The Support Broker will discuss with the consumer the frequency of delivery of each appropriate service;
 3. The Support Broker will ask the Participant who currently provides the service and whom the Participant chooses to provide the service;
 4. If the Participant chooses a family member or friend, the Support Broker will ask the Participant if this individual is willing and able to provide the service without pay, as a natural support;
 5. If the family member or friend is willing and able to provide a service without pay, it is documented as a natural support on the plan of care.
 6. If the family member or friend is unwilling or unable to provide the service without pay, the consumer may pay the individual for the service.
- F. This policy shall be reviewed and revised as necessary

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Statement of Policy and Purpose

It shall be the policy of the support broker and CDO participant using person centered planning principles to request a CDO budget based on the plan of care for services and supports adequate to meet the participant's needs. Budget requests shall never exceed the Medicaid maximum limits or service limitation outlined in the appropriate Kentucky Administrative Regulation.

Standard Operating Procedures

- A. The Participant's Budget amount is based on the historical cost paid by the Department for Medicaid Services (DMS) for waiver services prior authorized by the Quality Improvement Organization (QIO). For individuals that have never received a waiver service, the budget is based on the average utilization per service for all waiver participants in the waiver program. Because Michelle P is a new waiver program, annual costs are determined using regulatory limits, participant's needs, and the participant's completed plan of care.

After completing the assessment **and** plan of care the Support Broker will complete the CDO budget request form and submit the request form to DMS. Although this information is requested on the CDO budget request form it is important to note that the Support Broker shall also indicate if an exception budget was previously authorized and provide the date the exception budget was developed. The support broker must also provide the dollar amount for each good or Minor Home Adaptation requested.

DMS will review the request and develop a budget based on the regulatory criteria for the waiver program. Once approved, DMS will provide the CDO budget to the appropriate Support Brokerage Agency. The support broker will then access the information and ensure the approved CDO budget matches the support spending plan prior to submitting the completed packet to the QIO for processing.

Consideration of Taxes: The Financial Manager using the approved CDO budget shall deduct from the gross annual budget for services amount (after administrative five-percent, 5%, with-hold) any appropriate Federal, State and Local taxes, including any chosen Worker's Compensation premiums, prior to development of the Support Spending Plan in accordance with KRS 205.5606.

Worker's Compensation: In compliance with KRS 205.5607, the worker's compensation shall **not** apply for any CDO service rendered under KRS 205.5606, arranged by the consumer, support brokerage agency and financial management agency.

- B. This policy may be reviewed and revised as necessary.

Statement of Policy and Purpose

It shall be the policy of the support broker, financial manager, CDO participant, and other team members to plan services and supports adequate to meet the participant's needs without expending the allocated budget. When extenuating and catastrophic circumstances occur that demonstrate the needs of the participant exceed the capacity of the budget, the budget may be adjusted to a higher level for the purpose of preventing institutionalization and the protection of the Participant's health, safety and welfare. Regardless of the extenuating and catastrophic circumstance, the budget shall not exceed the regulatory average per capita annual cost of services provided to individuals in a nursing facility per waiver category (ABI: \$67,533; HCB: \$34,453; SCL: \$140,000). Because Michelle P is a new waiver program, annual costs are determined using regulatory limits, participant's needs, and the participant's completed plan of care.

Standard Operating Procedures

The Support Broker shall submit a written request for a budget to be adjusted to a higher level to the Department for Aging and Independent Living.

- A. The Support Broker must include the following information when requesting a Budget Adjustment (or Exception):
 1. A proposed Plan of Care and Support Spending Plan (MAP-109), the original Plan of Care and Support Spending Plan, the completed and signed "MAP-10, Statement of Need for Long-Term Care Services", the current "MAP-351, The Department for Medicaid Services, Medicaid Waiver Assessment", and the "DAIL-100, CDO Exception Request, Form" (Appendix M) identifying, in detail, the reason for requesting the Budget Adjustment; the exception criteria (Level I or Level II) and the reasons why a Budget Adjustment should be considered. The Support Broker shall also outline what changed in the Participant's situation that determined it necessary to request a Budget Adjustment
 2. All forms must be complete and include the information and documentation requested.
 3. All Budget Adjustments/Exception Request packets must be submitted via fax (502) 564-7572 to the attention of the DAIL CDO Branch Manager. No email packets or phone calls will be accepted.

4. **With the exception of the completed DAIL-100 form**, no email packets or phone calls outlining the details of the Budget Adjustment request will be accepted. The DAIL-100 form, initialed by the Support Broker, must be provided via email and fax. NOTE: Support Brokers must submit the “completed” DAIL-100 form via an email attachment to the DAIL CDO branch manager and the staff indicated on the DAIL-100 form instructions. The exception will not be reviewed until a completed packet and DAIL-100 form is correctly received.
 5. The CDO reviewer will contact the Support Broker by email to inform them if any additional information and/or documentation is needed and requested. The Support Broker will have ten (10) calendar days to submit the requested information to the CDO reviewer or the exception request will be denied for failure to provide information.
 6. Within three (3) full business days of the receipt of a complete and correct Budget Adjustment (Exception) Packet and barring no unforeseen circumstances, DAIL CDO staff will review and make a preliminary recommendation to the Commissioner of the DAIL. After considering the packet information and the recommendations of CDO staff, the DAIL Commissioner will make a final recommendation to the Department for Medicaid Services.
 7. The Department for Medicaid Services will review the final recommendation from the Commissioner of the Department for Aging and Independent Living and approve, deny, or modify the Budget Adjustment (Exception) request.
 8. If approved, DMS will provide an exception budget to DAIL. The DAIL CDO reviewer will log the determination on to the tracking log; notify the support broker via email; and place the approved exception budget on the secured MOVEIT FTP site for the support broker to access.
 9. If denied, DMS will prepare a denial letter to the CDO member outlining the reason for the denial and allowing the appropriate regulatory timeframe to request an appeal. DMS will provide DAIL a copy of the denial letter. The DAIL CDO reviewer will make this copy available to the support broker via the secured MOVEIT FTP site.
- B. The Department for Medicaid Services shall consider the language outlined in the Kentucky Administrative Regulation for the waiver program when determining whether to allow for a Budget Adjustment (Exception):
- C. This policy shall be reviewed and revised as necessary.

Statement of Policy and Purpose

A provider or employee of an eligible CDO service shall be selected by the Participant and meet regulatory requirements that serve to safeguard the health, safety and welfare of the Participant.

Standard Operating Procedures

- A. Each employee of an eligible CDO service shall:
1. Be selected by the Participant;
 2. Submit a completed Kentucky Consumer Directed Option Employee Provider Contract to the Support Broker;
 3. Be eighteen (18) years of age or older;
 4. Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a United States citizen;
 5. Be able to communicate effectively with the Participant, Participant Representative, or family;
 6. Be able to understand and carry out instructions;
 7. Be able to keep records as required by the Participant, the CDO Standard Operating and Reimbursement Procedure Manual and the regulations;
 8. Submit to a criminal background check (Appendix O);
 9. Submit to a check of the nurse aide abuse registry maintained in accordance with 906 KAR 1:100 and not be found on the registry (Appendices P);
 10. Not have pled guilty or been convicted of committing a sex crime or violent crime as defined in KRS 17.165(1) through (3);
 11. Complete training on the reporting of abuse, neglect or exploitation in accordance with KRS 209.030 or 620.030 and on the needs of the Participant;
 12. **For SCL, ABI and ABI-LTC** submit to a check of the central registry (Appendix R) maintained in accordance with 922 KAR 1:470 and not be found on the registry;

Note: *If all other CDO provider (employee) criteria is met and the individual is cleared to be a CDO employee, allow employment under SCL , ABI and ABI-LTC prior to receipt of the central registry result, however, if after thirty (30) days from submission **no** results are obtained employment shall cease until a favorable result is obtained.*

13. Be approved by the Department
 14. Maintain and submit timesheets documenting hours worked and services/activities performed; and
 15. Be a friend, spouse, parent, family member, other relative, employee of a provider agency or other person hired by the Participant.
- B. When employees are identified, trained, cleared through the criminal background check, Kentucky Nurse Aide Abuse Registry; Home Health Aide Abuse Registry and Central Registry as appropriate for the waiver regulation, the support broker submits a completed waiver packet containing a MAP-351, MAP-350, MAP-109, MAP-10, MAP-24 and the MAP-2000 to the QIO. The support broker also includes a copy of the approved CDO budget. Upon receipt of a Prior Authorization from the QIO, CDO services begin and traditional services end. The support broker submits immediately by fax the MAP-2000 to the traditional provider or if transferring CDO services, previous support brokerage agency, verification of the start date for current CDO services and the end date for any former traditional waiver services or CDO services.
- C. A Participant may hire a family member to provide the CDO service(s) included on the Participant's Plan of Care and Support Spending Plan and approved by Medicaid's Quality Improvement Organization, within the following guidelines:
- A parent, parents combined or a spouse shall not provide more than forty (40) hours of services in a calendar week (Sunday through Saturday) regardless of the number of children who receive waiver services.
 - Planned work schedules must be available and submitted to the support broker two (2) weeks in advance, and any variations to the work schedule must be noted and supplied with the current timesheet to the fiscal agent when billing;
 - The family member must maintain and submit time sheets and Service/Activity documentation logs and other required documentation

for hours paid; and

- Married individuals must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented on the plan of care and support spending plan.
 - The family member may live in the same household as the Participant and the family member may have power of attorney for the Participant.
 - The family member cannot serve as the Representative under CDO if they are being paid to provide a CDO service.
- D. The Participant may require an employee be trained on matters that relate to their individual health care needs, such as but not limited to, training regarding seizures and autism. **Such training shall not be paid from the CDO budget.**
- E. This policy may be reviewed and revised as necessary.

Statement of Policy and Purpose

Support Brokers are responsible to obtain Kentucky Nurse Aide Abuse Registry (Appendices P), Home Health Aide Abuse Registry (Appendices P), Central Registry (Appendix R), and Criminal Background (Appendix O) checks for potential employees as required by the waiver regulation. The Criminal Record and Central Abuse Registry Checks are paid through the Support Broker fee. It is permissible for the participant to receive a copy of the criminal background check if requested. The background checks are necessary to safeguard the Participant and their family from potential harm.

Standard Operating Procedures

- A. To obtain a background check for prospective CDO providers (employees) the support broker will send an email to the Administrative Office of the Courts (AOC) – Pretrial Services (Appendix O). The email is pretrailwebsite@kycourts.net. The support broker provides the prospective employees full legal name, maiden name (if appropriate), social security number, date of birth and current address. The support broker would provide his/her contact information in order to receive the documentation from AOC. After receiving documentation back from AOC the support broker will review and determine if the prospective employee meets employment criteria outlined in the regulation. The support broker would discuss any concerns related to eligible employees resulting from the background check with the consumer and allow the consumer to decide whether to hire the individual.

To obtain documentation from the Kentucky Nurse Aide Abuse Registry (Appendix P) on prospective CDO providers (employees) the support broker will send a request to the Nursing Background Website at <http://kbn.ky.gov/knar/verifications.htm>. The support broker will click on Basic Validation Search and enter the prospective employee's name (including any aliases). The support broker will file a hardcopy of the results in the case record. Additionally, if documentation comes back with the prospective employee's name included, then the support broker will document the case record and notify the CDO participant that the prospective employee does not meet eligibility criteria. The support broker will then request another prospective employee or if determined necessary, assist the participant with transitioning back to traditional waiver services.

Support brokers should contact Donna Hammond, Coordinator concerning any questions about the registry results. Ms. Hammond's direct telephone number, if needed, is (502) 429-3349. The mailing address for the Kentucky Nurse Aide Abuse Registry is:

312 Whittington Parkway, Suite 300-A
Louisville, Kentucky 40222-5172

To obtain documentation from the Central Registry Check on prospective CDO providers (employees) the support broker will mail a completed form DPP-156 (Central Registry Check) (Appendix R) to the following address:

Cabinet for Health and Family Services
Department for Community Based Services
Records Management Section
275 East Main Street, Section 3E-G
Frankfort, Kentucky 40621

Support Brokers must include a check or money order made payable to the "Kentucky State Treasurer" in the amount of ten dollars (\$10.00). The Central Registry Check will not be processed without payment. The cost of the Central Registry Check will be taken from the Support Broker payment in the same process as the Criminal Background Check. (DPP-156 form, Appendix R)

There is no appeal right for a decision excluding employment based on a criminal conviction by the court of competent jurisdiction, upon exhaustion or failure to timely pursue the judicial appeal process (907 KAR 1:671, Section 9 (3)).

B. This policy may be reviewed and revised as necessary.

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Statement of Policy and Purpose

The Participant shall maintain timesheets documenting hours worked and services or activities performed by their employees and submit them according to the Support Brokerage and Financial Management Agency's written policy. This policy must include forms used and individuals required to verify accuracy of documentation, including the Participant, CDO employee, Support Broker and Financial Managers roles and responsibilities. The Support Broker shall provide guidance and oversight for the timely process and accurate reporting for the purposes of protecting the Participant's right to receive prior authorized services according to their Plan of Care, Support Spending Plan and regulatory requirements.

Standard Operating Procedures

- A. The agency shall provide a copy of the written policy regarding documentation of CDO employee work hours and services or activities performed to the Participant at the time CDO services begin and a copy of the required documents.
- B. Participants will work out disputes regarding timesheets with their employees.
- C. Support Brokers shall ensure the Participant is following the written policy and take the following action for Resolution and Prevention when the disputes cannot be resolved between the Participant and their employee, or if processes and regulatory guidance is not followed.
- D. The provision of overtime is NOT allowed in CDO except in emergency situation. In these short-term emergency situations overtime should not exceed more than one (1) to two (2) week duration. Anything beyond two (2) weeks, either consecutively or sporadically, requires the development of a new plan of care and support spending plan or a corrective action. Continued usage of overtime beyond specific short instances may result in recoupment of monies paid to the Financial Management Agency and/or Support Brokerage Agency for inappropriate use of expended Medicaid funds. The FMA will follow Federal law requirements pertaining to payment for overtime in instances where overtime is approved; however, payment cannot exceed the traditional Medicaid waiver rate as outlined in the appropriate waiver regulation.

In most cases, Support Brokers will offer Participants assistance in rectifying a situation in which the Budget is over spent or mismanaged. A consumer's over spending or mismanaging of funds requires that the support broker develop a resolution, prevention and corrective action plan or make a

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recommendation of termination from CDO. If the situation cannot be rectified or persists, the support broker will discuss the needed action with their immediate supervisor.

If determined appropriate, the Support Broker or their immediate supervisor shall discuss with their agency director to need to recommend termination from CDO. The SBA should follow the language outlined in the appropriate waiver regulation and procedures outlined in the termination section of this CDO Standard Operating and Reimbursement Procedures Manual.

E. This policy may be reviewed and revised as necessary.

Statement of Policy and Purpose

Unless regulatory requirement necessitate immediate termination from CDO, the Participant shall be afforded the opportunity to develop a resolution and prevention plan with the guidance of the support broker following person centered planning principles prior to the support brokerage agency requesting termination.

Standard Operating Procedures

- A. When a situation arises that necessitates a resolution, prevention or corrective action plan, the support broker should do the following:
 - 1. Notify the traditional waiver provider of the “potential” termination and that a resolution and prevention plan is being developed;
 - 2. Work with the participant in developing a suitable resolution and prevention plan; and
 - 3. Allow at least thirty (30) calendar days but no more than ninety (90) calendar days for the participant (consumer) to resolve the issue; then
 - 4. If the issue(s) are unresolved after implementing a resolution, prevention or corrective action plan or if the consumer is unwilling to assign a designated representative the Support Broker will use a MAP-2000 for termination of CDO and follow the termination requirements outlined in the regulation and the CDO Standard Operating and Reimbursement Procedures Manual.

- B. Once action to terminate has been approved by Medicaid, the MAP-2000 is forwarded to the QIO and the traditional provider and the support broker will work with the traditional case manager to ensure a smooth transition.

- C. This policy may be reviewed and revised as necessary.

Statement of Policy and Purpose

The support broker and financial manager shall make every effort to assist the participant in all aspects of traditional and CDO waiver activities for the successful management of services, providers and employees; however, voluntary and involuntary termination from the CDO approach to service management may at times be necessary due to participant choice or there is a threat to the health, safety, or welfare of the participant. Prior to the recommendation of termination, every effort will be made to resolve an issue that may be impeding appropriate progress and service delivery.

Standard Operating Procedures

NOTE: The regulations outline the requirements and guidelines for initiating termination.

A. Participants, representatives, support brokers, the Department for Medicaid Services, or the Department for Aging and Independent Living may initiate termination from CDO at any time. Reasons for termination include, but are not limited to, the following:

1. Participant moved out of state.
2. Temporary or permanent long-term care facility admission.
3. Hospitalization for more than 30 days.
4. Loss of Medicaid eligibility.
5. Loss of waiver eligibility.
6. Representative not available.
7. Participant or Representative request.
8. Mismanagement of Budget.
9. Participant health or safety at imminent danger/risk.
10. Participant can no longer be served safely in the community.
11. The participant's (consumer's) plan of care indicates he/she requires more hours of service than the program can provide, which may jeopardize the consumer's safety and welfare due to being left alone without a caregiver present.
12. The participant (consumer), caregiver, family or guardian threaten or intimidate a support broker or other CDO staff.
13. Death of Participant.

Note: For termination procedure purposes; death of a participant would follow the voluntary termination process.

B. Involuntary Terminations

After following the language outlined in the appropriate waiver regulation; if a recommendation to **involuntary terminate** from CDO services is requested the procedures outlined below must be followed:

1. Support broker discusses request for termination with immediate supervisor and/or agency director and provides supporting documentation e.g., resolution and prevention plan, case

documentation); then A decision is made by the agency director on whether to pursue involuntary termination following regulatory requirements;

2. If determined appropriate to request termination from CDO, the agency director prepares a request letter that supports the termination and submits it to the DAIL Commissioner by faxing the letter, supporting documentation, MAP-2000 (Appendix I) and MAP-24 (Appendix F) to (502) 564-7572;
3. Once DAIL receives the termination request, a review of the supporting documentation will commence and if determined appropriate by DAIL Commissioner a recommendation memorandum will be forwarded to the DMS Commissioner recommending termination;
4. Medicaid will review recommendation from DAIL Commissioner and if approved, will forward termination letter to the consumer outlining the reason for termination and Medicaid will forward a copy of the termination letter to DAIL and the Support Brokerage Agency; then (as a courtesy)
5. DAIL will provide via the secured MOVEIT FTP site, a copy of the termination letter to the Support Brokerage Agency for appropriate action including the submission of the MAP-2000 (Appendix I) to the QIO and the traditional waiver provider. However,
6. If Medicaid denies recommendation to terminate, Medicaid will prepare a memorandum to the DAIL Commissioner outlining the reason for not approving termination; and
7. DAIL will notify the Support Brokerage Agency that CDO services will continue based on the language outlined on the Medicaid determination letter and/or the current CDO budget, plan of care, support spending plan and prior authorization.

C. Voluntary Terminations

In the event that termination is **voluntarily** requested by the consumer (participant), the support broker will have the consumer complete page two (2) of the MAP-2000 (Appendix I) by having the consumer initial and date the form. The support broker will forward the initialed and dated form to the QIO and traditional provider. The support broker shall coordinate with the traditional waiver provider to ensure a smooth transition from CDO to the appropriate Medicaid waiver program.

If the action to terminate the consumer from CDO totally discharges the individual from the waiver program (not just CDO), then the support broker will submit a completed MAP-24 (Appendix F) or MAP-24C (Appendix G) to Medicaid **via the QIO** and not directly to the DCBS office or the traditional provider. The QIO will review the form to ensure completed correctly and then update the Pro-Cert File appropriately to notify DCBS to take action.

D. This policy may be reviewed and revised as necessary.

Statement of Policy and Purpose

The right to a fair hearing is available to all Medicaid waiver Participants regardless if they choose the traditional waiver approach or the CDO options.

Standard Operating Procedures.

- B. Each participant receives written notification of their appeal and due process rights, "Notice of Right to an Administrative Hearing" when they enroll in a Medicaid waiver program including the Consumer Directed Option.
- C. The Support Brokerage Agency shall ensure each participant understand their rights to a fair hearing as described in 42 Code of Federal Regulation (CFR), Part 431, subpart E and the Kentucky Revised Statute (KRS) 13B.
- D. The support broker shall make available information on who to contact to request an appeal, but cannot act on behalf of the consumer as this would constitute a conflict of interest since the Support Brokerage Agency is a contracting agency working on behalf of the Department for Aging and Independent Living and the Department for Medicaid Services.
- E. Consumers will be provided by the Department for Medicaid Services a Notice to an Administrative Hearing.
- E. This policy shall be reviewed and revised as necessary.

Statement of Policy and Purpose

Case record documentation shall describe in detail all aspects of the coordination and delivery of CDO services. Unless otherwise stated, all Participant files must be maintained for a period of six (6) years from the date the individual was terminated from CDO or until all audits, questions, appeal hearings, investigations or court cases are resolved, whichever is longer.

Standard Operating Procedures

- A. The support broker shall document in the case record each contact made with a member (participant) or on behalf of the member, including the required monthly home visit. The information documented shall be relevant to the member's current situation, needs, or services provided. This documentation shall also include any issues or concern, including but not limited to the consumer's health, safety and welfare.
- B. Case notes should be structured as a chronological running record containing monthly contact and other relevant contacts.
- C. Case notes should document the discussion with the member concerning the participant's remaining budget balance and monthly expenditures.
- D. The minimum requirements for effective case notes should:
 - 1. Indicate date and length of time spent with consumer;
 - 2. Ensure notes are signed and credentialed;
 - 3. Ensure errors are corrected appropriately, by drawing a line through an error, initialing next to error, and date the error.
 - 4. Not contain white-out and write-over corrections.
 - 5. Be clearly written using black or blue ink or typed;
 - 6. Justify the needs of services for the member;
 - 7. Reflect progress towards goals and objectives listed on the Plan of Care;
- E. The following forms and documents must be maintained in the case record:
 - 1. MAP-351 (Appendix D), Assessment and reassessment document is completed annually and maintained by the Support Brokerage Agency in the member's record for consumer directed services. The support broker shall utilize the MAP-351 when completing the plan of care to ensure the most appropriate services are provided;
 - 2. MAP-350 (Appendix C), Freedom of Choice Document (choice of either institutional or waiver services) is completed annually and maintained in the member's record with the agency performing the level of care

assessment/reassessment and Support Brokerage Agency for the consumer directed option, and in the consumer's record with the case management agency and direct service providers.

3. MAP-2000 (Appendix I), Initiation/Termination of CDO is maintained in the member's record. A copy of the MAP-2000 shall be immediately faxed to the traditional provider at the time support broker services and CDO services begin;
 4. MAP-109 (Appendix E), Plan of Care and Support Spending Plan. The support brokerage agency shall utilize the MAP-109 when completing the plan of care and support spending plan. The MAP-109 shall be used in conjunction with the MAP-351;
 5. MAP-10 (Appendix B), statement of need for long-term care services is maintained in the member's record. The MAP-10 is also included in the packet submitted to the QIO to obtain prior authorization. A MAP-10 should be forwarded to the referring provider at minimum 4 weeks prior to the end of the current certification period. Included with the MAP-10 should be a memorandum from the support broker outlining what is being requested from the provider and the date that the MAP-10 is needed returned. Should the MAP-10 be sent using the U.S. Postal Service, a self-addressed stamped return envelope should be provided. The original MAP-10 signed by the appropriate provider must be filed in the case record;
 6. Prior authorization (PA) letter shall be obtained from the QIO prior to beginning CDO services and maintained in the member's record. A prior authorization shall not be requested from the QIO until an approved Medicaid budget has been received.
 7. Level of Care Certification shall be obtained from the QIO and maintained in the member's record.
 8. Timesheets and all optional forms shall be maintained by the Support Brokerage Agency in the member's record for consumer directed services.
- F. Member's files should be kept in a locked centralized location. The files or case records must be available upon request to the Department for Aging and Independent Living and the Department for Medicaid Services, and other federal or state entities as appropriate.
- G. The confidentiality of all Participant records, documents and transactions in accordance with federal and state laws and regulations shall be exercised

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and assured. All storage arrangements and transactions shall comply with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

- H. This policy may be reviewed and revised as necessary.

Statement of Policy and Purpose

It shall be the policy of the Area Agency on Aging; Area Development District; and Community Mental Health Centers to develop and follow a transition policy for participants served through one of the approved 1915c waiver programs for the purpose of coordinated care and uninterrupted services for the CDO participant.

Standard Operating Procedures:

- A. The AAAIL/ADD shall document evidence that supports a graduated transition has occurred for all CDO participants that include but are not limited to the following:
 - 1. Existing CDO Participants with an enrollment date up to June 30, 2008 shall be presented with a written summary describing their option to transition to a CMHC.
 - 2. New referrals on or after July 1, 2008 shall be provided CMHC contact information by the support brokerage agency. If client requests assistance the support broker will assist.

- B. The AAAIL/ADD shall document evidence that supports a coordinated transition has occurred for all CDO participants that include but are not limited to the following:
 - 1. The Support broker will provide a copy of the participant's file within three (3) business days of the participant's documented choice to transition to the CHMC, via U.S. Mail or direct delivery to the CMHC. The client's original file will be kept with the AAAIL/ADD.
 - 2. CMHC must complete the following documents:

MAP-2000 and the MAP 24C for SCL and ABI participant's in order to transition the participant from the AAAIL/ADD to the CMHC. All documents will be submitted within 24 hours to the QIO via fax at (800) 807-7840 and to the AAAIL/ADD.
 - 3. The AAAIL/ADD shall continue to provide services until the support broker of the CMHC confirms receipt of the prior authorization approving the CMHC to provide support brokerage service.

- C. The AAAIL/ADD shall document evidence that supports the transition from HCBW to MPW for all CDO participants that include but are not limited to the following:

1. The HCBW CDO Support Brokerage Agency is required to complete a discharging MAP-24 and send it to the QIO and MPW CDO Support Brokerage Agency.
 2. The MPW CDO Support Brokerage Agency is required to complete an admitting MAP-24 and a MAP-2000 showing CDO services have been chosen and send it to the QIO with the packet to obtain prior authorization of CDO services. Additionally, in order to show a coordinated transition, the MPW CDO Support Brokerage Agency is to forward a copy of the admitting MAP-24 along with the MAP-2000 (showing CDO services have been chosen under MPW) to the HCBW CDO Support Brokerage Agency.
- D. The transition process is complete.
- E. These procedures may be reviewed and revised as necessary.

Chapter 3:

Appendices Pertaining to:

- The Consumer Directed Option Standard Operating and Reimbursement Procedures Manual;
- County Contact Information for The DCBS Family Support/Protection and Permanency Offices; and
- The Department for Income Support, Child Support Offices

**Cabinet for Health and Family Services
 Department for Community Based Services
 Department for Income Support
 County Office Listing**

County	Family Support	Protection/Permanency	Child Support
ADAIR	270-384-2163	270-384-4731	270-384-5932
ALLEN	270-237-3661	270-237-3101	270-237-4450
ANDERSON	502-839-6933	502-839-5176	502-839-9872
BALLARD	270-335-5518	270-335-5173	270-335-3588
BARREN	270-651-5119	270-651-8396	270-651-2787
BATH	606-674-6344	606-674-6308	606-674-9624
BELL	606-337-7055	606-337-6171	606-337-3113
BOONE	859-525-6783	859-371-8832	859-586-9100
BOURBON	859-987-2455	859-987-4655	859-988-0586
BOYD	606-920-2013	606-920-2032	606-739-5826
BOYLE	859-239-7837	859-239-7105	859-238-1120
BRACKEN	606-735-2193	606-735-2195	606-845-3066
BREATHITT	606-666-2481	606-666-7506	606-666-5927
BRECKINRIDGE	270-756-2156	270-756-2194	270-756-2791
BULLITT	502-543-7081	502-955-6591	502-921-1155
BUTLER	270-526-3395	270-526-3833	270-526-6068
CALDWELL	270-365-3395	270-365-7275	270-365-6943
CALLOWAY	270-753-1871	270-753-5362	270759-4115
CAMPBELL	859-292-6700	859-292-6733	859-292-6632
CARLISLE	270-628-5442	270-628-3434	270-628-3407
CARROLL	502-732-4271	502-732-6681	859-732-7009
CARTER	606-474-5103	606-474-6627	606-286-8989
CASEY	606-787-8338	606-787-8369	606-787-2373
CHRISTIAN	270-889-6512	270-889-6503	270-886-5407
CLARK	859-737-7730	859-737-7771	859-744-1124
CLAY	606-598-2118	606-598-2027	606-598-8415
CLINTON	606-387-6446	606-387-6655	606-387-9752
CRITTENDEN	270-965-2254	270-965-5246	270-965-5476
CUMBERLAND	270-864-2556	270-864-3834	270-864-5819
DAVISS	270-687-7278	270-687-7491	270-685-8460
EDMONSON	270-597-2118	270-597-2163	270-597-9440
ELLIOTT	606-738-5193	606-738-5167	606-738-6046
ESTILL	606-723-5124	606-723-5146	606-723-4402
FAYETTE	859-246-2070	859-245-5414	859-254-4941
FLEMING	606-845-7561	606-845-2381	606-845-9151
FLOYD	606-889-1800	606-889-1724	606-886-7925
FRANKLIN	502-564-5390	502-564-5390	502-875-8745
FULTON	270-472-1638	270-472-1850	270-472-0100
GALLATIN	859-567-7281	859-567-7381	859-567-7281
GARRARD	859-792-2701	859-792-2186	859-792-1231

GRANT	859-824-5202	859-824-4471	859-824-0906
GRAVES	270-247-2862	270-247-4711	270-247-6323
GRAYSON	270-259-4041	270-259-3184	270-259-4200
GREEN	270-932-7484	270-932-7484	270-932-3044
GREENUP	606-473-7311	606-473-7366	606-473-1734
HANCOCK	270-927-8156	270-927-8142	270-927-8779
HARDIN	270-766-5029	270-766-5099	270-769-5380
HARLAN	606-573-2120	606-573-4620	606-573-9933
HARRISON	859-234-4151	859-234-3884	859-234-2433
HART	270-524-7211	270-524-7111	270-524-5992
HENDERSON	270-826-8351	270-826-6203	270-827-5753
HENRY	502-845-2110	502-845-2922	502-845-7655
HICKMAN	270-653-4338	270-653-4335	270-653-6335
HOPKINS	270-824-7555	270-824-7566	270-821-6666
JACKSON	606-287-7131	606-287-7114	606-287-5219
JEFFERSON	502-595-4238	502-595-4550	502-574-8300
JESSAMINE	859-885-3361	859-885-9451	859-881-5584
JOHNSON	606-788-7118	606-788-7100	606-789-3338
KENTON	859-292-6600	859-292-6340	859-491-4114
KNOTT	606-785-3137	606-785-3106	606-785-4866
KNOX	606-546-3121	606-546-5154	606-546-9516
LARUE	270-358-3176	270-258-4175	270-358-3963
LAUREL	606-330-2025	606-330-2001	606-878-7740
LAWRENCE	606-638-4526	606-638-4360	606-638-4426
LEE	606-464-2404	606-464-8801	606-464-9287
LESLIE	606-672-2306	606-672-2313	606-672-4452
LETCHER	606-633-9332	606-633-0191	606-633-9047
LEWIS	606-796-3037	606-796-2981	606-845-9151
LINCOLN	606-365-2171	606-365-3551	606-365-1619
LIVINGSTON	270-928-2101	270-928-2158	270-928-2531
LOGAN	270-726-9557	270-726-3516	270-726-2061
LYON	270-388-2206	270-388-2146	270-388-7301
MADISON	859-623-1310	859-986-8411	859-624-4718
MAGOFFIN	606-349-6131	606-349-3123	606-349-2032
MARION	270-692-6036	270-692-3135	270-692-6712
MARSHALL	270-527-1395	270-527-1354	270-527-4752
MARTIN	606-298-3577	606-298-7633	606-298-2817
MASON	606-564-6876	606-564-6818	606-564-3193
MCCRACKEN	270-575-7050	270-575-7110	270-444-7573
MCCREARY	606-376-5304	606-376-5365	606-376-5061
MCLEAN	270-273-3599	270-273-3599	270-273-5610
MEADE	270-422-3974	270-422-3942	270-422-3700
MENIFEE	606-768-2118	606-768-2154	606-768-3949
MERCER	859-734-7724	859-734-5448	859-734-6303
METCALFE	270-432-2521	270-432-2721	270-432-7116
MONROE	270-487-6798	270-487-6701	270-487-8403

MONTGOMERY	859-498-5398	859-498-6312	859-498-8718
MORGAN	606-743-3127	606-743-3158	606-743-1000
MUHLENBERG	270-338-2330	270-338-3072	270-338-5909
NELSON	502-348-9282	502-348-9048	502-349-1818
NICHOLAS	859-289-7101	859-289-7123	859-289-3745
OHIO	270-274-8201	270-274-8996	270-298-4458
OLDHAM	502-222-9191	502-222-9472	502-222-7342
OWEN	502-484-3458	502-484-3937	502-484-5070
OWSLEY	606-593-5133	606-593-5191	606-593-7300
PENDLETON	859-654-6123	859-654-3381	859-654-2838
PERRY	606-435-6043	606-435-6060	606-436-8865
PIKE	606-433-7760	606-433-7596	606-433-1822
POWELL	606-663-2293	606-663-2881	606-663-6424
PULASKI	606-677-4103	606-677-4086	606-678-0273
ROBERTSON	606-724-5414	606-724-5413	606-845-3066
ROCKCASTLE	606-256-2481	606-256-2138	606-256-5125
ROWAN	606-784-6602	606-784-4178	606-784-2225
RUSSELL	270-343-3196	270-343-3512	606-866-2555
SCOTT	502-863-1381	502-863-1381	502-867-3718
SHELBY	502-633-3530	502-633-1892	502-633-9569
SIMPSON	270-586-4433	270-586-8266	270-586-8079
SPENCER	502-477-2224	502-477-2224	502-477-6667
TAYLOR	270-465-6621	270-465-3549	270-789-4662
TODD	270-265-2596	270-265-2543	270-265-2912
TRIGG	270-522-6671	270-522-3451	270-522-3481
TRIMBLE	502-255-3278	502-255-3236	502-255-3332
UNION	270-389-1892	270-389-2314	270-389-0592
WARREN	270-746-7850	270-746-7447	270-781-3654
WASHINGTON	859-336-3977	859-366-3977	859-336-3901
WAYNE	606-348-3321	606-348-9361	606-340-8527
WEBSTER	270-639-5044	270-667-7043	270-639-0031
WHITLEY	606-528-5745	606-528-4234	606-528-4159
WOLFE	606-668-3175	606-668-3101	606-668-7021
WOODFORD	859-873-3191	859-873-8041	859-873-5001

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
WAIVER SERVICES
PHYSICIAN'S RECOMMENDATION

PLEASE RETURN TO THE REQUESTOR LISTED BELOW.

(Requestor's Name)

(Address)

(City) KY _____ (Zip) _____ (Phone)

PHYSICIAN'S RECOMMENDATION

I recommend Waiver services for:

(Member) _____ (Social Security #)

(Address)

(City) KY _____ (Zip) _____ (Phone)

DIAGNOSIS (ES): _____

Recommended Waiver Program:

- HCBW (ARNP, PA or Physician signature)
- ABI Waiver – Services to adults with acquired brain injury (21–65 yrs) with a potential for rehabilitation and retraining (Physician signature)
- SCL Waiver (SCL QMRP or Physician signature)
- Michelle P. Waiver – Non-residential Services to children and adults with mental retardation or developmental disabilities. (ARNP, QMRP, PA or Physician signature)

I certify that if Waiver services were not available, institutional placement in a Nursing Facility delete (NF) or Intermediate Care Facility for the Mentally Retarded/Developmentally Disabled shall be appropriate for this member in the near future.

(Authorized Signature) _____ (Date)

(Printed Name) _____ (UPIN#)

(Address)

(City) KY _____ (Zip) _____ (Phone)



Cabinet for Health and Family Services
Department for Medicaid Services
LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

Signature

Date

II. HOME AND COMMUNITY BASED (HCBS) WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, SUPPORTS FOR COMMUNITY LIVING (SCL) WAIVER, MICHELLE P (MP) WAIVER, MODEL II WAIVER, AQUIRED BRAIN INJURY (ABI) WAIVER, AQUIRED BRAIN INJURY LONG TERM CARE (ABI/LTC)WAIVER.

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS Waiver program as an alternative to NF placement is requested ; is not requested .

Signature

Date

B. SCL - This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation or developmental disabilities. Consideration for the SCL Waiver program as an alternative to ICF/MR/DD is requested ; is not requested .

Signature

Date

C. MP - This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation or developmental disabilities. Consideration for the MP Waiver program as an alternative to ICF/MR/DD or NF is requested ; is not requested .

Signature

Date

D. MODEL II - This is to certify that I/legal representative have been informed of the Model II Waiver program. Consideration for the Model II Waiver program as an alternative to ICF/MR/DD is requested ; is not requested .

Signature

Date

F. ABI - This is to certify that I/legal representative have been informed of the ABI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested ; is not requested .

Signature

Date



Cabinet for Health and Family Services
Department for Medicaid Services
LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

Signature

Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

Signature

Date

V. MEMBER INFORMATION

Name: _____ Medicaid Member ID #: _____

(Address)

(City) KY _____ (Zip) _____ (Phone)

Responsible Party/Legal Representative: _____

(Address)

(City) KY _____ (Zip) _____ (Phone)

Signature and Title of Person Assisting with Completion of Form:

Agency/Facility: _____

(Address)

(City) KY _____ (Zip) _____ (Phone)

SECTION I – MEMBER DEMOGRAPHICS		
Name (<i>last, first, middle</i>)	Date of birth (<i>mo., day, yr.</i>) / /	Medicaid Member ID #
Street address	County code	Sex (<i>check one</i>) <input type="checkbox"/> Male <input type="checkbox"/> Female
City, state and zip code	Emergency contact (<i>name</i>)	Marital status (<i>check one</i>) <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Member phone number () -	Emergency contact (<i>phone #</i>) () -	Member's height Member's weight
SECTION II – MEMBER WAIVER ELIGIBILITY		
Type of program applied for (<i>check one</i>) <input type="checkbox"/> Home and Community Based Waiver <input type="checkbox"/> Acquired Brain Injury Waiver <input type="checkbox"/> Supports for Community Living Waiver <input type="checkbox"/> Michelle P. Waiver <input type="checkbox"/> Consumer Directed Option <input type="checkbox"/> Blended	Adjudicated <input type="checkbox"/> / Nonadjudicated <input type="checkbox"/>	Type of application (<i>check one</i>) <input type="checkbox"/> Certification <input type="checkbox"/> Re-certification <input type="checkbox"/> Re-application
Member admitted from (<i>check one</i>) <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility <input type="checkbox"/> ICF/MR/DD <input type="checkbox"/> Other _____	Certification period (<i>enter dates below</i>) Begin date / / End date / / Certification number: _____	
Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form <input type="checkbox"/> Yes <input type="checkbox"/> No	Has member been informed of the process to make a complaint <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>see instructions</i>)	
Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number () -
Enter member's primary diagnosis: HCB (ICD-9 code); SCL (DSM code); ABI (ICD-9 and/or DSM)		
Enter all diagnoses including DSM or ICD-9 codes: AXIS I: (mental illness) AXIS II: (MR/DD) AXIS III: (Medical)	Is the member diagnosed with one of the following? <input type="checkbox"/> Mental Retardation/ IQ= (Date-of-onset / /) <input type="checkbox"/> Developmental Disability (Date-of-onset / /) <input type="checkbox"/> Mental Illness (Date-of-onset / /) <input type="checkbox"/> Brain Injury Cause of Brain Injury: Date of Brain Injury: / / Rancho Scale	
SECTION III – ASSESSMENT PROVIDER INFORMATION		
Assessment/Reassessment provider name:	Provider number	Provider phone number () -
Street address	City, state and zip code	
Provider contact person		

Name (<i>last, first</i>)	Medicaid Member ID #
SECTION IV SELF ASSESSMENT	
*For SCL, MP and ABI waivers only *add additional pages as needed	
Community Inclusion (what do you like to do or where would you like to go in the community, where do you go for recreation, do you not get to go somewhere that you would like to)	
Relationships (How do you stay in contact with your friends and family, do you need assistance in making or keeping friends, who are your friends)	
Rights (do you understand your rights, are any of your rights restricted, do you know what is abuse or neglect)	
Dignity and Respect (how are you treated by staff, do you have a place you can go to be with friends or to be alone or have privacy)	
Health (who are your doctors ,do you have any health concerns, what medicine do you take, how do they make you feel,)	
Lifestyle (do you have a job, do you want to work, do you want to go to school, do you go to the bank, do you have spending money to carry)	

Name (last, first)	Medicaid Member ID #
SECTION V – ACTIVITIES OF DAILY LIVING	
<p>1) Is member independent with dressing/undressing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires hands-on assistance with upper body</p> <p><input type="checkbox"/> Requires hands-on assistance with lower body</p> <p><input type="checkbox"/> Requires total assistance</p>	<p>Comments:</p>
<p>2) Is member independent with grooming</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p>Requires hands-on assistance with</p> <p><input type="checkbox"/> oral care <input type="checkbox"/> shaving</p> <p><input type="checkbox"/> nail care <input type="checkbox"/> hair</p> <p><input type="checkbox"/> Requires total assistance</p>	<p>Comments:</p>
<p>3) Is member independent with bed mobility</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Occasionally requires hands-on assistance</p> <p><input type="checkbox"/> Always requires hands-on assistance</p> <p><input type="checkbox"/> Bed-bound</p> <p><input type="checkbox"/> Required bedrails</p>	<p>Comments:</p>
<p>4) Is member independent with bathing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires hands-on assistance with upper body</p> <p><input type="checkbox"/> Requires hands-on assistance with lower body</p> <p><input type="checkbox"/> Requires Peri-Care</p> <p><input type="checkbox"/> Requires total assistance</p>	<p>Comments:</p>
<p>5) Is member independent with toileting</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Bladder incontinence</p> <p><input type="checkbox"/> Bowel incontinence</p> <p><input type="checkbox"/> Occasionally requires hands-on assistance</p> <p><input type="checkbox"/> Always requires hands-on assistance</p> <p><input type="checkbox"/> Requires total assistance</p> <p><input type="checkbox"/> Bowel and bladder regimen</p>	<p>Comments:</p>
<p>6) Is member independent with eating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires assistance cutting meat or arranging food</p> <p><input type="checkbox"/> Partial/occasional help</p> <p><input type="checkbox"/> Totally fed (by mouth)</p> <p><input type="checkbox"/> Tube feeding (type and tube location)</p>	<p>Comments:</p>

Name (<i>last, first</i>)	Medicaid Member ID #
<p>7) Is member independent with ambulation <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Dependent on device <input type="checkbox"/> Requires aid of one person <input type="checkbox"/> Requires aid of two people <input type="checkbox"/> History of falls (number of falls, and date of last fall)</p>	Comments:
<p>8) Is member independent with transferring <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Hands-on assistance of one person <input type="checkbox"/> Hands-on assistance of two people <input type="checkbox"/> Requires mechanical device <input type="checkbox"/> Bedfast</p>	Comments:
SECTION VI - INSTRUMENTAL ACTIVITIES OF DAILY LIVING	
<p>1) Is member able to prepare meals <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for meal preparation <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with meal preparation <input type="checkbox"/> Requires total meal preparation</p>	Comments:
<p>2) Is member able to shop independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for shopping to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with shopping <input type="checkbox"/> Unable to participate in shopping</p>	Comments:
<p>3) Is member able to perform light housekeeping <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for light housekeeping duties to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with light housekeeping <input type="checkbox"/> Unable to perform any light housekeeping</p>	Comments:
<p>4) Is member able to perform heavy housework <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for heavy housework to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with heavy housework <input type="checkbox"/> Unable to perform any heavy housework</p>	Comments:

Name (last, first)	Medicaid Member ID #
<p>5) Is member able to perform laundry tasks <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for laundry to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with laundry tasks <input type="checkbox"/> Unable to perform any laundry tasks</p>	<p>Comments:</p>
<p>6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of medication(s) and take them independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for medication to be obtained and taken correctly <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with obtaining and taking medication correctly <input type="checkbox"/> Unable to obtain medication and take correctly</p>	<p>Comments:</p>
<p>7) Is member able to handle finances independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for someone else to handle finances <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with handling finances <input type="checkbox"/> Unable to handle finances</p>	<p>Comments:</p>
<p>8) Is member able to use the telephone independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Requires adaptive device to use telephone <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance when using telephone <input type="checkbox"/> Unable to use telephone</p>	<p>Comments:</p>
SECTION VII-NEURO/EMOTIONAL/BEHAVIORAL	
<p>1) Does member exhibit behavior problems <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check below all that apply and explain the frequency in comments)</i> <input type="checkbox"/> Disruptive behavior <input type="checkbox"/> Agitated behavior <input type="checkbox"/> Assaultive behavior <input type="checkbox"/> Self-injurious behavior <input type="checkbox"/> Self-neglecting behavior</p>	<p>Comments: Date of functional analysis: / / and/or Date of behavior support plan: / /</p>

Name (<i>last, first</i>)	Medicaid Member ID #
<p>2) Is member oriented to person, place, time <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Unresponsive <input type="checkbox"/> Impaired Judgment</p>	<p>Comments:</p>
<p>3) Has member experienced a major change or crisis within the past twelve months <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i></p>	<p>Description:</p>
<p>4) Is the member actively participating in social and/or community activities <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i></p>	<p>Description:</p>
<p>5) Is the member experiencing any of the following <i>(For each checked, explain the frequency and details in the comments section)</i> <input type="checkbox"/> Difficulty recognizing others <input type="checkbox"/> Loneliness <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Anxiousness <input type="checkbox"/> Irritability <input type="checkbox"/> Lack of interest <input type="checkbox"/> Short-term memory loss <input type="checkbox"/> Long-term memory loss <input type="checkbox"/> Hopelessness <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Medication abuse <input type="checkbox"/> Substance abuse <input type="checkbox"/> Alcohol Abuse</p>	<p>Comments:</p>

Name (<i>last, first</i>)	Medicaid Member ID #:
<p>6) Cognitive functioning (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)</p> <p><input type="checkbox"/> Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</p> <p><input type="checkbox"/> Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.</p> <p><input type="checkbox"/> Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.</p> <p><input type="checkbox"/> Required considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.</p> <p><input type="checkbox"/> Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</p>	<p>Comments:</p>
<p>7) When Confused (Reported or Observed):</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> In new or complex situations only</p> <p><input type="checkbox"/> On awakening or at night only</p> <p><input type="checkbox"/> During the day and evening, but not constantly</p> <p><input type="checkbox"/> Constantly</p> <p><input type="checkbox"/> NA (non-responsive)</p>	<p>Comments:</p>
<p>8) When Anxious (Reported or Observed):</p> <p><input type="checkbox"/> None of the time</p> <p><input type="checkbox"/> Less often than daily</p> <p><input type="checkbox"/> Daily, but not constantly</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> NA (non-responsive)</p>	<p>Comments:</p>
<p>9) Depressive Feelings (Reported or Observed):</p> <p><input type="checkbox"/> Depressed mood (e.g., feeling sad, tearful)</p> <p><input type="checkbox"/> Sense of failure or self-reproach</p> <p><input type="checkbox"/> Hopelessness</p> <p><input type="checkbox"/> Recurrent thoughts of death</p> <p><input type="checkbox"/> Thoughts of suicide</p> <p><input type="checkbox"/> None of the above feelings reported or observed</p>	<p>Comments:</p>

Name (last, first)	Medicaid Member ID #:
10) Member Behaviors (Reported or Observed): <input type="checkbox"/> Indecisiveness, lack of concentration <input type="checkbox"/> Diminished interest in most activities <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Recent changes in appetite or weight <input type="checkbox"/> Agitation <input type="checkbox"/> Suicide attempt <input type="checkbox"/> None of the above behaviors observed or reported	Comments:
11) Behaviors Demonstrated at Least Once a Week: <input type="checkbox"/> Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24-hours, significant memory loss so that supervision is required. <input type="checkbox"/> Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions. <input type="checkbox"/> Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. <input type="checkbox"/> Physical aggression: aggressive or combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects). <input type="checkbox"/> Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions). <input type="checkbox"/> Delusional, hallucinatory, or paranoid behavior. <input type="checkbox"/> None of the above behaviors demonstrated.	Comments:
12) Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.: <input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> Once a month <input type="checkbox"/> Several times each month <input type="checkbox"/> Several times a week <input type="checkbox"/> At least daily	Comments:

Name (<i>last, first</i>)	Medicaid Member ID #:
<p>13) Mental Status:</p> <p><input type="checkbox"/> Oriented</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Disoriented</p> <p><input type="checkbox"/> Lethargic</p> <p><input type="checkbox"/> Agitated</p> <p><input type="checkbox"/> Other</p>	<p>Comments:</p>
<p>14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Comments:</p>
SECTION VIII-CLINICAL INFORMATION	
<p>1) Is member's vision adequate (<i>with or without glasses</i>)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined</p> <p>(<i>If no, check below all that apply and comment</i>)</p> <p><input type="checkbox"/> Difficulty seeing print</p> <p><input type="checkbox"/> Difficulty seeing objects</p> <p><input type="checkbox"/> No useful vision</p>	<p>Comments:</p>
<p>2) Is member's hearing adequate (<i>with or without hearing aid</i>)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined</p> <p>(<i>If no, check below all that apply, and comment</i>)</p> <p><input type="checkbox"/> Difficulty with conversation level</p> <p><input type="checkbox"/> Only hears loud sounds</p> <p><input type="checkbox"/> No useful hearing</p>	<p>Comments:</p>
<p>3) Is member able to communicate needs</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>)</p> <p><input type="checkbox"/> Speaks with difficulty but can be understood</p> <p><input type="checkbox"/> Uses sign language and/or gestures/communication device</p> <p><input type="checkbox"/> Inappropriate context</p> <p><input type="checkbox"/> Unable to communicate</p>	<p>Comments:</p>
<p>4) Does member maintain an adequate diet</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check all that apply and comment</i>)</p> <p><input type="checkbox"/> Uses dietary supplements</p> <p><input type="checkbox"/> Requires special diet (low salt, low fat, etc.)</p> <p><input type="checkbox"/> Refuses to eat</p> <p><input type="checkbox"/> Forgets to eat</p> <p><input type="checkbox"/> Tube feeding required (<i>Explain the brand, amount, and frequency in the comments section</i>)</p> <p><input type="checkbox"/> Other dietary considerations (<i>PICA, Prader-Willie, etc.</i>)</p>	<p>Comments:</p>

Name (<i>last, first</i>)	Medicaid Member ID #:
<p>5) Does member require respiratory care and/or equipment <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>) <input type="checkbox"/> Oxygen therapy (Liters per minute and delivery device) <input type="checkbox"/> Nebulizer (Breathing treatments) <input type="checkbox"/> Management of respiratory infection <input type="checkbox"/> Nasopharyngeal airway <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Aspiration precautions <input type="checkbox"/> Suctioning <input type="checkbox"/> Pulse oximetry <input type="checkbox"/> Ventilator (list settings)</p>	<p>Comments:</p>
<p>6) Does member have history of a stroke(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>) <input type="checkbox"/> Residual physical injury(ies) <input type="checkbox"/> Swallowing impairments <input type="checkbox"/> Functional limitations (Number of limbs affected)</p>	<p>Comments:</p>
<p>7) Does member's skin require additional, specialized care <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> Requires additional ointments/lotions <input type="checkbox"/> Requires simple dressing changes (i.e. band-aids, occlusive dressings) <input type="checkbox"/> Requires complex dressing changes (i.e. sterile dressing) <input type="checkbox"/> Wounds requiring "packing" and/or measurements <input type="checkbox"/> Contagious skin infections <input type="checkbox"/> Ostomy care</p>	<p>Comments:</p>
<p>8) Does member require routine lab work <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, what type and how often</i>)</p>	<p>Comments:</p>
<p>9) Does member require specialized genital and/or urinary care <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> Management of reoccurring urinary tract infection <input type="checkbox"/> In-dwelling catheter <input type="checkbox"/> Bladder irrigation <input type="checkbox"/> In and out catheterization</p>	<p>Comments:</p>
<p>10) Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, explain in the comments section</i>)</p>	<p>Comments:</p>
<p>11) Does member have total or partial paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, list limbs affected and comment</i>)</p>	<p>Comments:</p>

Name (<i>last, first</i>)	Medicaid Member ID #:
<p>18) Is any of the following adaptive equipment required (<i>If needs, explain in the comments</i>)</p> <p>Dentures <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Hearing aid <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Glasses/lenses <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Hospital bed <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Bedpan <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Elevated toilet seat <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Bedside commode <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Prosthesis <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Ambulation aid <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Tub seat <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Lift chair <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Wheelchair <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Brace <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Hoyer lift <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p>	<p>Comments:</p>
<p>19) Please describe in detail any information regarding health, safety and welfare/crisis issues:</p>	

Name (<i>last, first</i>)	Medicaid Member ID #:
SECTION IX-ENVIRONMENT INFORMATION	
<p>1) Answer the following items relating to the member's physical environment (<i>Comment if necessary</i>)</p> <p>Sound dwelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate furnishings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Indoor plumbing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Running water <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hot water <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate heating/cooling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tub/shower <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stove <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Refrigerator <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Microwave <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Telephone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>TV/radio <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Washer/dryer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate lighting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate locks <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate fire escape <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Smoke alarms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insect/rodent free <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Safe environment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Trash management <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Comments:</p>
<p>2) Provide an inventory of home adaptations <u>already present</u> in the member's dwelling. (<i>Such as wheelchair ramp, tub rails, etc.</i>)</p>	
SECTION X – HOUSEHOLD INFORMATION	
<p>1) Does the member live alone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, does the member receive any assistance from others <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Explain</i>)</p>	<p>Comments:</p>

Name (last, first)		Medicaid Member ID #:	
2) Household Members (Fill in household member info below)			
a) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
SECTION XI-ADDITIONAL SERVICES			
1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list below)			
a-Facility name		Facility address	
Reason for admission	Admission date / /		Discharge date / /
b-Facility name		Facility address	
Reason for admission	Admission date / /		Discharge date / /

Name (last, first)		Medicaid Number	
2) Does the member receive services from other agencies (Example: Both Waiver and Non-waiver Services.) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care and traditional Home health services covered by Medicare/Third party insurance)</i>			
a-Service(s) received	Agency/worker name	Phone number () -	
Agency address	Frequency	Number of units	
b-Service(s) received	Agency/worker name	Phone number () -	
Agency address	Frequency	Number of units	
c-Service(s) received	Agency/worker name	Phone number () -	
Agency address	Frequency	Number of units	
SECTION XII-CONSUMER DIRECTED OPTION			
Has the member been provided information on Consumer Directed Option (CDO) and their right to choose CDO, traditional or blended services? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give reason:			
Has the member chosen Consumer Direction Option? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include form MAP 2000			
SECTION XIII-SIGNATURES			
Person(s) performing assessment or reassessment:			
Signature:	Title:	Date / /	
Signature:	Title:	Date / /	
Verbal Level of Care Confirmation:			
Date: / /	Time: am/pm		
Assessment/Reassessment forwarded to Support Broker/Case Management provider:			
Date Forwarded: / /	Time Forwarded: am/pm		
Name of Person Forwarding:	Title of Person Forwarding:		
Receipt of assessment/reassessment by Support Broker/case management provider:			
Date Received: / /	Time Received: am/pm		
Name of Person Logging Receipt:	Title of Person Logging Receipt:		
QIO Signature:			
Level of Care Date / /	Approval dates From: / / To: / /		

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ Medicaid Member ID#: _____

Identification of Needs/Outcomes/Services/Providers

NEED(S)	OUTCOMES/GOAL(S)	OBJECTIVES/INTERVENTION(S)	SERVICE CODE	PROVIDER NAME/#

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ Medicaid Member ID#: _____ Date Services Start: _____

Support Spending Plan

Traditional Waiver Services

Service Code A	Provider Name and Number B	Units per Week C	Units per Month D	Cost per Unit E	Cost per Week (Column CxE) F	Total Cost Monthly (4.6xColumn F) G
						Total Cost per Month \$

Consumer Directed Services

Service Code A	Description of Service B	Employee Providing the Service C	Units per week D	Units per Month (Column D x 4.6) E	Hourly Wage F	Number of Hours per Month G	Sum of Wages Times Hours H	Administrative Costs I	Total Monthly Amount J
									Total Cost Per Month \$

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ Medicaid Member ID #: _____

Emergency Back-up Plan (CDO only)

I certify the information contained above is accurate and that I have made an informed choice when selecting the providers/employees to provide each service.

Member/Guardian Signature

Date

Case Manager/Support Broker Signature

Date

Representative Signature (CDO)

Date

Plan of Care/Support Spending Plan **Approved** **Denied**

QIO Signature/Title

Date

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

MEMORANDUM

TO: _____ County Office
(Department for Community Based Services)

FROM: _____
(Facility/Waiver Agency) (Provider Number)

DATE: _____

SUBJECT: _____
(Recipient Name) (Social Security Number)

(Previous Address)

(City) (State) (ZIP)

(Responsible Relatives Name)

(Street Address)

(City) (State) (ZIP)

This is to notify you that the above referenced recipient:

was admitted to this facility/waiver agency on _____ is in Title _____
(Date) (XVIII or XIX)

Placement Status, and was placed in a:

- | | |
|--|---|
| <input type="checkbox"/> NF Bed | <input type="checkbox"/> Home and Community Based Services (HCBS) |
| <input type="checkbox"/> ICF/MR/DD Bed | <input type="checkbox"/> Supports for Community Living (SCL) Services |
| <input type="checkbox"/> MH Bed | <input type="checkbox"/> Michelle P. Waiver Services |
| <input type="checkbox"/> ESPDT Bed | |

was discharged from this facility/waiver on _____ and went to _____
(Date) (Name of Facility)

(Home Address or Name and Address of New Facility/Waiver Agency)

(City) (State) (ZIP)

and or expired on _____
(Date)

was reinstated to HCBS, SCL, Michelle P. waiver services within 60 days of the Nursing Facility admission _____
(Date re-instated)

For HCB and Michelle P. waiver clients only – Last date service was provided _____
(Date)

(Signature)

Map – 24C
(Rev.
07/2008)

**Cabinet for Health and Family Services
Department for Medicaid Services**

Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program

TO: (1) _____ County Office
 Department for Community Based Services

(2) Quality Improvement Organization (QIO)

(3) Department for Mental Health, Developmental Disabilities and Addiction
 Services for SCL Waiver **or** Department for Medicaid Services/Acquired Brain
 Injury Branch for ABI Waiver

FROM: (4) _____
 Case Management Agency/Support Broker

DATE: (5) _____

(A) MEDICAID WAIVER PROGRAM

(Check program)

ABI SCL MP

(Check type of action)

<input type="checkbox"/> Admission	<input type="checkbox"/> Discharge
<input type="checkbox"/> Temporary Discharge	<input type="checkbox"/> Readmit from Temporary Discharge
<input type="checkbox"/> Change in Case Management Company	<input type="checkbox"/> Change in Primary provider
<input type="checkbox"/> Change of client address	<input type="checkbox"/> Facility / Hospital Admission/Discharge

Date of above action: _____

(B) CLIENT INFORMATION:

 (Last Name) (First Name) (MI) (Social Security Number)

 (Address)

 (City) KY (Zip) (Phone number)

(C) CASE MANAGEMENT AGENCY/SUPPORT BROKER INFORMATION

 (Name) (Provider #)

 (Address)

 (City) KY (Zip) (Phone number)



Map – 24C
(Rev.
07/2008)

**Cabinet for Health and Family Services
Department for Medicaid Services
Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program**

Re: CLIENT NAME: _____ SS#: _____

(D) PRIMARY PROVIDER INFORMATION

(1) Primary Provider

_____		_____	
(Provider Name)		(Provider #)	

(Address)			
_____	KY	_____	_____
(City)	(Zip)	(Phone)	

Monthly Cost: _____

(E) FACILITY/HOSPITAL INFORMATION

Admission Date: _____ Discharge Date: _____

(1) Facility/Hospital Name: _____

(Address)			
_____	KY	_____	_____
(City)	(Zip)	(Phone)	

(2) Reason for Admission

(3) Discharge Outcome

(F) WAIVER PROGRAM DISCHARGE

Voluntary: Involuntary:

(1) Reason for Program Discharge

****IF DISCHARGE IS VOLUNTARY, SUBMISSION OF DOCUMENTATION SIGNED BY THE GUARDIAN/LEGAL REPRESENTATIVE IS REQUIRED CONFIRMING INTENT TO DISCONTINUE SERVICES.**

APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES

Read attached instruction sheet before completing this application

Section 1

Sex: M or F

Name _____
First Middle Last

Social Security Number _____ Medical Assistance Number _____

Date of Birth: _____ Phone #: (____) _____
month day year

Present Address _____

Street

City

County

State

Zip Code

Section 2

Legal Representative/Guardian _____

Address _____

City

County

State

Zip Code

Phone _____ Relationship to Applicant _____
(Ex: mother, father, friend)

Legal Rep./Guardian's Signature _____ Date _____

Section 3

Case Management Provider Name
and Address

Name _____

Address _____

City

County

State

Zip Code

Phone Number

Section 4

No assistance in some self-help, daily living areas, and **Minimal assistance** for many skills, and **Complete assistance (caregiver completes all parts of task)** needed in **some** basic skills and all **complex** skills.

Partial (use of hands on guidance for part of task) to complete assistance needed in **most** areas of self-help, daily living, and decision making, and Cannot complete **complex** skills.

Partial to complete assistance is needed in **all areas** of self-help, daily living, decision making, and complex skills

Extreme Need: All tasks must be done for the individual, with no participation from the individual

10. HOW OFTEN ARE DOCTOR VISITS NEEDED?

- For routine health care only / once per year
- 2-4 times per year for consultation or treatment for chronic health care need
- More than 4 times per year for consultation or treatment
- Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

COMMENTS: _____

11. HOW OFTEN ARE NURSING SERVICES NEEDED?

- Not at all
- For routine health care only
- 1-3 times per month
- Weekly
- Daily
- Extreme Need:** Several times daily or continuous availability

COMMENTS: _____

12. ARE THERE BEHAVIORAL PROBLEMS? Yes No

IF YES-PLEASE CHECK ALL THAT APPLY.

- Self Injury
- Aggressive towards others
- Inappropriate sexual behavior
- Property destruction
- Life threatening (threat of death or severe injury to self or others)
- Takes prescribed medications for behavior control

PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED.

13. WHERE IS THE INDIVIDUAL CURRENTLY LIVING?

- | | | |
|--|--|---|
| <input type="checkbox"/> Living with family/relative | <input type="checkbox"/> Living in own home or apartment | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Group home or personal care home | <input type="checkbox"/> Nursing home | <input type="checkbox"/> Psychiatric Facility |
| <input type="checkbox"/> ICF/MR (Intermediate Care Facility) | <input type="checkbox"/> Living with a friend | <input type="checkbox"/> Other _____ |

14. DOES THE INDIVIDUAL CURRENTLY RECEIVE ANY OF THE FOLLOWING SERVICES? (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Supported Living | <input type="checkbox"/> Medicaid EPSDT (if under 21) |
| <input type="checkbox"/> Medicaid Acquired Brain Injury | <input type="checkbox"/> Medicaid Home & Community Based Waiver |
| <input type="checkbox"/> Supported Employment | <input type="checkbox"/> Mental Health Counseling or Medication for a mental health condition |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> In home Support |
| <input type="checkbox"/> Other Medicaid Services | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Day Program | <input type="checkbox"/> Respite |
| <input type="checkbox"/> School | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Behavior Support | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Speech Therapy | |
| <input type="checkbox"/> Physical Therapy | |

15. WHAT SERVICES ARE NEEDED NOW OR IN THE FUTURE?

- | | |
|---|---|
| <input type="checkbox"/> Day Program | <input type="checkbox"/> In home Support |
| <input type="checkbox"/> School | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Supported Employment |

16. THE FOLLOWING ARE 5 CHOICES FOR FUTURE LIVING ARRANGEMENTS. WHERE WOULD THE APPLICANT PREFER TO LIVE IN THE FUTURE? CHOOSE ONLY ONE (1):

- At home with a family member with someone to come in and help
 In the person's own home with minimal supports
 In a 24 hour staffed residence in the community
 In a 24 hour supervised family home in the community
 In a 24 hour staffed group home in the community
 In an ICF/MR

17. WHO IS THE PRIMARY CAREGIVER? (If staff, do not answer questions 18 & 19.)

- Mother Father Grandmother Grandfather Aunt Uncle Staff
 Sister Brother Friend Neighbor Other: Who? _____

18. WHAT IS THE AGE OF THE PRIMARY CAREGIVER?

- Less than 30 years old 31-50 years old 51-60 years old 61-70 years old
 71-80 years old Over 80 years old

19. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:

- Poor Stable Good Very Good



Comments: _____

Person Completing Application: _____

Print Name

Relationship to Individual (if not individual)

Phone Number

Signature

Date

Additional Comments: _____

Mail to:
The Division of Mental Retardation
100 Fair Oaks Lane, 4W-C
Frankfort, Kentucky 40621



INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

- SCL**
- MP**
- HCB**
- ABI**

Member Name: _____ Medicaid Member ID #: _____

Case Manager/Support Broker: _____
(Name) (Phone)

Provider Number: _____

Addition of CDO Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my Plan of Care (POC)/Support Spending Plan (SSP) if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO.
- Bring whomever I want to all meetings pertaining to the CDO.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a POC/SSP to meet my needs within the Consumer Directed Options (CDO) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO program, and follow all tax and labor laws,
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO.

*For addition of CDO services, attach revised MAP 109 Plan of Care.

Date traditional case management ends and Support Broker begins ____/____/____

Date traditional services end and CDO services begin: ____/____/____



INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

Member Name: _____ Medicaid Member ID #: _____

Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO) Program.

(Address)

_____ **KY** _____
(City) (Zip) (Phone)

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO service, attach revised MAP 109-Plan of Care.

Voluntary Termination of CDO Services Date: _____ Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

Involuntary Termination of CDO Services
(To be completed by the Support Broker)

Reason for termination of CDO:

- Health and Safety Concerns
- Exceeding Individual Budget
- Inappropriate Utilization of Funds
- Other (Describe)

Traditional Provider Agency _____
Traditional Provider Number _____

Consumer/Guardian Signature

Date

Representative Signature

Date

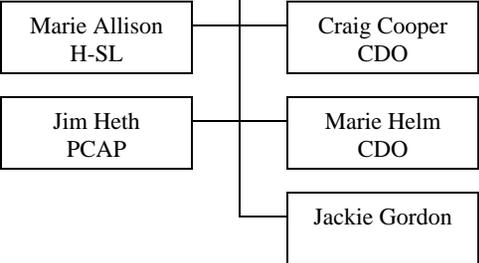
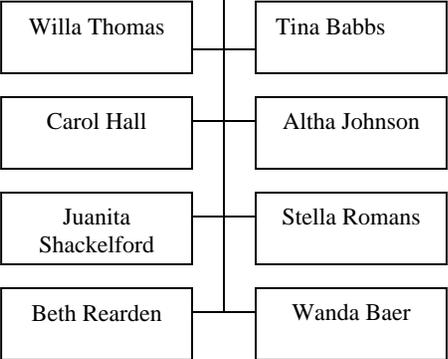
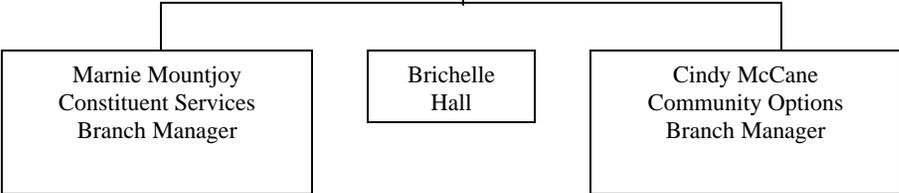
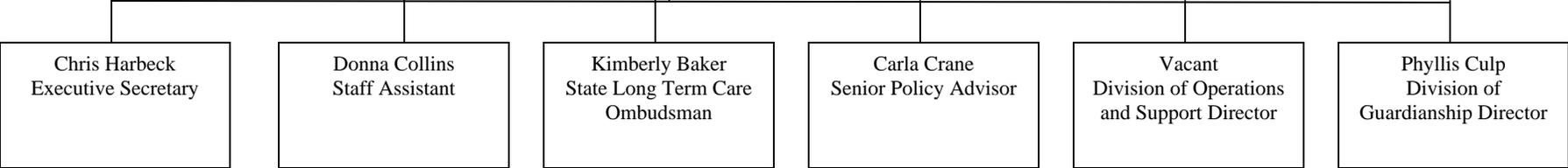
Case Manager/Support Broker Signature

Date

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Aging and Independent Living

Deborah S. Anderson
Commissioner

Bill Cooper
Deputy Commissioner



**Kentucky's Department for Aging and Independent Living's
Adaptation of Quality of Life Changes***

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(CDO/PRE – Caregiver or Participant)

Rev. 11/01/08

Regional ID

--	--

Participant ID

--	--	--	--

Interviewer ID

--	--	--

Date

M	M	D	D	Y	Y

Developed/adapted for Kentucky's Department for Aging and Independent Living

275 East Main Street, 2W-F

Frankfort, Kentucky 40621

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Adaptation of Quality of Life Changes*

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Consumer characteristics:

- a. Age _____ Years _____ Months
- b. Sex _____ 0 Male _____ 1 Female

Caregiver characteristics:

- c. Age _____ Years _____ Months
- d. Sex _____ 0 Male _____ 1 Female

Waiver:

- a. ABI _____
- b. HCB _____
- c. SCL _____
- d. Michele P. _____

If the caregiver plans to answer all the questions on behalf of the participant, please ask all the questions of the caregiver in Section I. **If the participant plans to answer the questions himself/herself, please skip Section I.**

In Section II ask the waiver participant or the caregiver on behalf of the participant to rate the qualities of his/her life at the point of time you are asking the question. For persons participating in the survey, this means trying to remember what life was like in the previous 3 months not just the current day. Specifically, the question should be asked in two consecutive formats. For example, for question #1, "Would you say your health is good or bad?" (In between is implied if the person says "neither" or "OK" or any other similar response; however, answers like that have to be checked by probing with "So, it's in between, not really good or bad?")

Each "good" or "bad" response received in Section I is then further defined with "Either-Or" questions. For example, if the response on the first item is "Good", the "Either-Or" clarification is, "Would you say your health is either "Good" or "Very Good"? (In between is implied, if the person says "Neither" or "OK" or "Neither" or any similar response; however, answers like that have to be checked by probing with "Oh, so it's in between, not really good or bad?")

SCRIPT: There will be multiple response options for the first three questions. After each question, I will summarize all of the possible answers and will ask you to choose only one.

Section I.

1. In your experience as a caregiver, what would you say is the one most positive aspect of caregiving?
[READ LIST. CHECK ONLY ONE.] Would you say that the one most positive aspect is ...

- Helping your care recipient, 1
- Helping your other family members, 2
- Feeling a sense of accomplishment, 3
- Caring for someone who cared for you, 4
- Being appreciated, or 5
- Providing companionship for you?..... 6
- OTHER (SPECIFY: _____)..... 7
- NONE..... 8
- REFUSED..... -7
- DON'T KNOW..... -8

2. Which of these difficulties is the greatest difficulty you have faced in your caregiving?
[READ LIST. CHECK ONLY ONE.] Would you say caregiving's greatest difficulty is that it...

- Creates a financial burden, 1
- Doesn't leave enough time for yourself, 2
- Doesn't leave enough time for your family, 3
- Interferes with your work, 4
- Creates or aggravates health problems, 5
- Affects your family relationships, or..... 6
- Creates stress? 7
- OTHER (SPECIFY: _____)..... 8
- REFUSED..... -7
- DON'T KNOW..... -8

3. What is your relationship to [CONSUMER'S NAME]? Are you his or her...

- Husband 1
 Wife 2
 Son 3
 Son-in-Law 4
 Daughter 5
 Daughter-in-Law 6
 Father 7
 Mother 8
 Brother 9
 Sister 10
 Granddaughter 11
 Grandson 12
 Niece 13
 Nephew 14
 Other relative [Not a relative mentioned above]
 (SPECIFY: _____) 15
 Friend or Neighbor or Another Person 16
 REFUSED - 7
 DON'T KNOW - 8

SCRIPT: The next and final section includes a total of ten (10) questions. Please feel free to ask me to repeat any question or answer category so that the question is fully understood.

Section II.

1. Would you say your health is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

2. Would you say your ability of running your own life and making your own choices is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

3. Would you say your family relationships are good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

4. Would you say your relationships with friends are good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

5. Would you say your ability of getting out and getting around is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

6. Would you say your overall quality of life is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

7. Would you say the quality of the services you receive is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

8. Would you say the respect you receive from employees or service providers is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

9. Do you have any unmet needs you would like to share?

Yes	No	Sometimes	Unsure/No Answer

Detail:

10. Are there any other concerns or experiences you would like to share with us?

Yes	No	Sometimes	Unsure/No Answer

Detail:

**Kentucky's Department for Aging and Independent Living's
Adaptation of Quality of Life Changes***

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(CDO/FOLLOW UP – Caregiver or Participant)

Rev. 11/01/08

Regional ID

--	--

Participant ID

--	--	--	--

Interviewer ID

--	--	--

Date

M	M	D	D	Y	Y

**Developed/adapted for Kentucky's Department for Aging and Independent Living
275 East Main Street, 2W-F
Frankfort, Kentucky 40621
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Adaptation of Quality of Life Changes*

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Consumer characteristics:

- a. Age _____ Years _____ Months
- b. Sex _____ 0 Male _____ 1 Female

Caregiver characteristics:

- c. Age _____ Years _____ Months
- d. Sex _____ 0 Male _____ 1 Female

Waiver:

- a. ABI _____
- b. HCB _____
- c. SCL _____
- d. Michele P. _____

If the caregiver plans to answer all the questions on behalf of the participant, please ask all the questions of the caregiver in Section I. **If the participant plans to answer the questions himself/herself, please skip Section I.**

In Section II ask the waiver participant or the caregiver on behalf of the participant to rate the qualities of his/her life at the point of time you are asking the question. For persons participating in the survey, this means trying to remember what life was like in the previous 3 months not just the current day. Specifically, the question should be asked in two consecutive formats. For example, for question #1, "Would you say your health is good or bad?" (In between is implied if the person says "neither" or "OK" or any other similar response; however, answers like that have to be checked by probing with "So, it's in between, not really good or bad?")

Each "good" or "bad" response received in Section I is then further defined with "Either-Or" questions. For example, if the response on the first item is "Good", the "Either-Or" clarification is, "Would you say your health is either "Good" or "Very Good"? (In between is implied, if the person says "Neither" or "OK" or "Neither" or any similar response; however, answers like that have to be checked by probing with "Oh, so it's in between, not really good or bad?")

SCRIPT: There will be multiple response options for the first three questions. After each question, I will summarize all of the possible answers and will ask you to choose only one.

Section I.

1. In your experience as a caregiver, what would you say is the one most positive aspect of caregiving?

[READ LIST. CHECK ONLY ONE.] Would you say that the one most positive aspect is ...

- Helping your care recipient, 1
- Helping your other family members, 2
- Feeling a sense of accomplishment, 3
- Caring for someone who cared for you, 4
- Being appreciated, or 5
- Providing companionship for you?..... 6
- OTHER (SPECIFY: _____)..... 7
- NONE..... 8
- REFUSED..... -7
- DON'T KNOW..... -8

2. Which of these difficulties is the greatest difficulty you have faced in your caregiving?

[READ LIST. CHECK ONLY ONE.] Would you say caregiving's greatest difficulty is that it...

- Creates a financial burden, 1
- Doesn't leave enough time for yourself, 2
- Doesn't leave enough time for your family, 3
- Interferes with your work, 4
- Creates or aggravates health problems, 5
- Affects your family relationships, or..... 6
- Creates stress? 7
- OTHER (SPECIFY: _____)..... 8
- REFUSED..... -7
- DON'T KNOW..... -8

3. What is your relationship to [CONSUMER'S NAME]? Are you his or her...

- Husband 1
 Wife 2
 Son 3
 Son-in-Law 4
 Daughter 5
 Daughter-in-Law 6
 Father 7
 Mother 8
 Brother 9
 Sister 10
 Granddaughter 11
 Grandson 12
 Niece 13
 Nephew 14
 Other relative [Not a relative mentioned above]
 (SPECIFY: _____) 15
 Friend or Neighbor or Another Person 16
 REFUSED - 7
 DON'T KNOW - 8

SCRIPT: The next section includes a total of ten (10) questions. Please feel free to ask me to repeat any question or answer category so that the question is fully understood.

Section II.

1. Would you say your health is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

2. Would you say your ability of running your own life and making your own choices is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

3. Would you say your family relationships are good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

4. Would you say your relationships with friends are good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

5. Would you say your ability of getting out and getting around is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

6. Would you say your overall quality of life is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

7. Would you say the quality of the services you receive is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

8. Would you say the respect you receive from employees or service providers is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

9. Do you have any unmet needs you would like to share?

Yes	No	Sometimes	Unsure/No Answer

Detail:

10. Are there any other concerns or experiences you would like to share with us?

Yes	No	Sometimes	Unsure/No Answer

Detail:

SCRIPT: The next and final section includes a total of nine (9) questions specifically related to Consumer Directed Options. Please feel free to ask me to repeat any question or answer category so that the question is fully understood.

Section III.

11. Would you say your satisfaction with consumer directed services is good or bad?

Very Bad (1)	Bad (2)	OK (3)	Good (4)	Very Good (5)

Detail:

12. Since you have been receiving consumer directed services, has your paid caregiver always arrived at your home when he or she was scheduled to arrive?

Yes	No	Sometimes	Unsure/No Answer

Detail:

13. Since you have been receiving consumer directed services, has your paid caregiver always completed the tasks that were stated on his or her timesheet?

Yes	No	Sometimes	Unsure/No Answer

Detail:

14. Since you have been receiving consumer directed services, have you been satisfied with your paid caregiver's schedule?

Yes	No	Sometimes	Unsure/No Answer

Detail:

15. Have the consumer directed services that you are receiving NOW made a positive difference in your life?

Yes	No	Sometimes	Unsure/No Answer

Detail:

16. Are your employees or service providers getting paid on time?

Yes	No	Sometimes	Unsure/No Answer

Detail:

17. Would you recommend this program to a friend?

Yes	No	Sometimes	Unsure/No Answer

Detail:

18. Do you have any unmet needs you would like to share?

Yes	No	Sometimes	Unsure/No Answer

Detail:

19. Are there any other concerns or experiences you would like to share with us?

Yes	No	Sometimes	Unsure/No Answer

Detail:



Consumer Directed Option (CDO) Exception Request

Completed by Support Broker:

Documentation/Information Must Be Typed

I. Member's Demographic Information:

Member's Name (Last, First, MI): ____

Member's MAID Number (10 Digits): ____ Age: ____

Member's DOB: ____ Telephone Number: (____) ____

C. Member Receives:

- HCB Waiver
- SCL Waiver
- ABI Waiver
- MP Waiver

A. New Medicaid Member Existing Medicaid Member

B. New CDO Participant (Never received a waiver service before)

Current/Previous 'Traditional Waiver' Participant Choosing CDO

D. LOC Dates:

____ To ____

II. Support Brokerage Agency Information:

AAA or CMHC Name: ____

AAA or CMHC Provider Number: ____

Support Broker Name: ____

Support Broker Telephone Number: (____) ____ Extension: ____

III. CDO Exception Request Information:

Request Date: ____

Date CDO Enrollment Began: ____

Original Gross ANNUAL Budget: \$____ (Total Amount Only)

SB Requested Budget:	
ONE MONTH:	\$ ____
ANNUAL:	\$ ____

Provide copy of the DMS approved budget with exception request

<u>For DAIL Commissioner Only:</u>	
DAIL Commissioner's Recommendation:	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Modified	
Comment:	

<input type="checkbox"/> Denied for Failure to Provide Reviewer's Requested Information/Documentation within 10 Calendar Days.	
Signature: _____	Date: _____

<u>For DMS Commissioner Only:</u>	
Exception Request:	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Modified	
Comment:	

Signature: _____	Date: _____

Appendix M

IV. Exception Consideration Policy:

Do not submit an exception request for budgets on existing waiver participants that do not exceed the historical utilization minus five percent. Do not submit an exception request for budgets on new waiver participants that do not exceed the average cost per service per member. There are two (2) levels of exceptions the Departments for Medicaid Services and Aging and Independent Living will consider. Support brokers must review and utilize the MAP-351 and MAP-109 when answering the following Level I or Level II criteria statements. An exception will not be approved unless a Level I or Level II criteria is met and appropriately documented.

Exception Level I: Any budget request of an existing waiver participant that exceeds the historical budget minus five percent to include up to the original plan of care (POC in place prior to requesting the exception) must be submitted as a request for a budget Exception. **Original plan of care must be included in the exception packet.**

In order to meet Level I criteria ALL of the following three (3) statements must be true:

- Participant's needs exceed the original DMS approved budget;
- Participant's needs DO NOT exceed the original plan of care; and
- Participant's needs are NOT catastrophic in nature as defined in Exception Level II

Exception Level II: In rare circumstances, the Departments will consider budget Exception requests above the original plan of care. **Original plan of care must be included in the exception packet.** The requests will only be considered under the following circumstances:

In order to meet Level II criteria, at least one (1) of the following statements must be true: (check all that apply)

- A catastrophic change in the physical condition has occurred that has resulted in additional major loss of function and limitations to ADLs and IADLs; or
- A catastrophic change in circumstances has occurred such as the death of a caregiver, loss of functioning of the caregiver or the caregiver is starting or returning to work; or
- A catastrophic change in the environmental living arrangement has resulted in the need to relocate the participant into different living conditions.

INDICATE WHICH EXCEPTION CRITERIA MET THIS REQUEST:

(If neither level, do not submit the exception request)

- Level I Level II

Note: Support brokers shall describe in detail the basis for Level I or Level II determination in the exception summary. The summary shall include, but not be limited to, why the participant's/consumer's needs go above the original POC; what has changed with the patient status, living situation, caregiver, natural support system; and who is included in the participant's/consumer's natural support system. The summary should also describe why an exception is requested and provide more detail than what is included in the MAP-109 clinical summary. The original plan of care must be included with every exception request in addition to the proposed (requested) plan of care and support spending plan.

Consumer's Diagnoses: Provide a complete explanation/definition for all diagnoses. The diagnoses are noted on the MAP-10 and MAP-351. Submit a copy of the MAP-10, MAP-109 and MAP-351 with the exception request packet.

Was an Exception Request previously approved? Yes No
If yes, provide the approval date, annual gross budget amount and date span for the annual budget:

➤ Previous Approval Date: _____ Budget Amount: _____ Date Span: _____ through _____

Date of the Current Plan of Care: _____
(Not the proposed plan of care resulting in the exception request)

Name of Agency Completing Original Plan of Care: _____
(Provide a copy of the original plan of care with exception request packet)

CDO Service(s) Requested:
(Include CDO Billing Code, Service Requested, Number of Monthly Hours and Hourly Pay Rate)

<u>CDO Billing Code</u>	<u>Service Requested</u>	<u>Monthly Hours</u>	<u>Pay Rate</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check for accuracy. Requested budget shall not exceed the traditional Medicaid rate for the appropriate program. Make sure the service requested is based on the consumer's documented needs and not the consumer's/representative's wants or desires. Services requested and documentation must be supported by the MAP-10, MAP-351 and MAP-109.

Appendix M

CDO Weekly Service Schedule: Develop a weekly calendar (service schedule) beginning with Sunday and ending with Saturday. Using the calendar, organize and provide a weekly CDO schedule for the consumer. On the days CDO services are requested, start with the time the consumer wakes up (example 6:00 AM) until he or she goes to bed (example 11:00 PM). The schedule must be shown in fifteen (15) minute increments and show what the consumer is scheduled to do each day a CDO service is requested. It is not necessary to provide times when the consumer is sleeping. There should be no blank times for each day CDO services are requested and scheduled. The weekly schedule must be typed and initialed by both the support broker and the consumer or representative to indicate the schedule is an agreed upon document. Support brokers must *include a clear typed copy of the signed weekly schedule in the submitted exception request packet.* The support broker must work with the consumer/representative to develop this schedule by following the person-centered planning and principles.

CDO Exception Request Questions:

- Using the exception level indicated above, if needing **RESPITE SERVICES**, why is this service needed? If the consumer attends *Adult Day Care* or *school* during the day, what is the caregiver's schedule that requires the addition of **RESPITE SERVICES**? Does the caregiver work during the day? Does the caregiver work full-time or part-time?

- Using the exception level indicated above, if needing **ADULT DAY TRAINING** or **SUPPORTED EMPLOYMENT** what exactly will the consumer be doing? Give a detailed description of the activities and learning objectives. For **Supported Employment**, who will the consumer work for? What is the consumer's schedule (days, hours/times)?

- Using the exception level indicated above, if needing more than an average of two (2) hours of **PERSONAL CARE** per day; explain in detail why additional units/hours are needed beyond the normal bathing and grooming needs.

- Using the exception level indicated above, if needing **COMMUNITY LIVING SUPPORTS** give a detailed description of the therapeutic goals and an outline to achieve the set goals.

Support Broker Exception Request Summary: The information provided in this summary needs and must clearly explain in detail the reason the exception is requested; what circumstances changed in the consumer's health and living situation to necessitate the exception; which exception criteria level (I or II) was determined and why; who are the natural supports; why are the natural supports not able or not willing to provide the service; is the consumer receiving other non-Medicaid services such as the Personal Care Attendant Program, Homecare Program; Hart Supported Living Program, DCBS State Supplementation, etc. The summary does not need to repeat the diagnoses indicated above but should provide more explanation than what is included on the MAP-109 Clinical Summary.

NOTE: INDICATE IN SB EXCEPTION SUMMARY IF AN EMPLOYEE IS A FAMILY MEMBER AND THE RELATIONSHIP TO THE CONSUMER.

—



COMPLETED BY DAIL CDO REVIEWER ONLY:

DAIL CDO Reviewer's Recommendation: (Reviewed by:___)

DAIL CDO Reviewer is RECOMMENDING the following exception budget based on review of the MAP-109, MAP-351 and exception request submitted by the Support Broker:

ONE MONTH: \$____ ANNUAL: \$____

If REVIEWER'S recommended budget is different from Support Broker's requested budget, provide explanation below:

The DAIL Recommendation is:

- BASED ON PA COST:** 907 KAR 1:145, Section 5(13) (b); 907 KAR 1:160, Section 6(13) (b); 907 KAR 3:090, Section 8(13) (b).
- ABOVE PA COST:** 907 KAR 1:145, Section 5(13) (b); 907 KAR 1:160, Section 6(13) (b); 907 KAR 3:090, Section 8(13) (b).

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME:

DOB:

MAID or MEMBER #:

DX:

Estimated Time Needed: Months Indefinitely Permanently
One Time Only

Procedure Code:

Date:

ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)

AGENCY NAME:

PROVIDER NUMBER:

CASE MANAGER/SUPPORT BROKER:

TELEPHONE NUMBER:

AUTHORIZED DMS SIGNATURE:

DATE APPROVED:



ADMINISTRATIVE OFFICE OF THE COURTS
RECORDS UNIT
100 MILLCREEK PARK
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
records@kycourts.net



Appendix O

The process to obtain the information contained in CourtNet is as follows:

Individuals

Requesting a record on yourself requires a \$10.00 fee (**check or money order**). Enclose a self addressed stamped envelope for a return reply or e-mail address.

Nonprofit/Commercial/Others

Requesting a record on individuals requires a \$10.00 fee (**check or money order**) . Your return envelope must be addressed with adequate postage, and the other envelope only needs the address of the person being checked or e-mail address for both.

Licensing

A request for licensing purposes and on another person requires a \$10.00 fee (**check or money order**) and must include two envelopes. Your return envelope must be addressed with adequate postage, and the other only needs the address of the person being checked or e-mail address for both.

Government/EMS

Government entities must provide both envelopes mentioned above, a tax exempt number for waiver of fees, contact person, phone number, and mailing address on their request. Multiple inquires can be made on a continuation form or e-mail address for both.

Fees are paid to the order of the KENTUCKY STATE TREASURER by check or money order ONLY. FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact the Records Unit at (502) 573-1682 or (800) 928-6381.

PLEASE **PRINT OR TYPE** THE INDIVIDUALS INFORMATION **CLEARLY**.

SOCIAL SECURITY NUMBER: _____ DLN: _____

NAME: _____

MAIDEN NAME(S) AND/OR ALIAS: _____

DATE OF BIRTH: _____

STREET ADDRESS / P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

E-MAIL ADDRESS: _____

I understand the information supplied by me must be truthful and falsification with an intent to mislead may result in my prosecution under KRS. 523.100. I have provided the basic information necessary to qualify for record processing and exemption of fees - **if applicable**.

Individual's Signature _____ Date _____

Tax Exempt Number _____ E-mail address (sent to this e-mail only) _____

Company _____ Telephone Number _____

Requestor/Contact Person _____ **Please denote which purpose applies to this request:**

Address _____ Employment

City, State, Zip _____ Criminal Investigation

Would you like the CourtNet Records e-mailed? Yes No

Screening Housing Applicants

Volunteer/Care over Juvenile

Licensing

Other (please explain) _____

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[Kentucky Board of Nursing](#) > **Bulk License Validation**

Validation by identifier:

- ARNP registration numbers are 4 digit numbers
- License numbers are 7 digit numbers beginning with the digit "1" for RNs or "2" for LPNs
- Provisional license numbers are 8 digits beginning with the digit "2"
- Temporary work permit numbers are 5 digit numbers
- SRNA numbers are 8 digit numbers beginning with digit "5"
- We are no longer offering the option of entering a social security number when you access the Basic License Validation service

Validate by identifier

Identifier

Search by name:

- Please enter first name or last name or both and click Search button. After the results are displayed please select the names you would like to validate and click on "Validate Selected" button at the bottom of the results. To select all names please click on Select All column.

Search by name

First Name

Last Name

Maximum number of results

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COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Protection and Permanency

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATIONS REQUIRE A CHILD ABUSE/NEGLECT (CAN) CHECK AS A CONDITION OF EMPLOYMENT. KENTUCKY ADMINISTRATIVE REGULATIONS MAY BE FOUND ON THE INTERNET AT <http://www.lrc.ky.gov/kar/titles.htm>. PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

Day Care Related Categories

- Day Care Center Employee or Volunteer (Required by 922 KAR 2:090)
- Applicant for Day Care Center Licensure (Required by 922 KAR 2:090)
- Registered Child Care Provider Applicant (Required by 922 KAR 2:180)

Other Categories

- Foster/Adoption/Independent Living Agency Employee (Required by 922 KAR 1:310)
- Residential Child-Caring Facility Employee (Required by 922 KAR 1:300)
(Institution/Group Home/Emergency/Wilderness)
- IMPACT-PLUS Subcontractor (Required by 907 KAR 3:030)
- Supports for Community Living (SCL) Employee (Required by 907 KAR 1:145)

Other (If none of the above categories is applicable, please explain the reason for requesting a child abuse or neglect check, including the statutory or regulatory authority for the request):

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card, or birth certificate):

NAME: _____
(first) (middle) (maiden/nickname) (last)

Sex: ___ Race: _____ Date of Birth: _____ Social Security #: _____

Date of Initial Hire: _____

Present Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Please list your addresses for the last five years. Use another sheet of paper, if necessary.



CENTRAL REGISTRY CHECK

Appendix R

A check or money order made payable to the "Kentucky State Treasurer" in the amount of ten dollars (\$10.00) must accompany your request to process a Child Abuse or Neglect Check. The Child Abuse or Neglect Check will NOT be processed without payment. Mail check or money order to:

The Cabinet for Health and Family Services
Department for Community Based Services
Records Management Section
275 East Main St., 3E-G
Frankfort, Kentucky 40621

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and provide the results of the check to the employer or agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

All the information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

Signature of the Individual Submitting to the Child Abuse or Neglect Check Date

Witness Date

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization to Disclose Protected Health Information form, authorizing the Cabinet to disclose additional information regarding a substantiated finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

NAME OF EMPLOYER/AGENCY:
ADDRESS: CITY:
STATE: ZIP: PHONE:

RESULTS OF CHILD ABUSE OR NEGLECT CHECK [FOR OFFICIAL USE ONLY]
[] No reportable incident found in accordance with 922 KAR 1:470.
[] Substantiated child abuse found on the registry Date of substantiated finding:
[] Substantiated child neglect found on the registry Date of substantiated finding:
CHECK CONDUCTED ON BY

CONSUMER DIRECTED OPTION RIGHTS, RESPONSIBILITIES AND RISKS STATEMENTS

Appendix S

As a participant of the Consumer Directed Option, a service delivery option offered under a 1915 (c) Medicaid waiver program, I understand I have certain rights, responsibilities and risks including, but not limited to, those described in the following statement:

I understand that I have the **RIGHT** to:

- Choose whether an authorized service will be provided by a traditional waiver provider or through the consumer directed option;
- Have a monthly face-to-face visit with my support broker and be informed of the balance remaining in my approved consumer directed option budget; and
- Work with my support broker in developing my plan of care and support spending plan
- .

I understand that I have the **RESPONSIBILITY** to:

- Pay my monthly patient liability on time;
- Work with my support broker to determine my natural supports (family and friends) who can assist me when my consumer directed option services are not being provided;
- Identify, hire and train my employees to perform the services outlined in my plan of care and if needed terminate employees who fail to meet my standard of care;
- Determine appropriate rates of pay within the Medicaid guidelines and determine work schedules for my employees;
- Work with my support broker to ensure my employees are cleared through the criminal background check, Kentucky Nurse Aide Registry and the Home Health Aide Registry prior to starting services;
- Track my employees time and the services provided and ensure timesheets and service notes are documented correctly;
- Stay within my approved consumer directed option monthly budget;
- Maintain my eligibility for Medicaid as long as I continue to meet eligibility requirements;
- Be trained to coordinate my care and manage my budget prior to beginning consumer directed option services;
- Use my Medicaid Waiver budget responsibly and be a good custodian of public money;
- Make purchases based on need and that will help me to remain at home and in my community and out of a nursing home or institution; and
- Make informed decisions about the best way to meet my needs, receive services, make changes as needed and stay within my budget.

I understand that I have the **RISK** of:

- Being terminated from consumer directed option if I fail to pay my monthly patient liability;
- Being terminated from consumer directed option if I do not use my consumer directed option services within sixty (60) consecutive days;
- Being terminated from consumer directed option if I do not make appropriate decisions concerning my consumer directed option services and place my health, safety and welfare in jeopardy; and
- Being terminated from consumer directed option if I over-spend or mismanage my approved consumer directed option budget.

As the consumer or designated representative choosing consumer directed option I have read the above Rights, Responsibilities and Risks statements. I have had all my questions answered by my support broker and I have received a copy of these statements from my support broker.

Consumer's or Representative's Signature

____/____/_____
Date

Support Broker's Initials