Agenda Item #: **3E-27**

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: October 19, 2010 **(X) Consent** **( ) Regular**
( ) Ordinance **( ) Public Hearing**

Department
Submitted By: **Community Services**

Submitted For: **Division of Senior Services**

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to approve: Home and Community Based Waiver Case Management Referral Agreement with the State of Florida Department of Children and Families' (DCF), Southeast Zone, Circuit 15, Adult Services Program for the period of July 1, 2010 with no expiration date.

Summary: The purpose of this agreement is to enable eligible disabled adult participants 18 to 59 years old, choice of case management services from the Division of Senior Services (DOSS) in Palm Beach County. DCF authorizes these services in order for the participant to remain in the least restrictive setting and avoid or delay nursing home placement. As a service provider under the Home and Community Based Services program, DOSS will be reimbursed at a unit rate of $45.00 per hour for Case Management, $21.00 per hour for Case Aide, $10.00 per hour In Facility Respite. There will be approximately thirteen (13) case management clients per month. (DOSS) Countywide (TKF)

Background and Justification: HCBS programs are used to fund services not otherwise authorized by the federal Medicaid statute, such as case-management and personal assistance services. Because this contract is generated by a State entity, the Inspector General (IG) language is not included.

Attachments:

Home and Community Based Case Management Referral Agreement

Recommended by: _____ 10/8/10
Department Director **Date**

Approved By: _____ 10/13/10
Assistant County Administrator **Date**

II. FISCAL ANALYSIS IMPACT

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2011	2012	2013	2014	2015
Capital Expenditures					
Operating Costs	7,020	7,020	7,020	7,020	7,020
External Revenue	(7,020)	(7,020)	(7,020)	(7,020)	(7,020)
Program Income (County)					
In-Kind Match (County)					
NET FISCAL IMPACT	-0-	* see below -0-	-0	-0-	-0-
# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included in Current Budget: Yes X No ___
Budget Account No.: Fund 1006 Dept 144 Unit 1467 Obj. various
Program Code various

B. Recommended Sources of Funds/Summary of Fiscal Impact:

Departmental Fiscal Review: Tawna Malhotra 9/29/10

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Administration Comments:
There is no fiscal impact on this item.

OFMB VA 10/7/10 10/6/10

Contract Administration 10/8/10

This Contract complies with our contract review requirements.

B. Legal Sufficiency:

Assistant County Attorney 10/12/10

C. Other Department Review:

Department Director

This summary is not to be used as a basis for payment.

State of Florida
Department of Children and Families
Southeast Region
Circuit 15, Palm Beach County

ADULT PROTECTIVE SERVICES
HOME AND COMMUNITY BASED WAIVER
CASE MANAGEMENT REFERRAL AGREEMENT

This Referral Agreement made this _____ day of September 2010, between the State of Florida, Department of Children and Families' (DCF), Southeast Region, Circuit 15, Adult Protective Services Program Office, and Palm Beach County Board of County Commissioners, hereinafter referred to as "case management agency", details the responsibilities and the expectations associated with the Aged and Disabled Adult Medicaid Waiver Program. This Referral Agreement is in effect from the date of signature for as long as the Aged and disabled Adult Medicaid Waiver program remains enrolled with the State of Florida's Medicaid fiscal agent or as otherwise provided herein. Provider noncompliance, nonperformance, unacceptable performance or failure to adhere to the DCF guidance on eligibility and referral for services may require a corrective action plan addressing the problems identified by state agency Quality Assurance Reviews and/or recoupment of program funds or provider disenrollment as an Aged and Disabled Adult Medicaid Waiver Program provider.

The purpose of this agreement is to enable eligible disabled adult participants' choice to receive case management services from qualified providers with oversight of case management services and quality of care by the State of Florida, Department of Children and Families, Southeast Region, Circuit 15, Adult Protective Services Program Office and the Medicaid Waiver Specialist employed by the Department of Elder Affairs (DOEA). These services are authorized in order that the participant may remain in the least restrictive setting and avoid or delay nursing home placement. Services and care are to be furnished in a way that fosters the independence of each participant and facilitates an increased functional capacity. All parties agree that routines of care provision and service delivery must be consumer-driven to the maximum extent possible. All parties agree to and will treat each participant with dignity and respect.

I. Objectives

A. To maintain a climate of cooperation and consultation with and between agencies, in order to achieve maximum efficiency and effectiveness.
B. To participate together by means of shared information in the development and expansion of services.
C. To promote programs and activities designed to prevent the premature institutionalization of disabled adults.
D. To provide technical assistance to and consultation between agencies on matters pertaining to actual service delivery and share appropriate assessment information and care plans to avoid duplication.
E. To establish an effective working relationship between the case management agency, the service provider, and the Florida Department of Children and Families; the case management agency being responsible for the development of care plans and authorization of services available under the waiver, the service provider being responsible for the direct provision of those services to consumers served under the waiver program, and the Department being responsible for management and oversight of the waiver program.

II. Under this Agreement, the Southeast Region, Circuit 15 (Palm Beach County) Adult Protective Services Program Office agrees to the following:

A. To provide technical assistance and training to the case management agency.
B. To monitor and project provider expenditures.
C. To conduct telephone screenings on all new referrals requesting services through the Aged and Disabled Adult-Home and Community Based Services (ADA-HCBS) Medicaid Waiver within the timeframes set forth in the Adult Services Wait List Policy guidelines, and using the Adult Services Screening for Consideration for Community-Based Programs (CF-AA 1022).
D. To complete all initial face-to-face assessments on all pre-screened individuals referred by the Adult Protective Services Central Office for service consideration and program application, using the Adult Services Client Assessment (CF-AA 3019).
E. To maintain an accurate and current active ADA-HCBS Medicaid-Waiver case list.
F. To provide newly approved consumers a choice of agencies offering case management services. Upon consumer decision, the record will be forwarded to the selected agency.
G. To provide existing consumers at least one month prior to their annual care plan review information on the availability of case management agencies in Palm Beach County encouraging consumer choice for management of the consumer's services. The current case management agency will confirm receipt of the letter by the consumer whereby the consumer will inform the department of their decision by an identified date. If the current case management agency is not selected, the current case management agency will forward the entire record to the Department of Children and Families. The department will transfer the record to the newly selected case management agency and the case management agency will be responsible to develop the new annual care plan.

H. To maintain a current monthly billing ledger of all provider claims submitted to the Agency for Health Care Administration, including all corrected claims and adjustments to claims for Medicaid services that were delivered to consumers being served through this Agreement.
I. To notify, on a timely basis, the Adult Protective Services Central Office budget staff of all waiver service terminations, service increase requests and typical monthly expenditure trends with regards to the terms of this Agreement.
J. To complete and submit the Provider Monthly Report Form (CF-AA 1119) to Central Office the 20th day of the month immediately following the month being reported.

III. Under this Agreement, the Case Management Agency agrees to the following:

A. Adhere to the Department of Children and Families' guidance on eligibility and referral for services, as established through the Aged and Disabled Adult (ADA) Waiver Handbook policy and the ADA Waiver format 1915(c).
B. Assign qualified case managers in accordance with the Aged and Disabled Adult Medicaid Waiver Handbook to provide case management under the Medicaid Home and Community Based Waiver (HCBS) for Aged and Disabled Adults.
C. Explain to each individual requesting consideration for ADA-HCBS Medicaid-Waiver services that the Medicaid-Waiver program maintains a centralized Waiting List on which the individual will be placed according to his or her score received through the Adult Services Screening for Consideration for Community Based Services (CF-AA 1022).
D. Supply all new disabled adult referrals (individuals requesting Aged and Disabled Adult Home and Community Based Waiver services) with the name of the DCF Circuit 15 Adult Services Counselor Supervisor and the phone number to the nearest DCF Adult Protective Services unit for the individual to pursue service consideration and program screening.
E. Maintain and permit circuit access to:
    1. A current and accurate log of all Medicaid waiver claims, activities and payments by individual consumer;
    2. A listing of each Medicaid waiver consumer served by full name, date of birth, Social Security ID and Medicaid ID;
    3. Current (within one year) Consumer Care Plans indicating present authorized service(s) and cost analysis by service on each waiver consumer serviced through this agreement; and,
    4. Current log of consumer terminations of service (if applicable) with cost analysis of the terminated consumer's unexpended care plan budget, date of termination and reason for termination through the Client Transfer/Termination (CF-AA 1122).
F. Develop and implement the initial and ongoing Care Plan (CF-AA 1025), which must be signed by the consumer, submitted to the Southeast Region Adult Protective Services & provider Specialist out posted to Circuit 15 (Palm Beach County) for review and implement the Care Plan once final approval is received by the Adult Protective Services Central Office that specifically outlines:
    1. The consumer's health conditions and treatment utilizing a Registered Nurse;
    2. Challenges and impediments to the consumer's daily living functionality identified by the assessment and to be addressed with the Care Plan and reviewed by a Registered Nurse;

3. Service(s) authorized;
4. The frequency and intensity of the arranged service interventions;
5. Service gaps;
6. Expected outcomes to be achieved;
7. Cost analysis, by service, of those service units authorized for consumer delivery; and,
8. The formal and informal support persons (agencies) responsible for delivering both the DCF funded services authorized by the case manager and all other non-DCF funded services.

G. Conduct a face to face visit with the client quarterly;

H. Reevaluate the Care Plan at least every six months.

I. Minimally reassess the client annually or more often (quarterly) if significant changes in the client's situation warrant, with the Adult Services Client Assessment Instrument (CF-AA 3019) with the assistance of a Registered Nurse and amend the Care Plan and cost analysis accordingly. The Care Plan and cost analysis should be sent to the Southeast Region Adult Protective Services & Provider Specialist out posted to Circuit 15 (Palm Beach County) for review prior to the implementation of revised services and costs. If the Care Plan has been amended resulting in increased costs, the case management agency must complete the Request for Approval of Care Plan Services Increase (CF-AA 1116). Once the Care Plan amended and cost increase has been approved, the provider is to make the required changes to authorized services and/or service providers as needed.

J. Confirm receipt of a letter sent to the consumer regarding the availability of case management agencies in Palm Beach County during the annual care plan review and remind the consumer to respond to the Department of Children and Families by an identified date.

K. Adhere to the policies and procedures as outlined in the following manuals published by the Agency for Health Care Administration: Aged and Disabled Adult Waiver Guidelines and the Medicaid Provider Reimbursement Handbook (Non-Institutional 081), including any and all attachments or updates.

L. Conduct semi-annual client satisfaction surveys to assess the quality of services being provided by sub-contracted service providers. Surveys need to assess service satisfaction service delivery and service outcomes.

M. Provide to the Southeast Region, Circuit 15 (Palm Beach County) Adult Protective Services Program Office, by the 15th of each month, a completed Provider Monthly Report (CF-AA 1119), which is a detailed expenditure report showing the number of clients served, defined units and type of services provided, cost of each service unit, number of units of service provided, totaled monthly cost of services delivered, and a year to date total cost of services delivered. This report will also include the number of active clients at the beginning of the month, the number added and deleted during the month, and the final count at the end of the month.

N. Refer clients to the qualified direct service provider as selected by the client, whenever reasonable and possible.

O. Issue written service authorizations to subcontracted service providers with at least 24 hours notice. The authorization will contain at a minimum:
   1. Client's name;
   2. Client's address (with directions if not easily accessible);

3. Pertinent information regarding client's health or disabilities and living situation; and,
4. Detailed service description including frequency, duration and specific tasks to be performed.

P. Evaluate quality of services and service documentation by the subcontracted service provider.

Q. Perform semi-annual administrative monitoring of subcontracted services provider.

R. Hold the Department of Children and Families harmless from financial responsibility for service claims found out of compliance if they are the result of a failure by the case management agency to update, renew, or terminate a client care plan or service authorization.

S. Develop and implement a policy to ensure that its employees, board members, and management, will avoid any conflict of interest or the appearance of a conflict of interest when disbursing or using the funds described in this agreement or when contracting with another entity, which will be paid by the funds described in this agreement. A conflict of interest includes, but is not limited to, receiving, or agreeing to receive, a direct or indirect benefit, or anything of value from a service provider, consumer, vendor, or any person wishing to benefit from the use or disbursement of funds. To avoid a conflict of interest, the case management agency must ensure that all provider staff, volunteers, and board members bound by this service agreement make a disclosure to the undersigned provider of any relationship which may be a conflict of interest, within thirty (30) days of original appointment or placement on a board, or if the individual is serving as an incumbent, within thirty (30) days of the commencement of the contract.

T. Follow-up with the undersigned on all billing errors identified by the Agency for Health Care Administration and/or the local DCF office to ensure that all void or adjustment claims are submitted no later than 45 days after each billing error has been identified by either party. Any provider error not adjusted or voided within 45 days may be adjusted or voided by the Florida Department of Children and Families' Southeast Region, Circuit 15 (Palm Beach County) Adult Protective Services Program Office. The provider's refusal to adjust or void erroneous claims will result in termination of this agreement.

U. If required by 45 CFR Parts 160, 162, and 164, the following provisions shall apply [45 CFR 164.504(e)(2)(ii)]:

(a) The provider hereby agrees not to use or disclose protected health information (PHI) except as permitted or required by this Agreement, state or federal law.

(b) The provider agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement or applicable law.

(c) The provider agrees to report to the department any use or disclosure of the information not provided for by this Agreement or applicable law.

(d) The provider hereby assures the department that if any PHI received from the department, or received by the provider on the department's behalf, is furnished to provider's subcontractors or agents in the performance of tasks required by this Agreement, that those subcontractors or agents must first have agreed to the same

restrictions and conditions that apply to the provider with respect to such information.

(e) The provider agrees to make PHI available in accordance with 45 C.F.R. 164.524.

(f) The provider agrees to make PHI available for amendment and to incorporate any amendments to PHI in accordance with 45 C.F.R. 164.526.

(g) The provider agrees to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528.

(h) The provider agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the department or created or received by the provider on behalf of the department available for purposes of determining the provider's compliance with these assurances.

(i) The provider agrees that at the termination of this Agreement, if feasible and where not inconsistent with other provisions of this Agreement concerning record retention, it will return or destroy all PHI received from the department or received by the provider on behalf of the department, that the provider still maintains regardless of form. If not feasible, the protections of this Agreement are hereby extended to that PHI which may then be used only for such purposes as make the return or destruction infeasible.

(j) A violation or breach of any of these assurances shall constitute a material breach of this Agreement.

V. Adhere to the Adult Services' Preliminary In-house Procedures for transferring an Aged and Disabled Adult Medicaid Waiver client and the client's budget from one circuit to another at the consumer's request.

IV. The following services will be delivered by the Service provider in accordance with the plan of care or service authorization:

Service	Unit Rate	County/Region Served
A. Case Management	$45.00 per hour	Palm Beach County
B. Case Aide	$21.00 per hour	Palm Beach County
C. In Facility Respite	$10.00 per hour	Palm Beach County

V. Termination

In the event this agreement is terminated, the case management agency agrees to submit, at the time notice of intent to terminate is delivered, a plan, which identifies procedures to ensure services to consumers will not be interrupted or suspended by the termination.

A. Termination at Will

This agreement may be terminated by either party upon no less than thirty (30) calendar days notice, without cause, unless a lesser time is mutually agreed upon by both parties, in writing. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

B. Termination Because of Lack of Funds

In the event funds to finance this agreement become unavailable, the Florida Department of Children and Families may terminate this agreement upon no less than twenty-four (24) hours notice in writing to the other party. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Florida Department of Children and Families shall be the final authority as to the availability of funds.

C. Termination for Breach

Unless a breach is waived by the Florida Department of Children and Families in writing or the parties fail to cure the breach within the time specified by the Florida Department of Children and Families, the Florida Department of Children and Families may, by written notice to the parties, terminate the agreement upon no less than twenty-four (24) hours notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

D. Retroactive Clause

The Palm Beach County Board of County Commissioners will be providing Adult Services Home and Community Based Waiver Case Management Referral services to eligible clients beginning July 1, 2010; however, since the contract will not be signed by that time, it will require retroactive payment back to July 1, 2010.

In witness whereof, the parties have caused this eight (8) Page Memorandum of Agreement to be executed by their undersigned officials as duly authorized.

Florida Department of Children & Families
Southeast Region, Circuit 15, Adult Services
Program Office

Signature

Perry Borman
Print Name

Circuit Administrator (Circuit 15)
Title

9/2/10
Date

Palm Beach County, Florida, a Political Subdivision of the State of Florida

By: _____
Burt Aaronson, Chairperson

Date: _____

SHARON R. BOCK, Clerk and Comptroller

By: _____

Date: _____

FEDERAL ID NUMBER: 59-6000785

FISCAL YEAR END DATE: _____

Approved as to form and legal sufficiency

By: _____
Assistant County Attorney

Approved as to term and conditions

By: _____
Department Director

AS Screening for Consideration for Community-Based Programs

PART I

1. Name:_____

2. Address:

District/Region:_____

3. Phone:_____

4. Race:_____ Gender:_____ Age/DOB:_____

5. Marital Status:_____

6. Social Security Number:_____

7. Primary Language:_____

8. Medicaid ☐ Number:_____

A. Date of Referral (Initial Contact):_____

B. ☐ Walk In ☐ Phone ☐ Other:_____

C. Referral Source (include phone number):

D. Relationship to Individual Being Referred:

_____

E. Is Individual Aware of Referral? ☐ Yes ☐ No

9. Medicare ☐ Number:_____

10. Other Insurance:_____

11. Financial: **(for Placement & Supportive Services only)**

$_____ (SSDI)

$_____ (SSI)

$_____ (Workers Comp)

$_____ (Other)

$_____ (Other)

12. Other Essential Person(s): physician, family member(s), POA, guardian, caregiver (include address and phone number)

Emergency Contact (and phone):_____

13. Directions to Home (as needed):

14. Problem/Diagnosis:

15. How Long a Problem? _____ 16. Urgency of Need:_____

17. Services Requested:

18. Other Agencies Contacted for Help:

19. AS Counselor's Signature:_____ Date:_____

20. Disposition: ☐ Protective Intervention Placement ☐ Protective Intervention Supportive Services ☐ Short-Term Case Mgmt.

☐ Information & Referral ☐ CCDA Application ☐ ADA Medicaid Waiver Application ☐ HCDA Application

☐ CCDA Waiting List - Score _____ ☐ ADA Medicaid Waiver Waiting List - Score _____ ☐ HCDA Waiting List - Score _____

21. Due Process Pamphlet (CF/PI 140-43) Given/Mailed by:_____ Date:_____

22. Given to Supervisor for Review by:_____ Date:_____ 23. Reviewed/Approved by:_____ Date:_____

24. PART I sent to:_____ Date:_____ By:_____

25. Referred to AS Counselor/Case Manager:_____ Date:_____

PART II

FUNCTIONAL ASSESSMENT (ADLs AND IADLs)

26. Check sources of information used for FUNCTIONAL ASSESSMENT Section.

☐ Individual Requesting Services ☐ Other (specify):_____

27. Has individual requesting services had any ongoing problems with memory or confusion that **seriously interfere** with daily living activities?

Describe:_____

Indicate name and phone number of physician/other who is treating individual for memory/confusion problem(s):

_____

(Address all questions to the individual requesting services if possible. The purpose of these questions is to determine actual ability to do various activities. Sometimes, caregivers help the individual with an item regardless of the person's ability. Ask enough questions to make sure the individual requesting services is telling you what he/she can or cannot do.)

Response Definitions:
No help: Individual can perform activity without assistance from another person.
Some help: Needs physical help, reminders or supervision during part of the activity.
Can't do it at all: Individual cannot complete activity without total physical assistance from another person.

Total Score: Add numbers from "Some help" and "Can't do it at all" columns to points given in question #33, and put sum in Total Score boxes.

ACTIVITIES OF DAILY LIVING (ADLs)

(Read all choices before taking answer)

Would you say that you need help from another person?
(Does not include assistance from devices)
0 = No help 2 = Some help 3 = Can't do it at all

		Comments/Care Plan Implications: (Include services, supplies, equipment, etc.)
28. Dressing (includes getting out clothes and putting them on and fastening them, and putting on shoes)	**0**	
29. Bathing (includes running the water, taking the bath or shower and washing all parts of the body including hair)	**0**	
30. Eating (includes eating, drinking from a cup and cutting foods)	**0**	
31. Transferring (includes getting in and out of a bed or chair)	**0**	
32. Toileting (independently includes adjusting clothing, getting to and on the toilet, and cleaning one's self. If accidents occur and person manages alone, count it as independent. If reminders are needed to clean up, change diapers, or use the toilet this counts as some help)	**0**	
33. Bladder/Bowel Control - How well can you control your bladder or bowel? -- Never have accident (0) -- Occasionally have accidents (2) Enter Score -- Often have accidents (3) -- Always have accidents (4)	**0**	
ADL Total Score (Total possible score = 19)	**0**	

INSTRUMENTAL ACTIVITES OF DAILY LIVING (IADLs)

(Read all choices before taking answer)

Would you say that you need help from another person?
(Does not include assistance from devices)
0 = No help 1 = Some help 2 = Can't do it at all

		Comments/Care Plan Implications: (Include services, supplies, equipment, etc.)
34. Transportation Ability (includes using local transportation, paratransit, or driving to places beyond walking distance)	**0**	
35. Prepare Meals (includes preparing meals for yourself including sandwiches, cooked meals and TV dinners)	**0**	
36. Housekeeping (dusting, vacuuming, sweeping, laundry)	**0**	
IADL Total Score (Total possible score = 6)	**0**	

SUPPORT AND SOCIAL RESOURCES OF INDIVIDUAL REQUESTING SERVICES (No Score for Questions 37-46)

37. Check source(s) of information used for this section.

☐ Individual Requesting Services ☐ Other (specify):_____

SERVICES/HELP Do you receive ...	Yes	No	NOTES
38. Personal Care Assistance (bathing, dressing, getting out of bed, toileting and eating)			
39. Housekeeping (laundry, cleaning, meals, etc)			
40. Transportation			
41. Shopping/Errands			
42. Personal Finances (money management)			
43. Services from a health professional such as an RN or Therapist?			
44. Adult Day Care			
45. Home delivered meals (Formal only)			
46. Any other kind of help (Specify)			

PART III - SCORING MATRIX

For items 1,2,3,4,5 and 6 in the scoring matrix below, enter the value (in parenthesis) following the question response which corresponds to the response obtained during the interview or through reviews. Example: If the answer was "yes" to the question "Is individual homebound?", a score of 1 point is placed on the line next to the answer line marked "Yes." For item 7, enter the score for ADLs and IADLs from the screening form. For item 8, subtract 40 points if the individual interested in HCDA or CCDA services appears eligible **or** is receiving comparable services from other programs. See the Adult Services Waiting List Policy for Community-Based Programs for a definition/description of "comparable services."

Comments From Individual Requesting Services That May Result in Re-Adjustment of Score:

Total Score: Add and subtract (as appropriate) the individual scores for each item to determine the total score and place the score in the box marked Total Score.

Domain/Question	Score
1. Is individual requesting services a victim **and** at high risk of abuse, neglect, or exploitation based on Protective Investigator's report?	_____ Yes (4 pt.)
2. Is individual requesting services a victim **and** at intermediate risk of abuse, neglect, or exploitation based on Protective Investigator's Report?	_____ Yes (2 pt.)
3. Does individual live alone or is individual solely responsible for minor children (under the age of 12) in the home?	_____ Yes (1 pt.)
4. Is individual homebound? (See AS Screening for Consideration for Community-Based Programs INSTRUCTIONS for definition of homebound.)	_____ Yes (1 pt.)
5. Does individual have ongoing memory/confusion problems?	_____ Yes (2 pt.)
6. Is individual receiving SSI or SSD because of primary diagnosis of sensory impairment?	_____ Yes (3 pt.)
7. Functional Assessment: ADLs.....	**0** (enter ADL total score)
IADLs.....	**0** (enter IADL total score)
8. Support for Individual Requesting Services: Does individual currently receive help/services (formal/informal) in ADL or IADL deficit areas noted?	_____ No help (4 pt.) _____ Help is available but overall inadequate or changing, fragile or problematic (2 pt.) _____ Help is adequate overall in deficit areas (0 pt.)
For HCDA and CCDA Programs Only: Individual appears eligible or is receiving comparable services from other departmental programs, APD, or vocational rehabilitation. (Does not include AS programs – see waiting list policy for definition of "comparable services.") Specify program(s) to which individual is being referred for eligibility determination and steps taken to refer individual to other program(s).	_____ Minus 40 pt.

TOTAL SCORE
(Total Possible Score = -40 to +40)

CCDA	ADA MW	HCDA
0	**0**	**0**

Florida Department of Children and Families

ADULT SERVICES CLIENT ASSESSMENT

Client Name:_____ **Client ID:**_____

Information Source / Relationship to Client:_____ / _____

I. HEALTH ASSESSMENT

SUBJECTIVE EVALUATION OF HEALTH: Overall, do you consider your health as excellent, good, fair, poor or serious?

_____ Excellent (0) _____ Good (5) _____ Fair (10) _____ Poor (15) _____ Serious (20)

SUBJECTIVE EVALUATION OF HEALTH SCORE ☐

HEALTH PROBLEMS

1. Do you have any health problems, and how do they affect you? For instance, has your doctor told you that you have any of the following health problems or symptoms?

Health Condition	Present	Interferes with Living	Condition Not Under Treatment
Allergies (Type) (Drug/skin/etc.)	___	___	___
Amputation	___	___	___
Anemia (Type)	___	___	___
Arthritis (Type)	___	___	___
Asthma (Type)	___	___	___
Bladder/Kidney Problems (UTI, etc)	___	___	___
Broken Bones (Type; Site)	___	___	___
Cancer (Type)	___	___	___
Cerebral Palsy	___	___	___
Decubitus	___	___	___
Dehydration	___	___	___
Dementia (Type) (Alz., OBS, etc)	___	___	___
Dialysis (Type)	___	___	___
Diabetes (Type)	___	___	___
Dizziness	___	___	___
Emphysema (COPD, etc)	___	___	___
Head Trauma	___	___	___
Hearing Problems	___	___	___
Heart Problems (CHF, MI, etc)	___	___	___
High Blood Pressure (Type)	___	___	___
Liver Problems (Cirrhosis/Hepatitis)	___	___	___
Lupus	___	___	___
Multiple Sclerosis	___	___	___
Muscular Dystrophy	___	___	___
Osteoporosis	___	___	___
Paralysis (Site)	___	___	___
Parkinson's Disease	___	___	___
Pneumonia	___	___	___
Potassium/Sodium Imbalance	___	___	___
Seizure Disorders (Epilepsy, etc)	___	___	___
Shingles (Herpes Zoster)	___	___	___
Sleep Problems	___	___	___
Spina Bifida	___	___	___
Spinal Injury	___	___	___
Stroke (CVA, etc)	___	___	___
Tuberculosis	___	___	___
Ulcers	___	___	___
Vision Problems (Type)	___	___	___
Thyroid Problems (Graves, etc)	___	___	___
Other:_____	___	___	___
Other:_____	___	___	___

Describe concerns regarding health problems:

HEALTH ASSESSMENT SCORE ☐

0 = No Health Conditions, 5 = Minor Health Conditions, 10 = Moderate Health Conditions
15 = Substantial Health Conditions, 20 = Serious Health Conditions

I. HEALTH ASSESSMENT

MEDICAL TREATMENTS AND THERAPIES (Place a ✓ mark next to any of the following medical treatments received by the client)

☐	Aseptic dressing	☐	Insulin therapy	☐	Physical therapy
☐	Bedsores treatment	☐	Lesion irrigation	☐	Occupational therapy
☐	Bowel/bladder rehab	☐	Ostomy care (type:)	☐	Speech therapy
☐	Catheter care (type:)	☐	Oxygen	☐	Respiratory therapy
☐	Dialysis (type:)	☐	Respiratory treatment	☐	Radiation
☐	IV fluids	☐	Suctioning	☐	Chemotherapy
☐	IV medicines	☐	Tube feeding	☐	Other (specify below)

NOTE ANY SPECIAL EQUIPMENT OR PROVIDERS USED OR NEEDED BY THE CLIENT:

MEDICATIONS (List current prescription and non-prescription medications)

Name of Medication	Dosage	Frequency	Physician	Name of Medication	Dosage	Frequency	Physician

What pharmacy does client use?

Describe concerns regarding medication use:

NUTRITION

(Enter scores below)

1. How is your appetite? Would you say that your appetite is good, fair or poor?
   ____ Good (0) ____ Fair (2) ____ Poor (6)

2. Current weight and height? Weight:_____ Height:_____

3. Have you gained or lost significant (10% change) amount of weight in the last 6 months? ____ Yes (4) ____ No (0)
   Describe gain or loss: _____ Gain _____ Loss
   Note: If significant gain or loss of weight was recommended by a physician, a "Yes" response receives no score.
   Was significant gain or loss recommended by a physician?

4. Do you have difficulty eating? Why?

	Yes	No		Yes	No
Tooth or mouth problems?	____ (4)	____ (0)	Taste problems?	____ (0)	____ (0)
Swallowing Problems?	____ (4)	____ (0)	Problems eating certain foods?	____ (0)	____ (0)
Nausea/Vomiting?	____ (4)	____ (0)	Any food allergies?	____ (0)	____ (0)

   Any other problems with eating (describe below)? ____ Yes (0) ____ No (0)

5. Are you on any special diets for medical reasons? ____ none (0) ____ 1 diet (4) ____ 2 or more diets (6)
   ____ Low sodium (salt) ____ Low fat/cholesterol ____ Low sugar ____ Calorie supplement ____ Other (describe below)

6. Describe concerns regarding nutrition problems:

NUTRITION SCORE ☐

I. HEALTH ASSESSMENT

MEDICAL TREATMENTS AND THERAPIES (Place a ✓ mark next to any of the following medical treatments received by the client)

☐	Aseptic dressing	☐	Insulin therapy	☐	Physical therapy
☐	Bedsores treatment	☐	Lesion irrigation	☐	Occupational therapy
☐	Bowel/bladder rehab	☐	Ostomy care (type:)	☐	Speech therapy
☐	Catheter care (type:)	☐	Oxygen	☐	Respiratory therapy
☐	Dialysis (type:)	☐	Respiratory treatment	☐	Radiation
☐	IV fluids	☐	Suctioning	☐	Chemotherapy
☐	IV medicines	☐	Tube feeding	☐	Other (specify below)

NOTE ANY SPECIAL EQUIPMENT OR PROVIDERS USED OR NEEDED BY THE CLIENT:

MEDICATIONS (List current prescription and non-prescription medications)

Name of Medication	Dosage	Frequency	Physician	Name of Medication	Dosage	Frequency	Physician

What pharmacy does client use?

Describe concerns regarding medication use:

NUTRITION

(Enter scores below)

1. How is your appetite? Would you say that your appetite is good, fair or poor?
   ____ Good (0) ____ Fair (2) ____ Poor (6)

2. Current weight and height? Weight:_____ Height:_____

3. Have you gained or lost significant (10% change) amount of weight in the last 6 months? ____ Yes (4) ____ No (0)
   Describe gain or loss: _____ Gain _____ Loss
   Note: If significant gain or loss of weight was recommended by a physician, a "Yes" response receives no score.
   Was significant gain or loss recommended by a physician?

4. Do you have difficulty eating? Why?

	Yes	No		Yes	No
Tooth or mouth problems?	____ (4)	____ (0)	Taste problems?	____ (0)	____ (0)
Swallowing Problems?	____ (4)	____ (0)	Problems eating certain foods?	____ (0)	____ (0)
Nausea/Vomiting?	____ (4)	____ (0)	Any food allergies?	____ (0)	____ (0)

   Any other problems with eating (describe below)? ____ Yes (0) ____ No (0)

5. Are you on any special diets for medical reasons? ____ none (0) ____ 1 diet (4) ____ 2 or more diets (6)
   ____ Low sodium (salt) ____ Low fat/cholesterol ____ Low sugar ____ Calorie supplement ____ Other (describe below)

6. Describe concerns regarding nutrition problems:

NUTRITION SCORE ☐

II. FUNCTIONAL ASSESSMENT

FUNCTIONAL ASSESSMENT

Do you need someone to assist you with:

Activities of Daily Living (ADLs)	No Help	Some Help/Supervision	Total Assistance
1. Dressing. Includes getting out clothes and putting them on and fastening them, and putting on shoes.	0	2	3
2. Grooming. Includes combing hair, washing face, shaving, and brushing teeth.	0	2	3
3. Bathing. Includes running the water, taking the bath or shower and washing all parts of the body, including hair.	0	2	3
4. Eating. Includes eating, drinking from a cup and cutting foods.	0	2	3
5. Transferring. Includes getting in and out of a bed or chair.	0	2	3
6. Walking/Mobility. Includes walking. Independence in walking refers to the ability to walk short distances at home. (Does not include climbing stairs.)	0	2	3
7. Climbing Stairs. Ability to climb stairs.	0	2	3
8. Toileting. Includes ability to manage use of toilet.	0	2	3
9. Bladder/Bowel Control ____ Never have accidents (0) ____ Occasionally have accidents (2) ____ Often have accidents (3) ____ Always have accidents (4) (enter score)			
10. Does client wear special briefs for incontinence? ____ Yes ____ No (If no, skip next question)			
11. How well do you manage changing them?	0	2	3

ADL SCORE (sum of circled 2's, 3's & Bladder Control Score) ____

ADL IMPAIRMENT COUNT (# of 2's & 3's circled) ____

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III. CLIENT SUPPORT ASSESSMENT

CLIENT SUPPORT

What help are you receiving? (detail who, what, how often) What equipment would aid in the performance of these activities?	Is Amount of Help Adequate?
1.	☐ Yes ☐ No
2.	☐ Yes ☐ No
3.	☐ Yes ☐ No
4.	☐ Yes ☐ No
5.	☐ Yes ☐ No
6.	☐ Yes ☐ No
7.	☐ Yes ☐ No
8.	☐ Yes ☐ No
9.	☐ Yes ☐ No
10.	
11.	☐ Yes ☐ No

II. FUNCTIONAL ASSESSMENT

FUNCTIONAL ASSESSMENT Do you need someone to assist you with: **Instrumental Activities of Daily Living (IADLs)**	No Help	Some Help/Supervision	Total Assistance
12. Answering the Telephone. Includes the use of an amplifier or special equipment.	0	2	3
13. Making Telephone Calls. Includes ability to call another party on the telephone.	0	2	3
14. Shopping. Includes shopping for food and other things, but does not include transportation.	0	2	3
15. Transportation Ability. Includes using local transportation or driving to places beyond walking distance.	0	2	3
16. Preparing Meals. Includes preparing meals for yourself including sandwiches, cooked meals and TV dinners.	0	2	3
17. Laundry. Includes doing laundry; putting clothes in the washer or dryer, starting and stopping the machine, and drying clothes.	0	2	3
18. Light Housekeeping. Includes dusting, vacuuming, sweeping, etc., but does not include laundry.	0	2	3
19. Heavy Chores. Includes yard work, windows, moving furniture, but does not include laundry.	0	2	3
20. Taking Medication. Includes ability to take own medication.	0	2	3
21. Handling Money. Includes managing own money, such as paying bills, and/or balancing checkbook.	0	2	3

IADL SCORE (Sum of circled 2's & 3's in IADL section) ____

IADL IMPAIRMENT COUNT (# of 2's & 3's circled) ____

III. CLIENT SUPPORT ASSESSMENT

CLIENT SUPPORT What help are you receiving? (detail who, what, how often) What equipment would aid in the performance of these activities?	Is Amount of Help Adequate?
12.	☐ Yes ☐ No
13.	☐ Yes ☐ No
14.	☐ Yes ☐ No
15.	☐ Yes ☐ No
16.	☐ Yes ☐ No
17.	☐ Yes ☐ No
18.	☐ Yes ☐ No
19.	☐ Yes ☐ No
20.	☐ Yes ☐ No
21.	☐ Yes ☐ No

CLIENT SUPPORT SCORE (includes Client Support Items 1 - 21) ____

0 = No need, 5 = Low need, 10 = Moderate need, 15 = Substantial need, 20 = Serious need

CLIENT SUPPORT COUNT(# N's) (includes Client Support Items 1 - 21) ____

Comments / Functional and Client Support Assessment Sections:

IV. ENVIRONMENTAL ASSESSMENT

SUBJECTIVE EVALUATION OF ENVIRONMENT

1. Are you concerned about your safety in your home or neighborhood? ____ Yes ____ No (If yes, explain)

POTENTIAL SAFETY/ACCESSIBILITY PROBLEMS

1. (Check all of the following areas that apply)

Area		Comments
Structural damage/dangerous floors	____	
Barriers to access	____	
Electrical hazards	____	
Fire hazards	____	
Unsanitary conditions/odors	____	
Insects or other pests	____	
Poor lighting	____	
Insufficient hot water/water	____	
Insufficient heat/air conditioning	____	
Inaccessible shopping	____	
Inaccessible transportation	____	
Inaccessible telephone	____	
Unsafe neighborhood	____	
Inability to evacuate in emergency	____	
Other (describe)	____	

ENVIRONMENTAL COUNT(# of √'s) ☐ **ENVIRONMENT SCORE** ☐

0 = No need, 5 = Low need, 10 = Moderate need
15 = Substantial need, 20 = Serious need

V. INDICATION OF OTHER PROBLEMS

Is there any indication of cognitive functioning problems? ..... ____ Yes ____ No **(If yes, complete Page 6)**

Is there any indication of mental health/substance abuse problems? ..... ____ Yes ____ No **(If yes, complete Page 7)**

Is caregiver assessment warranted? ..... ____ Yes ____ No **(If yes, complete Page 8)**
(Check yes for HCDA, and others as warranted)

CLIENT ASSESSMENT SCORING MATRIX

DOMAIN	LEVEL 1		LEVEL 2		LEVEL 3		LEVEL 4		LEVEL 5		
	Range	Score	Range	Score	Range	Score	Range	Score	Range	Score	Count
Subjective Evaluation of Health	0		5		10		15		20		
Health Assessment	0		5		10		15		20		
Nutrition	≤4		6-10		12-16		18-22		24-28		
Functional - ADLs	≤5		6-11		12-17		18-24		25-31		
Functional - IADLs	≤5		6-11		12-17		18-24		25-30		
Client Support	0		5		10		15		20		
Environment	0		5		10		15		20		
Total Ranges (L1 - L5)	≤14		15-52		53-90		91-130		131-169		
TOTAL CLIENT SCORE: (Does not include Count)											

Signature of Assessor ____ Program/Unit ____ Date ____

Signature of Assessor ____ Program/Unit ____ Date ____

VI. COGNITIVE ASSESSMENT

(Complete only if indication(s) of cognitive functioning problems)

COMMUNICATION ABILITY

1. Rate the client's speaking and communication ability based on performance in the interview:

Speaking	Communication
____ Speaks clearly with others of the same language	____ Transmits/receives information
____ Some defect in speech--usually gets message across	____ Limited ability
____ Unable to speak clearly/does not speak	____ Nearly or totally unable

2. Assessor's rationale and concerns regarding indication(s) of cognitive impairment:

(The following mental status exam may be used to document assessor's concerns.)

MENTAL STATUS QUESTIONNAIRE (MSQ) Orientation-Memory-Concentration Test (Katzman et al., 1983)

Now I'm going to read you a list of questions. These are questions that are often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Items	Maximum Errors	Score	Weight	Weighted Score
What year is it now?	1	_____	x 4 =	_____
What month is it now?	1	_____	x 3 =	_____

(Tell the client you are giving them a man's name and address to memorize.)

Memory phrase: John Brown, 42 Market Street, Chicago

(Elicit 3 correct repetitions from the client, phrase by phrase or word by word, if necessary, before continuing.)

Without looking at a clock, about what time is it? (Within 1 hour) ..... 1 _____ x 3 = _____

Count backwards from 20 to 1. (Check missed/out of order numbers in boxes.) ..... 2 _____ x 2 = _____

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

Say the months in reverse order. Hint: For ease in scoring, start with the month of December.
(Check missed/out of order months in boxes.) ..... 2 _____ x 2 = _____

Dec.	Nov.	Oct.	Sept.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.

Ask the client to repeat the memory phrase. Prompt the client if necessary: "It was John Brown..."
(Write the client's response on the line below to score.) ..... 5 _____ x 2 = _____

	John	Brown,	42	Market Street,	Chicago
Error Points:	(1)	(1)	(1)	(1)	(1)

weighted risk score: (0-4 = Low) (5-9 = Moderate) (10-28 High)

Total Weighted Error Score: _____

VI. COGNITIVE ASSESSMENT

(Complete only if indication(s) of cognitive functioning problems)

COMMUNICATION ABILITY

1. Rate the client's speaking and communication ability based on performance in the interview:

Speaking	Communication
____ Speaks clearly with others of the same language	____ Transmits/receives information
____ Some defect in speech--usually gets message across	____ Limited ability
____ Unable to speak clearly/does not speak	____ Nearly or totally unable

2. Assessor's rationale and concerns regarding indication(s) of cognitive impairment:

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Items	Maximum Errors	Score	Weight	Weighted Score
What year is it now?	1	_____	x 4 =	_____
What month is it now?	1	_____	x 3 =	_____

(Tell the client you are giving them a man's name and address to memorize.)

Memory phrase: John Brown, 42 Market Street, Chicago

(Elicit 3 correct repetitions from the client, phrase by phrase or word by word, if necessary, before continuing.)

Without looking at a clock, about what time is it? (Within 1 hour) ..... 1 _____ x 3 = _____

Count backwards from 20 to 1. (Check missed/out of order numbers in boxes.) ..... 2 _____ x 2 = _____

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

Say the months in reverse order. Hint: For ease in scoring, start with the month of December.
(Check missed/out of order months in boxes.) ..... 2 _____ x 2 = _____

Dec.	Nov.	Oct.	Sept.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.

Ask the client to repeat the memory phrase. Prompt the client if necessary: "It was John Brown..."
(Write the client's response on the line below to score.) ..... 5 _____ x 2 = _____

	John	Brown,	42	Market Street,	Chicago
Error Points:	(1)	(1)	(1)	(1)	(1)

weighted risk score: (0-4 = Low) (5-9 = Moderate) (10-28 High)

Total Weighted Error Score: _____

VII. MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

(Complete only if indication(s) of mental health/substance abuse problems)

Are you currently or have you previously received mental health services or counseling? ____ Yes ____ No

What is your mental health diagnosis? _____

Name of provider:_____. Describe services:

EMOTIONAL WELL BEING: Now I have some questions about how you have been feeling during the past month.

	Yes	No
Are you satisfied with life?	____	____
Have you been depressed or very unhappy?	____	____
Have you been very anxious or nervous?	____	____
Have you had difficulty sleeping?	____	____
Have you seen or heard things that other people didn't see or hear?	____	____
Have you become physically aggressive, or made threats to harm anyone?	____	____
Have you had a serious thought about harming or killing yourself?	____	____
Is anyone plotting against you?	____	____

MEMORY ASSESSMENT: I'd like to ask you some questions about your memory and ability to find things. In the past month have you:

	Yes	No
Had problems with your memory?	____	____
Frequently lost items such as your purse/wallet or glasses?	____	____
Failed to recognize family members or friends?	____	____
Lost your way around the house; can't find the bedroom or bathroom?	____	____
Forgotten to turn the stove off?	____	____
Wandered away from home for no apparent reason?	____	____

ALCOHOL/SUBSTANCE USE

Do you drink alcoholic beverages including beer and wine? ____ Yes ____ No (If no, skip next question.)

On average, counting beer, wine, and other alcoholic beverages, how much do you drink? (Describe frequency.)

Do you have a history of substance abuse? ____ Yes (Describe) ____ No

Do you smoke or use tobacco? ____ Yes ____ No (If no, skip next question.)

On average, how much do you smoke per day? (Describe frequency.)

Assessor's rationale and concerns regarding indication(s) of mental health issues/substance abuse:

VIII. CAREGIVER ASSESSMENT

(Complete for all HCDA clients and for other client's if there is an indication of caregiver issues.)
(Address to caregiver only)

1. Name:_____ Relationship:_____

2. How long have you given care to (Name of client)? _____ Years _____ Months

3. How often do you give care to (Name of client)? Would you say you give care:

____ Every day ____ At least once a week
____ Several times a week ____ Less than once a week
____ Don't know

4. Are you employed full-time, part-time, or not working at all?

____ Full-time ____ Part-time ____ Not working

5. If you were suddenly unable to provide care, who would take your place?

____ No one ____ Other (specify):_____

6. How is your own health? Would you say it is excellent, good, fair or poor?

____ Excellent ____ Good ____ Fair ____ Poor

7. Considering the care you provide for (Name of client), I would like to ask you if various aspects of your life have become better, the same, or worse. Let's start with...

	Better	Same	Worse	Don't Know
Relationship with (Name of client)	____	____	____	____
Relationship with other family members	____	____	____	____
Relationship with friends	____	____	____	____
Your health	____	____	____	____
Your work (if applicable)	____	____	____	____
Your emotional well-being	____	____	____	____

8. Is there anything else we need to know that makes it difficult for you to manage care? ____ Yes (explain) ____ No

9. Do you (caregiver) need training or services? ____ Yes (describe) ____ No

10. Assessor's concerns regarding caregiver's ability to provide care:

CASE MANAGEMENT PROVIDER MONTHLY REPORT

Report Month:_____

DCF District/Region:_____

Provider Name:_____

Annual Allocation:_____

COSTS BILLED MEDICAID FOR SERVICES DELIVERED TO DCF ADA MEDICAID WAIVER CONSUMERS

	Recipient Name	Recipient Medicaid ID	Waiver Service Received (one line per service)	Date(s) of Service (by service)	Monthly # Units Billed Medicaid (per service)	Cost Per Unit (by service)	Total Monthly Costs Billed Medicaid (by service)
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							

TOTAL MONTHLY ALLOCATION EXPENDITURES: $0.00

Person Completing This Report

_____

(Name and Position Title)

Date

_____

REPORT DUE TO THE DISTRICT THE 15TH DAY OF THE MONTH IMMEDIATELY FOLLOWING THE MONTH BEING REPORTED ON

Provider End Balance:_____

District/Region End Balance:_____

Adult Protective Services

CLIENT TRANSFER/TERMINATION

for Home Care for Disabled Adults, Community Care for Disabled Adults, and Aged or Disabled Adults Medicaid Waiver Programs

Region/County/Circuit: _____ (Region) / _____ (County) / _____ (Circuit)

Program

HCDA ..... ☐

*Total Number of Months Vouchered in Current FY:_____

CCDA ..... ☐

ADA Medicaid Waiver ..... ☐

Reassignment

☐ Transfer ..... Date:_____

From (County):_____ To (County):_____

Status Code

☐ Death ..... Date:_____

☐ Client No Longer Eligible ..... Date:_____

☐ Moved Out of State ..... Date:_____

☐ Nursing Home Placement ..... Date:_____

☐ Transferred to Other Program ..... Date:_____

☐ Aged Out ..... Date:_____

☐ Other (specify):_____. Date:_____

1	2	3	4	5	6	7
Client Name	Date of Birth	Annual Authorized Care Plan Amount for HCDA, CCDA or Medicaid Waiver Client (For HCDA Clients ONLY, this would be the amount authorized for the Fiscal Year in which the activity is occurring. If only a partial year's amount, then indicate so.)	Total Amount Paid in Subsidies or Services Rendered To Date Toward Client's HCDA, CCDA or Medicaid Waiver Care Plan *(DO NOT Include Special Subsidies, OTEs, etc.)*	HQ Authorized One-Time Expenditures *DO NOT Include Special Subsidies*	Total Amount Paid in HQ Authorized One-Time Expenditures *DO NOT Include Special Subsidies*	Total Amount Remaining To Be Transferred **OR** Total Amount NOT Spent To Date (sum of columns 3 & 5 minus sum of columns 4 & 6)
						$0.00

Print Name:_____ Title:_____

DCF Authorized Signature:_____ Date:_____

CARE PLAN

CLIENT NAME:_____ CASE MANAGER:_____

SOCIAL SECURITY #: _____ DATE OF INITIAL CARE PLAN:_____

GOAL (check all goals that apply):

CARE PLAN REVIEW DATE (initial for each Review):

☐ 1. Self Support ☐ 2. Prevent abuse/neglect/exploitation ☐ 3. Prevent institutionalization _____ _____ _____ _____

☐ 4. Institutionalization ☐ 5. Other:_____ _____ _____ _____ _____

Problems			Desired Outcomes	Service and Provider (Informal and Formal)	Pattern of Delivery (Frequency & Duration)		Date Service Began (B) Ended (E)	Date Problem Resolved (RS) Revised (Rv)
No.	Date	Problem			Needed	Actual		

This Care Plan has been discussed with me (client) and/or significant family members or friends and I accept the services described in the plan.
(For Medicaid Waiver Clients, also read:) I accept the service described and discussed with me in this Care Plan instead of nursing home placement.

CLIENT/RESPONSIBLE PARTY:_____ DATE:_____

CASE MANAGER:_____ DATE:_____

Request for Approval of Care Plan Services Increase

Part I: Recipient Information

Name: Last name, first name, middle name or initial	Date of birth:
Social security number:	Medicaid/Medicare Medical assistance number:
Current Address: County:	Address where services will be received: County:
Status: Indicate current monthly authorized units of service by your agency and any other subcontracted agency by service type(s): Medicaid waiver eligibility date: _____	Describe reason for service funding increase. An Adult Services client reassessment was completed on _____ by _____ and respective revised care plan revisions made on _____ by _____, to reflect that this Recipient is justifiably in need of increased Service(s) based on (check all situations which apply): ☐ Failing Support System ☐ Decrease in Functional Capacity ☐ Rapidly Deteriorating Health

Provider Information

Agency name:	Agency contact person:
Agency address:	Phone:_____ Fax:_____ E-mail address:

Part II: Summary of Recipient's Presenting Situation. (Refer to form instructions for details about the type of information required here. Attach further summary pages if necessary.)

Part III: Proposed New Service Request. (Please indicate each new care plan service being requested, with its corresponding ***hourly*** rate for service and annualized service cost.)

Service *	Hourly Rate for Service	Annualized Service Cost

* Any new service increase is conditional upon available budget.

Part IV: Specific Description of Proposed New Service(s) As Tailored To Meet Recipient's Need. (Refer to the form instructions for details about the type of information required here. Use the space below or include attachment.)

Part V: Care Plan Modification of Number of Service Units. The Region will not consider authorization to increase service unit quantity of an authorized service on a Recipient's care plan for any of the following documented reasons unless this section is accurately and fully completed.

[To justify unit service rates, please present comparative information: unit rate quotes from a minimum of three other service agencies providing this same service within a ten mile radius; reasons for choosing this specific vendor; a statement attesting to the fact that the selected vendor is a sole source provider of this service in this geographic area; etc. Attach information as necessary (e.g., agency administrative costs, your agency salary scale, etc.). Refer to the form instructions.]

☐ Failing Support System: List proposed add-on number of monthly service units by service component with annualized service costs projected to safely maintain Recipient at home and to ameliorate this risk factor.

☐ Decrease in Functional Capacity: List proposed add-on number of monthly service units by service component with annualized service costs projected to safely maintain Recipient at home and to ameliorate this risk factor.

☐ Rapidly Deteriorating Health: List care plan add-on number of monthly service units by service component with annualized service costs projected to safely maintain Recipient at home and to ameliorate this risk factor.

Part VI. Signatures. (Please note: Final approval of all requests for Care Plan increases rest with the Budget Entity Team. Providers will receive an Award Letter from the Budget Entity Team [or one of its members] when the plan has been approved.)

Provider: (Signature indicates that the information presented in this Request for Care Plan Services Increase and attachments are accurate and complete.)	Date:
Provider Agency Waiver Program Coordinator: (Signature indicates that the agency program coordinator has reviewed the Request for Care Plan Services Increase and attachments.)	Date:
Recipient/Representative: (Signature indicates that the Recipient/Representative has reviewed the Request for Care Plan Services Increase and attachments.)	Date:
Regional Waiver Specialist: (Signature indicates that the regional program staff and provider have agreed upon the services to be funded.)	Date:
Regional Adult Protective Services Program Administrator: (Signature indicates regional approval of the Service Funding Plan.)	Date: