## Policy Revisions Record

**Part II Policies and Procedures Manual for SOURCE Services**

<table>
<thead>
<tr>
<th>REVISION DATE</th>
<th>SECTION</th>
<th>REVISION DESCRIPTION</th>
<th>REVISION TYPE</th>
<th>CITATION</th>
<th>Reason for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2016</td>
<td>904</td>
<td><strong>Routine Reevaluations/ Reassessments</strong> (Complete Re Evaluation Packets)</td>
<td></td>
<td></td>
<td>Consistency in policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>for the sentence that states:</em> “Source members are evaluated for continued eligibility at least annually, and more often as necessary (e.g. improvements, as directed by GMCF, as directed by DCH). “ Transfers excluded from this statement</td>
<td>D</td>
<td>N/A</td>
<td></td>
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<tr>
<td>1/2016</td>
<td>905</td>
<td>Modified Reevaluation/ Readmission into SOURCE</td>
<td>A</td>
<td>N/A</td>
<td>Relieve burden on CM agency</td>
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<td></td>
<td>905</td>
<td>Members with a greater than 3 month LOC do not have to have an evaluation packet submitted to GMCF. If a transfer, submit appendix X</td>
<td>A</td>
<td>N/A</td>
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<td>1/2016</td>
<td>905</td>
<td>Modified Reevaluation/ Readmission into SOURCE</td>
<td>A</td>
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<td>As above</td>
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<td></td>
<td>905</td>
<td>Members who meet certain requirements, may qualify for a modified evaluation packet.</td>
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<tr>
<td>1/2016</td>
<td>Section 904 and Appendix QQ</td>
<td>New form/ form requirements for Modified reevaluation</td>
<td>A</td>
<td>N/A</td>
<td>Assist in clarification of new policy</td>
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<tr>
<td>1/2016</td>
<td>1406</td>
<td>Right to appeal</td>
<td>A</td>
<td>N/A</td>
<td>GMCF requirement</td>
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<tr>
<td></td>
<td>1406</td>
<td>If agency discharges a member, and member appeals, GMCF requires the evaluation packet to be uploaded to GMCF to extend the LOC thru the hearing process. Clearly ID packet as agency denied</td>
<td>A</td>
<td>N/A</td>
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<tr>
<td>4/2016</td>
<td>701.</td>
<td>Eligible Members</td>
<td>A</td>
<td>N/A</td>
<td>Clarification</td>
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<td></td>
<td>701.</td>
<td>Need to determine eligibility factors annually or more often</td>
<td>A</td>
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<tr>
<td>4/2016</td>
<td>1404</td>
<td>Removed all references to notify DCH with an appendix F for member discharges…</td>
<td>D</td>
<td>N/A</td>
<td>No longer applicab le</td>
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<tr>
<td>4/2016</td>
<td>Appendix F Provisional Level of Care</td>
<td>Provisional Level of Care removed. This process no longer applicable with newly implemented PA Service process</td>
<td>D</td>
<td>N/A</td>
<td>N/A for program</td>
</tr>
<tr>
<td>4/2016</td>
<td>Appendix Z (pages 6 and 7)</td>
<td>Forms updated for discharge planning and any References in manual to Appendix Z specific pages updated to reflect new documents</td>
<td>M/A</td>
<td>N/A</td>
<td>Update</td>
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<tr>
<td>4/2016</td>
<td>Appendix Z page 6</td>
<td>Form needed for legal updated</td>
<td>M</td>
<td>N/A</td>
<td>Update</td>
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<tr>
<td>4/2016</td>
<td>1404. Member Discharge</td>
<td><strong>Discharge Planning Policy Statement added and</strong></td>
<td>A</td>
<td>N/A</td>
<td>Consistency</td>
</tr>
</tbody>
</table>
## Table of Contents

**Part II Policies and Procedures Manual for SOURCE Services**

<table>
<thead>
<tr>
<th>Date</th>
<th>Section</th>
<th>Description</th>
<th>Change</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/2016</td>
<td>1404</td>
<td>Member Discharge Reinforcement of steps for discharge planning: Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix - 8 to be filed in the member’s chart.</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>4/2016</td>
<td>806</td>
<td>SOURCE CASE MANAGEMENT TEAM Each SOURCE Enhanced Case Management Team convenes a formal multidisciplinary team meeting at least weekly, to perform the following functions: a) Review new admissions b) Complete / Review Discharge Planning (see Appendices) for new members, reassessed and discharging members</td>
<td>A</td>
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<tr>
<td>4/2016</td>
<td>Appendix H</td>
<td>New SOP for provision of resources to members with an involuntary discharge and follow up with member</td>
<td>A</td>
<td>N/A</td>
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<tr>
<td>4/2016</td>
<td>Appendix BB</td>
<td>Discharge planning information added</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>4/2016</td>
<td>1405</td>
<td>SOURCE MEMBER INVOLUNTARY DISCHARGE 2 The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>4/2016</td>
<td>1406.</td>
<td>Right to Appeal Procedures after decision of non-eligibility: a 2nd level review option will be present in the GMCF letter to members. How it works is described.</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>4/2016</td>
<td>Appendix MM</td>
<td>How to attach the new information to GMCF in a 2nd level appeal</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>4/2016</td>
<td>APPENDIX LL GMCF</td>
<td>Provider Workspace User Manual that will show SOURCE Providers how to submit Second Level Reviews/ Reconsiderations. How providers should submit additional documentation for Second Level Review/ Reconsideration via the Reconsideration Link ONLY.</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table of Contents

Part II Policies and Procedures Manual for SOURCE Services

1305 Scheduled Contacts With Service Providers
1306 Procedures
1307 Scheduled Contacts With Case Management Supervisor
1308 Procedures
1309 PRN Contacts
1310 Disease State Management (DSM)

CHAPTER 1400 POLICIES AND PROCEDURES
1400 Provider Performance Monitoring
1401 Utilization Management
1402 24 Hour Phone Line
1403 Health System Linkages
1404 Member Discharge
1405 Right To Appeal Process and Right To A Hearing
1406 Confidentiality of Information
1407 Non-Reimbursed Items and Services
1408 Due Process
1409 HIPAA Regulations
1410 SOURCE Sentinel Event Policy
1411 Transfers Between SOURCE Case Management Agencies
1413 Case Management Reimbursement Hierarchy

APPENDIX A SCREENING FORM
APPENDIX B PARTICIPATION FORM
APPENDIX C SOURCE ASSESSMENT ADDENDUM
APPENDIX D RIGHTS AND RESPONSIBILITIES
APPENDIX E AUTHORIZATION FOR RELEASE
APPENDIX F SOURCE LEVEL OF CARE and PLACEMENT INSTRUMENT and Instructions
APPENDIX G CAREPATH LEVEL CRITERIA
Appendix H STANDARDS OF PROMPTNESS
APPENDIX I LEVEL OF CARE COLUMNS
APPENDIX I-1/2 Instructions/guidelines for Appendix I
APPENDIX J LEVEL I CARE PATH
APPENDIX K MEMBER VERSION FOR LEVEL I
APPENDIX L HOUSING AND INCONTINENCE CAREPATH
Appendix M CAREPATH VARIANCE REPORT
# Table of Contents

Part II Policies and Procedures Manual for SOURCE Services

(Appendix N, O, P, Q, R Removed at this time)

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>MINIMUM DATA SET – HOME AND COMMUNITY BASED (MDS-HC v9)</td>
</tr>
<tr>
<td>T</td>
<td>SIGNATURE PAGE FOR MDS-HC (V-9)</td>
</tr>
<tr>
<td>U</td>
<td>CONTACT SHEETS</td>
</tr>
<tr>
<td>V</td>
<td>Referral Form</td>
</tr>
<tr>
<td>W</td>
<td>MEMBER INFORMATION FORM</td>
</tr>
<tr>
<td>X</td>
<td>SOURCE Member Transfer Form</td>
</tr>
<tr>
<td>Y</td>
<td>HOSPITALIZATION TRACKING FORM</td>
</tr>
<tr>
<td>Z</td>
<td>REDUCTION IN SERVICE, TERMINATION AND DENIAL FORM (Z-1), NOTICE OF YOUR RIGHT TO A HEARING</td>
</tr>
<tr>
<td>AA</td>
<td>SOURCE SENTINEL EVENT REPORT</td>
</tr>
<tr>
<td>BB</td>
<td>SOURCE Discharge Summary,</td>
</tr>
<tr>
<td>CC</td>
<td>Billing</td>
</tr>
<tr>
<td>DD</td>
<td>NATIONAL CODE TABLE</td>
</tr>
<tr>
<td>EE</td>
<td>SOURCE Case Management Provider Main Offices</td>
</tr>
<tr>
<td>FF</td>
<td>Enhance Primary Care Case Management Application</td>
</tr>
<tr>
<td>GG</td>
<td>Enhance Primary Care Case Management Expansion Application</td>
</tr>
<tr>
<td>HH</td>
<td>HCBS Providers Referral/ Monitoring</td>
</tr>
<tr>
<td>II</td>
<td>HCBS Provider Enrollment</td>
</tr>
<tr>
<td>JJ</td>
<td>SOURCE Site Monthly Activity Report Rev.</td>
</tr>
<tr>
<td>KK</td>
<td>Determination of Need – Revised</td>
</tr>
<tr>
<td>KK-1</td>
<td>Instructions for the DON</td>
</tr>
<tr>
<td>LL</td>
<td>GMCF</td>
</tr>
<tr>
<td>MM</td>
<td>Claims, Billing</td>
</tr>
<tr>
<td>NN</td>
<td>Non-mandatory Forms for SOURCE</td>
</tr>
<tr>
<td>OO</td>
<td>SLUMS Examination</td>
</tr>
<tr>
<td>PP</td>
<td>Documentation Guidelines</td>
</tr>
<tr>
<td>QQ</td>
<td>Modified Re Evaluation Contact Sheet for Members</td>
</tr>
</tbody>
</table>

Service Options Using Resources In Community Environments April 1 2016
PREFACE

Policies and procedures in this manual apply to all SOURCE Case Management Providers. All service providers must refer to Community Care Services Program for specific program requirements for policies and procedures specific to each service type, unless otherwise indicated by the SOURCE DCH Policy and Procedure Manual.

- Part II Chapter 1100 Adult Day Health
- Part II Chapter 1200 Alternative Living Services
- Part II Chapter 1300 Home Delivered Services
- Part II Chapter 1400 Personal Support Services
- Part II Chapter 1500 Out-of-Home Respite Care
- Part II Chapter 1600 Emergency Response
- Part II Chapter 1700 Home Delivered Meals

All SOURCE Case Management Providers and service providers must adhere to Part I – Policies and Procedures Applicable to All Medicaid Providers, unless otherwise indicated by the SOURCE Policy and Procedure Manual.
As used in this policy manual, unless the content indicates otherwise, the term:

**Activities of Daily Living (ADLs)** – include fundamental activities related to community living, such as eating, bathing/dressing, grooming, transferring/locomotion and toileting.

**Caregiver (CG)** – Person providing significant non-paid support to a SOURCE member; most typically a family member. Has formal or informal authority to receive information and participate in decision-making on behalf of a SOURCE member.

**Carepath** – A standardized set of expected outcomes for each SOURCE level of care, with an individualized plan for each member to achieve them. SOURCE Carepaths address risk factors associated with chronic illness and functional impairment. Replacing conventional HCBS care plans, SOURCE Carepaths provide structure and accountability for case management practices of a chronic care population.

**Carepath Variance** – When an expected Carepath outcome doesn’t occur; a Carepath goal not met. Variances require action on the part of the Case Manager to ensure that issues are promptly resolved and goals will be met in the following review period.

**Case Management Supervisor (CM Supervisor)** – The staff member with direct supervisory authority over Case Managers; may also serve as Program Manager. Responsible for ensuring that CMs address Carepath variances and work in accordance with program goals. Assists CM in problem solving, reviews documentation and monitors provider performance.

**Case Manager (CM)** – The staff person serving as the SOURCE member’s liaison and representative with other program key players; the CM’s primary responsibility is to ensure that goals of the program and of individual members are met. Performs functions of needs assessment, Carepath monitoring and coordination with other health system or social service personnel.

**Case Note** – An entry in a SOURCE member’s chart by a Case Manager or Case Management Supervisor. Case notes document contacts with or on behalf of SOURCE members; actions taken on behalf of SOURCE members; or observations/follow-up planning by case management staff. Case notes should give the date, the person contacted, the setting and a description of the exchange. Case notes are used to note problems identified, to document resulting follow-up activity and to indicate when problems are resolved. Notes written on SOURCE Contact Sheets are considered case notes.

**Community Care Services Program (CCSP)** – Medicaid funded program in Georgia providing a range of community-based services to nursing home eligible persons, administered by the state’s Department of Human Resources under a 1915 (c) waiver.

**Community Services** – The menu of possible services reimbursed through SOURCE according to the care path plan authorized by the site, provided in a home or community setting.

**Community Service Provider** – An organization participating in the program as a provider of community services authorized by the CM and reimbursed through SOURCE.
Concurrent Review – The process of regular and thorough review of essential information about individual SOURCE members, by a Case Manager and key players; used to ensure that Carepath and program goals are met.

DON-R - The Screening tool entitled Determination of Need Revised.

Enhanced Primary Care Case Management – The service provided through the SOURCE program, blending primary medical care with case management and community services for Medicaid recipients with chronic illness.

GMCF - Georgia Medical Care Foundation, medical management vendor, subcontractor of DCH.


Medicaid – A jointly funded, federal/state healthcare assistance program administered by the Division of Medical Assistance (DMA) under the Georgia Department of Community Health, serving primarily low-income individuals: children, pregnant women, the elderly, blind and disabled. SOURCE falls under DMA’s Aging and Community Services.

Home and Community Based Services (HCBS) – Supportive services delivered in a home or community setting, as opposed to a nursing home or other institution. Personal care services and home delivered meals are examples of HCBS. In addition to a private residence, HCBS settings also include personal care homes and adult day health centers.

Instrumental Activities of Daily Living (IADLs) – Include supportive activities related to community living, such as meal preparation, housekeeping, using the telephone, financial management, etc.

Key Players – Individuals or organizations bearing major responsibility for ensuring that program and Carepath goals are met: SOURCE members and/or informal caregivers, Case Managers, CM Supervisors, PCPs and service providers.

Member Information Form (MIF) – Form used to record communication between SOURCE Case Management Provider and SOURCE service providers. Required for documenting key exchanges (service level changes, etc.), the MIF may be initiated by either party.

Program Manager – The staff member responsible for ensuring proper implementation of all policies and procedures of the SOURCE program. Primary responsibilities include coordination among key players, developing site-specific policies and procedures, leading data analysis and serving as liaison with the Department of Community Health.

SOURCE Level of Care and Placement Instrument (Appendix F) – Document used to formally enroll Medicaid members into the SOURCE program.
SOURCE Definitions/Abbreviations

SOURCE Member – A Medicaid recipient who is formally enrolled in the SOURCE Enhanced Primary Care Case Management program.

SOURCE Primary Care Provider (PCP) – The chief clinical partner in providing enhanced case management to SOURCE members; may be a physician or a nurse practitioner. Responsibilities include direct primary medical care and coordinating with other key players in the program. All SOURCE members must be under the care of a PCP participating in the program.

SOURCE Enhanced Case Management – The entity under contract with the Georgia Department of Community Health, Division of Medical Assistance, to provide the “enhanced primary care case management” service described in this manual and in the SOURCE Memorandum of Understanding. Program components may be provided directly by the entity holding the contract or by sub-contract, but the site bears responsibility for implementation of program policies and procedures.

ABBREVIATIONS

Behavior – abbreviation for the behavior Carepath outcome

Clin – abbreviation for the clinical indicators/lab value Carepath outcome

Comm – abbreviation for the community residence Carepath outcome

EPCCM – abbreviation for Enhanced Primary Care Case Management

Housing – abbreviation for the housing Carepath outcome

Incont – abbreviation for the incontinence Carepath outcome

Inf support – abbreviation for the informal support Carepath outcome

Meds – abbreviation for the medication Carepath outcome

Nutr’n – abbreviation for the nutrition Carepath outcome

Skin – abbreviation for the skin Carepath outcome

Trans/mob – abbreviation for the transfer/mobility Carepath outcome
601. **Introduction to SOURCE**

SOURCE operates under authority of the Elderly and Disabled 1915-c Home and Community Based Services (HCBS) Medicaid Waiver approved by the Centers for Medicare and Medicaid Services (CMS). Individuals eligible for enrollment in SOURCE must be eligible for full Medicaid (this excludes SLMB, QMB, and QI). Individuals served by SOURCE must be physically, functionally impaired and in need of services to assist with the performance of the activities of daily living (ADLs). Without waiver services, eligible SOURCE members would require placement in a nursing facility. While individuals, participating in SOURCE under the Elderly and Disabled waiver, do not have specific exclusions related to age, the waiver targets individuals who are elderly and physically disabled. SOURCE through its case management model, Enhanced Primary Care Case Management (EPCCM), links primary care to community services.

SOURCE Case Management Provider is enrolled with DCH to provide Enhanced Primary Care Case Management (EPCCM) services for eligible older and physically disabled Medicaid recipients. The model is comprised of three principal components – primary medical care, community services and case management – integrated by the site’s authority to approve Medicaid-reimbursed services.

SOURCE sites receive an enhanced case management fee per member per month. Community and physician services for SOURCE members are covered under conventional Medicaid fee-for-service reimbursement with authorization by the site. For dually insured members, Medicare remains the primary payer for services traditionally covered by Medicare. While the SOURCE Case Management Provider is expected to coordinate services delivered under Medicare, no authorization is required for Medicare reimbursement. For services covered by Medicaid, in addition to community and physician services (hospitalizations, lab/diagnostics, co-pays for dually insured members, etc.), the SOURCE Enhanced Case Management authorization number may be required.

602. **SOURCE Goals**

Goals identified for SOURCE include:

a) Reducing the need for long-term institutional placement and increasing options in the community for older and disabled Georgians, by designing an effective model replicable across the state

b) Preventing the level of disability and disease from increasing in members with chronic illness

c) Eliminating fragmented service delivery through coordination of medical and long term support services

d) Increasing the cost-efficiency and value of Medicaid Long Term Care (LTC) funds by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible for individual members

603. **Core Refinements to Traditional HCBS**

The SOURCE Program implements four core refinements to traditional HCBS programs:

a) SOURCE financially and operationally integrates primary medical care with the case management of home and community-based services.
b) SOURCE has developed and implemented a series of Carepaths for chronically ill persons (targeted conditions include: diabetes, high blood pressure, Alzheimer’s Disease, dementia, stroke, heart disease, asthma or other pulmonary conditions) at different functional levels, replacing the traditional HCBS care plan. Carepaths constitute a structured case management accountability system that regularly measures the achievement of key objectives for individual members, for the caseload of each Case Manager or Primary Care Provider and for the entire program.

c) SOURCE measures the performance of providers of community services by standards that exceed basic licensing requirements. Providers of personal/extended support services (the most highly accessed category of service) will honor member and site expectations of:

- **Reliability of service**, including early morning or late evening visits
- **Competency, compatibility and consistency** of staffing
- **Responsiveness to member and staff concerns**, including the scope of care as described by the member or caregiver
- **Coordination** with Case Manager

The provider’s role in achieving care path objectives – including member satisfaction with services – is regularly measured, addressed with performance improvement strategies as indicated and used to determine case assignments.

### 604. SOURCE Themes

The SOURCE vision of an ethical and disciplined community-based long term care system is described by several key themes that apply broadly to all members in the program (sites, members, providers, DMA):

a) **Integration:**

- **Empowerment** via the authority to enforce expectations of key players by authorizing payments
- **Communication** – scheduled and as needed to meet individual and program goals

- **Common objectives** that keep members at the center

b) **Member centered approach:**

- **Member/family contribution** and cooperation encouraged and valued
- **Advocacy** for individual members, across all settings
- **Inclusiveness** of varying ages, disabilities and functional capacities

c) **Continuous improvement:**

- **Collecting and reviewing** data regularly to identify problem areas
- **Marshalling resources** to help individuals address problems
- **Redesigning systems** to help DCH address problems for chronic care populations
605. Partnership with DCH

All sites will maintain a partnership with DCH to continuously improve overall program performance and to ensure that individual sites are working toward stated goals. The partnership may be fulfilled by sites in several ways:

a) Participation at scheduled meetings with DCH staff to discuss program guidelines, performance improvement strategies and site-specific updates
b) Monthly reporting to DCH on program activity due on the 15th of the month following the reporting period
c) Compliance with quality assurance protocols for waiver programs developed for CMS by DCH

DCH maintains oversight of all program components and reserves the right to give final approval of all aspects of the program including determination of eligibility and ILOC.

606. Enrolling as a SOURCE Enhanced Case Management Provider

Due to the complex nature of SOURCE and the fragility of the population, only established businesses with a history of providing case management may enroll. Other stipulations are as follow below and in Appendix FF:

A. SOURCE contractors receive a per member, per month case management fee billed on the CMS 1500, in return for providing Enhanced Primary Care Management.

Enrollment for EPCCM requires completion of the Medicaid enrollment application located at the HP web portal www.mmis.georgia.gov. The SOURCE Enhanced Case Management Application, which is included in Appendix FF must also be completed. Completed applications should be mailed to:

Department of Community Health, Long Term Care Section, 2 Peachtree Street NW, 37th Floor, Atlanta, GA 30303.

B. Compliance – Applicants must demonstrate maintenance of a satisfactory record of compliance with federal and state laws and regulations, and must not be currently or previously prohibited from participation in any other federal or state healthcare program or have been convicted or assessed fines or penalties for any health related crimes, misconduct, or have a history of multiple deficiencies cited by Utilization Review and/or deficiencies that endanger the health, safety, and welfare of the member.

In addition, the provider agency must have no deficiencies within the past 3 years from any licensing, funding, or regulatory entity associated with enrollment in any Medicaid services, or with the provision of any related business unless such deficiencies have been corrected to the satisfaction of the imposing entity.

C. Sponsor or Parent Organization – If a provider has a sponsor or parent organization, the sponsor or the parent organization must maintain full responsibility for compliance with all conditions of participation. Daily operation of the program may be delegated to a subdivision or subunit of the sponsor or parent organization.

D. Application Review - DCH will approve new applications for EPCCM Providers based on the following criteria:

- Successful completion of the provider application located on the HP website: mmis.georgia.gov
PART II – CHAPTER 600
SOURCE Overview

- Successful completion of the EPCCM Application (see Appendix FF)
- If DCH is unable to recommend approval of the application as submitted, the applicant will be notified in writing (including electronic mail) that the Department of Community Health (DCH) has denied the application.
- DCH will conduct site visits, if applicable. If the site visit results in unsatisfactory review, DCH will deny the enrollment application.
- If the application is denied, DCH will notify the applicant of the reason for the denial. Applicant agencies have the right to appeal enrollment denial as indicated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual.
- If the enrollment material meets submission and enrollment requirements, and no other information is required, the applicant will be notified in writing by DCH of its approval to become an EPCCM Agency.

NOTE: Applicant may not re-apply as an EPCCM for one (1) year after date of denial

607. Expansion Procedures

Prior to opening any new office or expansions to additional counties by an existing office, all sites that have been previously approved for SOURCE Enhanced Primary Care Case Management (EPCCM) must submit an expansion application to the Department of Community Health, Long Term Care Section for review and approval (see Appendix GG)

Department of Community Health
Long Term Care Section
Two Peachtree Street N.W.
37th Floor
Atlanta, Georgia, 30303

NOTE: Newly approved EPCCM Sites may not apply for additional counties for six (6) months after date of approval.

Providers seeking expansion are required to be in compliance with all applicable laws, rules, regulations, policies and procedures of all services the provider is currently enrolled to provide. DCH will not process an expansion request for a provider against whom there are unresolved complaints/deficiencies cited by Utilization Review/Program Integrity or other licensing or regulatory agencies.

Note: New provider EPCCM agencies as well as Expansion EPCCM agencies that have more than one location must have a separate provider number for each approved location

608 Community Service Provider Enrollment Procedure

A. All participating SOURCE providers must first be enrolled as a CCSP provider for the same services. Please note that a separate SOURCE provider number must be obtained prior to rendering services.

Note: Provider agencies requesting to become a SOURCE Provider must have completed a minimum of 6 months as a CCSP provider before applying to become a SOURCE Provider.
B. Letter of Intent is no longer required.

C. Providers must complete the following enrollment steps:

- Complete the Facility Enrollment Application located on the HP website: mmis.georgia.gov

- Attach the following documentation with the Facility enrollment application: See checklist in Appendix II for needed documentation

- Mail the completed provider enrollment application to 2 Peachtree Street N.W.
- 37th floor c/o SOURCE Program
- Atlanta, GA 30017
- Or scan and email to tunderwood@dch.ga.gov or lstewart@dch.ga.gov (SOURCE enrollment in subject line)

B. DCH will review the SOURCE Provider applications to determine if enrollment materials meet submission and enrollment requirements. If no further action is required, DCH will notify the applicant of approval of the Medicaid enrollment.

C. DCH will distribute the Community Service Provider’s information to appropriate SOURCE agencies in applicable counties to be placed on their rotation log.

D. Once Community Service Providers have a SOURCE member, the provider must attend regular conferencing with SOURCE and other contract expectations as outlined in this manual and CCSP.

E. Non-compliance maybe associated with suspension or removal from the rotation log/list
701. Eligible Members

SOURCE operates under authority of the Georgia Elderly and Disabled 1915c Medicaid Waiver. For core waiver requirements see section 801.3-- The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home Level of Care (LOC). Eligibility factors must be met annually or more often per guidelines in this manual, referenced manuals and the federal Waiver.

a) Aged 65 and older, or under 65 and physically disabled
b) Receiving full Medicaid (this excludes SLMB, QMB, QI)
c) Eligible based on meeting criteria for Intermediate Nursing Home Level of Care
d) Cost of necessary services can be provided by SOURCE at less cost than the Medicaid cost of nursing facility care
e) Willing participants who choose enrollment in the SOURCE Program (Member choice)
f) Residing in a SOURCE Enhanced Case Management’s designated service area; and
g) Capable, with assistance from SOURCE and/or informal caregivers, of safely residing in the community (with consideration for a recipient’s right to take calculated risks in how and where he or she lives)

Member General Exclusions

- Members currently enrolled as members in the Georgia Families program (this is not the Georgia 360° program)
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the PRTF program
- Members of a federally-recognized Indian Tribe
- Qualified Medicare Beneficiaries (QMBs) without SSI (or full Medicaid);
- SLMB or QI without SSI (or full Medicaid)
- Members Residing in an Institution
- Members not meeting eligibility requirements
Programs or Waivers that would cause duplication of services*

*Dual Waiver Enrollment Exclusions and Allowances:

In some instances, SOURCE members are allowed to participate in more than one waiver or program. There are still some Waiver and program exclusions. In the instance where a member would need to choose, individuals have the option of transfer from one waiver to another, contingent upon eligibility and available funding.

Exclusions from enrolling in two Waivers/Programs:

A member enrolled in SOURCE cannot receive duplicate services. Medicaid Waiver Programs that would cause duplication of services or excluded.

Waivers or programs where the member would need to be enrolled as an inpatient/ or in an institution are excluded from SOURCE.

All members considered for SOURCE must meet all SOURCE eligibility requirements.

Examples of Exclusions:

- Members who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including skilled nursing facilities, hospital swing bed units, hospice inpatient, intermediate care facilities for people with developmental disabilities, or correctional institutions
- CCSP, Independent Care Waiver, the NOW and COMP Waiver Programs members are excluded

Allowances:

The SOURCE agency continues to assume full responsibility for the professional management of the individual’s SOURCE care in accordance with the SOURCE manual. When an individual enrolled in SOURCE elects a second program or when an individual in another non excluded program elects SOURCE: See lists below for allowances:

- SOURCE dual enrollment in GAPP may be permitted
  
  Please refer to the GAPP manual for more information

- SOURCE dual enrollment in Hospice may be permitted without duplication of services.
  
  PSS services and Skilled Nursing are not a covered service from the SOURCE provider.
  
  An individual or a child currently enrolled in a Medicaid waiver program that is diagnosed with a terminal illness may elect to enroll in the Hospice program Please see Community Care Services General Manual section 901 Covered Services for more information
PART II - CHAPTER 700
Eligibility

- Children Receiving Services under Title V/CMS without duplication of Services may be permitted.

Caution should be given for children in this category, member must demonstrate all eligibility requirements including a need for SOURCE services.

Procedure for Dual Enrollment:

If dual enrollment is desired by the member and meets the guidelines above (and of course all eligibility requirements) the agency should follow these procedures:

A) The member’s SOURCE team and the 2nd program’s case manager and member **must** communicate, establish, and agree upon a coordinated plan of care for both providers that prevents duplication of services. Distinct Case management services must be agreed upon to be given by each CM agency. Information on these areas is documented at the beginning of the relationship and quarterly. More frequent communication should be documented if the need arises.

B) Both companies must keep records that indicate: that multiple Medicaid plans of care have been coordinated. Failure to demonstrate this coordination will be considered a failure to comply with the terms of this policy. As such, lack of evidence of coordinated care in documentation will result in a terminated lock-in and any paid claims for services will be subject to recoupment.

C) If Hospice is the designated 2nd program, the hospice agency MUST be the provider of the skilled nursing and personal support services. SOURCE may provide extended personal support services (in-home respite). If SOURCE member is in a PCH, the PCH must continue to give all care and not designate the normal care of a member to the Waiver such as hospice.

D) All hospice services must continue to be provided directly by hospice employees. The services cannot be delegated. When the member is in a waiver program residential facility (SOURCE Personal Care Home), the hospice agency may involve the facility staff in assisting the administration of prescribed therapies that are included in the plan of care; this is only to the extent that the hospice would routinely utilize the service of the patient’s family/caregiver in implementing the plan of care.

E) When the member is a resident in a waiver program’s residential facility, the facility must continue to offer the same services to the individual that elects the hospice benefit. The hospice member should not experience any lack of facility services because of his/her status as a hospice member.

The following activities are not allowed by SOURCE providers of any type:

**SOLICITATION OF MEMBERS FOR THE SOURCE PROGRAM**

This includes:
• Developing Carepaths, using amount or frequency of services, to encourage member choice of providers
• Soliciting clients from other providers or other programs

Neither SOURCE case management providers nor HBCS providers shall solicit Medicaid members for the purpose of SOURCE following the policy outlined in:
Part I, Policies and Procedures for Medicaid/Peachcare for Kids-- which all Medicaid providers agree to follow. The policy states:

106. General Conditions of Participation

E) Not contact, provide gratuities or advertise “free” services to Medicaid or PeachCare for Kids members for the purpose of soliciting members’ requests for services. Any activity such as obtaining a list of Medicaid or PeachCare for Kids members or canvassing neighborhoods (or offices) for direct contact with Medicaid or PeachCare for Kids members is prohibited. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited. It is not the intent of this provision to interfere with the normal pattern of quality medical care that results in follow-up treatment. Direct contact of patients for follow-up visits is not considered solicitation, nor is an acknowledgment that the provider accepts Medicaid/PeachCare for Kids patients.
801 – Levels of Care

801.1 Carepath Levels

a) All members are assigned Carepath level I. Indicate if members has intensifying needs for medical monitoring and assistance in the carepath.

b) On the Care Path signature page, indicate if member has functional impairments due to physical disability and/or cognitive impairment. Give Prior Authorization dates, Disease Management information, and signatures as indicated.

Note, members will be moved to single care path of Care Path Level I, upon full evaluations starting July 2015.

801.2 Level Of Care Criteria

a) The Intermediate Level Of Care (LOC) determination for SOURCE is based on:  the medical criteria used by Department of Community Health (DCH), Division of Medicaid to establish an individual’s LOC certification for nursing facility placement. SOURCE members must meet the Level of Care criteria for Intermediate Nursing Home Placement (see 801.3). Level of care determination is a function of the assessment process which includes: the SOURCE RN/LPN, through the use of the MDS-HC (v-9), Level of Care criteria (Appendix I), and professional judgment, gives a preliminary determination of Level of Care (LOC) for members during the assessment process.

b) GMCF or DCH gives final approval on all members for an active Level of Care.

c) Assessments and re-assessments completed by the LPN must be signed and certified by the designated RN within 10 business days of completion.

b) SOURCE services rendered to a member will be ordered by a physician and listed on the Carepath and Appendix F (level of care and placement instrument). The Primary Care Physician/Medical Director’s signature orders the services listed on the Appendix F.

e) Providers may render SOURCE Services only to members with a current LOC as reflected on current SOURCE Level of Care and Placement Instrument (APPENDIX F), approved by GMCF (all members as of 9/30/2013), and affirmed by the completed MDS-HC (v9) assessment.

f) Members must meet all SOURCE eligibility criteria to participate in the program.

g) Each qualifying SOURCE member is given an approved LOC certification for SOURCE program participation by GMCF. A LOC certification is approved for no more than 12 months (usually 365 days). Members approved for a length of stay less than one year require assessment at least 30 days prior to the expiration of the LOC in order to re-determine eligibility for the Program.
h) The GMCF Prior Authorization effective date is to be the LOS start date on the “Appendix F” LOC form, the GMCF expiration date is to be the LOS end date.

As of 8/1/2012, approved LOC with enrollment date (Prior Authorization date) will be issued by GMCF for all newly admitted SOURCE members; as of 9/30/2013 approved LOC with enrollment date will be issued by GMCF for all reassessments/re-evaluations.

Note: DCH maintains oversight of all program components and reserves the right to give final approval on all aspects of the program including eligibility and ILOC. DCH may extend LOC with legal documents or provisional level of care document. This may be especially necessary during the months when transitioning from MMIS locks to Prior Approval system.
801.3 For Source, the eligible individual will meet the target population guidelines and Intermediate Nursing Home LOC:

The target population for SOURCE is physically disabled individuals who are functionally impaired or who have acquired a cognitive loss that results in need of services to assist with the performance of the activities of daily living (ADLs). All individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE:

Summary for Intermediate Nursing home LEVEL OF CARE CRITERIA and SOURCE Program guidelines (use to interpret Appendix I):

1. Services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND either a mental/ cognitive (column B) and/or functional impairment that would prevent self-execution of the required nursing care (Column C Functional Status).

2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric or related to a developmental disability rather than medical need. This individual must also have medical care needs that meet the criteria for intermediate care facility placement. In some cases a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

Use the following table to assist with Appendix F and I for SOURCE clients:

To meet an intermediate nursing home level of care the individual must meet item # 1 in Column A AND one other item in Column A, PLUS at least one item from Column B or C (with the exception of #5, Column C)

Items in red are interpretive guidelines for SOURCE eligibility.

<table>
<thead>
<tr>
<th>COLUMN A</th>
<th>COLUMN B</th>
<th>Column C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Status</td>
<td>Mental Status (must include a cognitive loss) rev. 04/11</td>
<td>Functional Status impairment with etiologic diagnosis not related to a developmental disability or mental illness</td>
</tr>
<tr>
<td></td>
<td>Mental Status impairment with etiologic diagnosis not related to a developmental disability or mental illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The mental status must be such that the cognitive loss is more than occasional forgetfulness</td>
<td></td>
</tr>
<tr>
<td>1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. In addition to the</td>
<td>1. Documented short or long-term memory deficits with etiologic diagnosis such that it interferes significantly with the activities of</td>
<td>1. Transfer and locomotion performance of resident requires limited/extensive assistance by</td>
</tr>
</tbody>
</table>

Service Options Using Resources In Community Environments April 1 2016
criteria listed immediately above, the patient’s specific medical condition must require any of the following (2-8) plus one item from Column B or C.

2. Nutritional management; which may include therapeutic diets or maintenance of hydration status.

3. Maintenance and preventive skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti.

4. Catheter care such as catheter change and irrigation.

5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly for SOURCE).

6. Restorative nursing services such as range of motion exercises and bowel and bladder training.

7. Monitoring of vital signs and laboratory studies or weights.

8. Management and administration of medications including injections.

daily living. Cognitive loss must also be addressed on MDS/care plan for continued placement.

2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis as above for daily decision making such that it interferes significantly with the activities of daily living. Cognitive loss addressed on MDS/care plan for continued placement.

3. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed.

4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed.

staff through help or one-person physical assist.

2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals.

3. Requires direct assistance of another person to maintain continence.

4. Documented communication deficits in making self-understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement.

5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required).

Procedures once ‘slot’ is available for member:

1) Complete MDS-HC with member
   2) Obtain member signature on the SOURCE Level of Care and Placement Form (Appendix F)
   3) Forward all material as requested by GMCF, to GMCF per web portal.
   4) IF GMCF validates/confirms Level of Care then give the MDS-HC document, placement form and all assessment documents and member information to the multidisciplinary
team meeting with the Medical Director (physician) (see section 903 if ILOC is not confirmed).

5) If physician agrees that member meets the definition in section 801.3 including ILOC, physician signs SOURCE Level of Care and Placement Form

6) the agency RN certifies the definition in section 801.3 including ILOC by his/her signature on the SOURCE Level of Care Placement Form

NOTE: Prior to completing the MDS-HC Assessment the RN and/or LPN who conducts or coordinates the assessment process must attend an annual MDS-HC training session scheduled through the Department of Community Health (DCH). Once the MDS-HC assessment is completed by the RN/LPN, the level of care assessment tool can be accessed by an authorized user designated by the SOURCE Site. Should training be needed for new RN’s sooner than the annual training, contact the SOURCE Program Specialist.

All SOURCE team members who have access to the MDS-HC System must be an authorized user approved by the Department of Community Health.

802 Primary Medical Care

SOURCE Case Management Provider engages a limited panel of primary care providers who work closely with Case Managers on meeting program and Carepath goals for members. An effective enhanced case management model demands from participating Primary Care Providers a commitment of time, energy and focus. Providers include physicians, (e.g. Internal Medicine, Family Practice and geriatricians), and nurse practitioners.

In addition to traditional functions of evaluation/treatment for episodic illness and minor injury, key features of SOURCE primary care are:

a) Initial visit upon enrollment, unless member is already under the care of their Primary Care Provider prior to enrollment

b) Chronic disease management, including:
   • Risk factor modification and secondary disease prevention
   • Monitoring key clinical indicators, including review of data from ancillary services
   • Education for members/caregivers about disease treatments, common complications and preventive interventions
   • Medication review and management, with current medication list on file
   • Referral and authorization for specialists or diagnostic services, as needed
   • Coordination of ancillary services

See also Section 1310, Disease State Management.
PART II – CHAPTER 800
SOURCE Program Policy and Procedures

803 Site Medical Director

The Site Medical Director occupies a unique position of influence in local perceptions of Community Based Long-Term Care. The Medical Director will ideally have a strong history and connection with the local medical community, facilitating understanding of the model and fostering support for member and program goals. The Medical Director will participate actively on the site’s multidisciplinary team, and will advocate on behalf of the program or individual member with the local health system or other physicians.

Specific responsibilities of the Medical Director include working with the Multi-disciplinary team to:

a) Advise on the local site’s policies/procedures
b) Advise on the local site’s internal grievances
c) Advocate on behalf of the program or individual member with the local health system(s), other site physicians or non-participating community physicians
d) Review, sign and date Carepaths and APPENDIX F forms of all members
e) Confirm the HCBS services ordered, frequency and duration as indicated by the MDS-HC assessment tool, signing the APPENDIX F form for new members, and reassessments, at least annually.
f) Confirm ongoing eligibility for members requiring reassessment to include continuation of level of care eligibility criteria.
g) Confirm and sign APPENDIX F when member fails to meet nursing home Level of Care and requires discharge

Rev
10/08,
10/09,
04/10
PART II – CHAPTER 800
SOURCE Program Policy and Procedures

h) Review service delivery issues
i) Review repeated hospital encounters for individual members
j) Review issues of chronic non-compliance
k) Review Carepath variances as requested by case management staff
l) Review discharges to nursing homes, prior to the date of discharge
m) Review utilization data
n) Review complex referrals

804 Case Management

Case Management is a collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed. SOURCE case managers may consist of nurses, RN and LPN, currently licensed in Georgia and social services workers.

The four components of case management are described as follows:

- Assessment and periodic reassessment – determines service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessments are comprehensive in nature and should address all needs of the individual, including an individual’s strengths and preferences, and consider the individual’s physical and social environment.

- Development and periodic revision of the Carepath – specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, as collected through an assessment or reassessment.

- Referral and related activities – help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs.

- Monitoring and follow-up activities – include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. These activities should take place at least on a quarterly basis for face to face contacts and at least monthly for phone contacts. The monitoring and follow-up activity determines whether the services are being furnished in accordance with the individual’s care plan; services are adequate to meet the needs of the individual; and there are changes in the needs or status of the individual.

- Note: The Department of Community Health requires that new SOURCE Case Managers complete training in SOURCE Policies and Procedures within 90 days of employment as well as annually thereafter, as provided by the DCH approved contractor(s).
805 **Case Management Supervision**

In supporting people with physical and cognitive impairments in living outside of institutions, Case Managers regularly face difficult situations requiring sound judgment and painstaking review of options. To best assist members in maintaining sometimes fragile and complex Carepath plans, Case Managers need active supervisory support. An engaged supervisor will ensure that Case Managers have the benefit of an additional perspective in developing, implementing and adapting responsive Carepaths.

To help meet program and member goals, the case management supervisor’s role includes:

a) Regular conferencing to review case management activity around each member and signing SOURCE contact sheets.
b) Availability between supervisory conferences to help Case Managers solve problems around key member issues.
c) Administrative support for Case Managers making significant decisions or recommendations.

The case management supervisor may serve in other program capacities, such as the overall program manager.

Note: The Department of Community Health requires that new SOURCE Case Management Supervisors complete training in SOURCE Policies and Procedures within 90 days of employment as well as annually thereafter, as provided by the DCH approved contractor(s).

806 **SOURCE CASE MANAGEMENT TEAM**

Each SOURCE Enhanced Case Management Team convenes a formal multidisciplinary team meeting at least weekly, to perform the following functions

c) Review new admissions and confirm/verify the care path and need for HCBS services, along with service type, frequency and duration
d) Complete / Review Discharge Planning (see Appendices) for new members, reassessed and discharging members
e) Authorize service plans for ongoing members
f) Develop site-specific policies and procedures
g) Track and analyze repeated hospital encounters for individuals
h) Hear issues of non-compliance and involuntary discharge
PART II – CHAPTER 800
SOURCE Program Policy and Procedures

i) Review chronic Carepath variances and potential nursing home discharges
j) Review provider or service delivery complications
k) Review discharges to nursing homes, prior to the date of discharge
l) Review utilization data
m) Review complex referrals

Membership on the team may be fluid but will at least include the Medical Director, the program manager, case management supervisory staff, an RN/LPN and case manager presenting new members or information. Other clinical, case management or administrative staff members may participate as needed. At the team meetings, the Medical Director confirms the member meets the definition in 801.3 for a new member’s initial assessment as well as annual re-assessments (or members with a change in level of care) by signature on the member’s Carepath and SOURCE Level of Care and Placement Instrument (APPENDIX F) form.

807 Community Services Providers

All community services providers must first be enrolled under CCSP and must comply with CCSP policies and procedures unless indicated otherwise in this manual. As of July 1st, 2013, SOURCE opened enrollment to all current CCSP HCBS providers in good standing. Providers will need to enroll in SOURCE per directions found in section 608. Compliance with increased performance expectations is expected for all SOURCE providers to achieve optimal health states for SOURCE members. SOURCE emphasizes the provider role in achieving outcomes associated with community residence and optimal health status for SOURCE members. This is accomplished by working closely with the Care Management agency and remaining compliant with current policy. When contacted by the SOURCE Case Management Agency and a client is brokered, the provider must abide by all SOURCE rules and conditions, including maintaining current on CCSP policy.

Reimbursed services through SOURCE are:

- Personal Support Services/Extended Personal Support (PSS/EPS)
- Adult Day Health (ADH)
- Home Delivered Meals (HDM)
- Alternative Living Services (ALS)
- Emergency Response System (ERS)
- Home Delivered Services (HDS)
- Skilled Nursing Services (SNS) (only used when all other home health agency options have been exhausted, ref. chapter 1900 of CCSP Manual)

Community services primarily offer assistance to members in activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Self-care and informal sources are first maximized before accessing HCBS...
in SOURCE. The Community Care Services Program provider manuals may be referenced for definitions of these service categories. Unless otherwise noted in this document, Community service providers will operate in accordance with CCSP provider-specific manuals. Copies of CCSP provider-specific manuals are available through the HP Website: www.mmis.georgia.gov

Key characteristics of the SOURCE provider role (and used for provider compliance):

a) Intensified communication/coordination with case management staff, over conventional HCBS programs
b) Commitment to continued service for members with challenging personal situations or diagnoses
c) Demonstrated efforts to serve manpower shortage areas
d) Service for members needing PSS/EPS hours both above traditional service levels and below
e) Willingness to flex service levels as authorized by Case Manager, in response to the complex or unpredictable status of individual members
f) Customer satisfaction standards exceeding basic licensing requirements; specific areas of accountability include:

   - **Reliability of service**, including early morning or late evening visits
   - **Competency, compatibility and consistency** of staffing
   - **Responsiveness to member and staff concerns**, including the scope of care as described by the member or caregiver
   - **Coordination** with Case Manager

g) Regular measurement of performance
h) Monthly utilization and reconciliation reports of all providers
i) Carepath measurement of customer/site satisfaction with services every quarter
j) Monthly score generated for PSS/EPS providers* (may use for other providers as desires)
k) External Care Coordination Complaint log will be maintained for all providers
l) Internal and External Complaint log will be maintained for the providers that don’t receive score cards
m) Monthly Score and Complaint log will be used for Corrective Action
n) An active 24-hour on-call service that coordinates dependably with Case Manager and members/Caregiver

(*Applicable only to PSS/EPS providers, the service category most heavily utilized by SOURCE members.)
901. SCREENING

Potential SOURCE members will be screened to determine likely eligibility using the Determination of Need – Revised (DON-R) screening tool. The tool was designed and validated for use in telephonic screening and provides a method for prioritizing SOURCE applicants for admission. SOURCE screening is performed by the SOURCE Enhanced Case Management agencies, usually at the time of applicant inquiry by telephone. Screening is conducted by phone or can be conducted face to face in the case of difficult to screen individuals (those with communication impairment, no telephone, or cognitive impairment). Referrals may come from many sources, including but not limited to:

a) Hospital discharge planners
b) Physician offices
c) Family members or other informal caregivers
d) Community social service agencies
e) Home health agencies or other health system organizations

Procedures:

a) Inquiries will be documented using the DON-R tool along with the SOURCE screening form used for collection of demographic data (Appendix C).

b) Medicaid Eligibility: Screening staff will access the GAMMIS website to confirm a potential member’s eligibility status. For persons not eligible for SOURCE or not interested in joining the program, appropriate referrals to other services or organizations will be made (including referral to the Social Security Administration if the person screened may be eligible for SSI). See also Policy No. 1405, Right to Appeal.

c) Functional Eligibility: Full screening is completed within three business days of the initial inquiry. Extenuating circumstances which prevent meeting the standard of promptness will be documented on the screening form (Appendix A). All telephone screening is only considered complete when performed using the Determination of Need – Revised assessment tool attached at Appendix KK.

d) Depending upon availability of SOURCE benefit funds, applicants who have been telephone screened and determined eligible for the Program may have to be placed on a waiting list for full assessment. When placed on a waiting list, an applicant will be advised of his right to be re-screened if his functional need or status changes. In the absence of applicant-initiated contact, applicants will be rescreened by the SOURCE EPCCM agency that conducted the first
screening using telephone contact and re-administration of the DON-R every 120 days if held on the waiting list.

e) In the case of wait lists for SOURCE admission, the EPCCM Agency sends the completed DON-R with legible demographic information to the DCH Program Specialist via facsimile or use of the www.source.dch.ga.gov e-mail address via secure method of transmission.

f) For those meeting SOURCE Medicaid eligibility criteria and wishing to pursue enrollment, information gathered from the screening will be used to determine admission priority and returned to the submitting EPCCM Agency to schedule assessment as program slots are available. In the case of a waiting list, those with the highest level of need as identified through use of the DON-R are admitted to the SOURCE Program.

902. ASSESSMENT

All persons who meet screening requirements for SOURCE, and program slots are available will be formally assessed in their homes by the EPCCM RN/LPN (exceptions noted below) prior to initiation of services, using the MDS-HC (v9) and other SOURCE approved Assessment Tools. The purposes of assessments are:

a) Evaluation of the member's medical and health status; functional ability; social, emotional and environmental factors related to illness, and support system, formal and informal; Level of Care determination, Carepath development and delivery of community services.

b) Identification of urgent problems which require prompt attention.

c) Gather data regarding the population served by the program, for Division of Medicaid review and to develop protocols for care.

d) Evaluate the member's home environment (assessing the physical structure and home safety, meeting caregivers or family members as indicated to assess informal support system, etc.). See Section 1005, Self Care and Informal Support.

Exceptions to member “in home” assessment

a) Member is receiving in-patient care in an acute care facility awaiting discharge to a community based environment

b) Member is currently residing in a nursing home
PART II – CHAPTER 900
SOURCE Member ENROLLMENT

Procedures:

a) Following screening and slot allocations, within 30 days, the case management staff schedules the initial assessment.

b) A Case Manager or a nurse may complete the Assessment Addendum Form;

c) Nurses will assess all potential members using the MDS-HC (v9) assessment tool and determine eligibility for the Program based on ILOC criteria and need for community-based services.

d) When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs Appendix T to indicate supervisory review.

e) Appendix T is a signature page that confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment.

f) Applicants who meet ILOC but have all needs met by informal supporters are not appropriate for admission to SOURCE.

g) Assessments will take place in the home of the potential member, unless enrollment is necessary prior to discharge from a hospital, nursing home or rehabilitation facility.

h) A caregiver, family member or advocate shall be present whenever possible during assessments for members with:

(1) A legally appointed guardian
(2) A known diagnosis of Alzheimer’s or dementia
(3) Other known significant cognitive or psychiatric conditions

Note: Individuals who are wards under legal guardianship procedures may not enroll themselves in the SOURCE Program nor sign program-related documents

i) While an informal caregiver may assist with answering assessment questions as needed (see above in particular), the potential new member is the primary source of information whenever possible, and is interviewed in person.

j) The Case Manager or nurse will review the program’s operations with the potential member following the assessment, including selection of the site as primary care provider.

k) The following forms will be reviewed with the SOURCE member and signed (see Appendices).

(1) SOURCE Rights and Responsibilities, obtaining signatures on two copies (one left with the member, one for filing in the administrative chart) and including information on a member’s right to appeal decisions of the site, signed at admission and at reassessment, at least annually.

(2) Consent for Enrollment form signed at admission.
(3) Records Release Authorization signed at admission and at reassessment, at least annually. Rev. 10/09, 07/10

(4) SOURCE Level of Care and Placement form, formally selecting SOURCE as primary care provider under Medicaid at admission and level of care status.

l) The Case Manager will provide the member/caregiver with the names of participating Primary Care Providers. All members enrolling must select and agree to use a designated Primary Care Provider.

m) All new members, not currently an established patient of a SOURCE physician must have an initial visit with the program Primary Care Provider selected. The member/informal caregiver OR the Case Manager may schedule the initial visit.

n) The assessment process will be initiated within 30 business days of release from wait list for members who must go through the wait list process. In situations where the standard of promptness is unmet, justification for failure to meet standard will be documented in the case notes of the member file. 

o) The Case Manager must include directions to the member’s home starting from the local SOURCE Enhanced Case Management office to member’s home address.

p) Following completion of the admission assessment, the Case Manager will record all recommended services on the Services Recommended Form.

q) Case Manager will request and record member feedback and signatures from both member and Case Manager will be secured.

903. **Program Admission Procedures**

SOURCE admission occurs with these steps following assessment:

1. Initial determination of eligibility using the definition in section 801.3 as recommended by the assessment nurse using the information gathered from the MDS-HC (v9) and compared to the Level of Care Criteria (Appendix I)

2. Submitting the assessment packet to Georgia Medical Care Foundation (GMCF), the Division of Medicaid’s medical management vendor, for validation of level of care.

   *Note: assessment packets are submitted only through the secure GMCF web portal for review. All correspondence related to admissions will be conducted through the secure web portal.*
3. Prepare information on Community Supports available to member that may be used to support the patient during their stay in SOURCE or information that can be used to support member at termination (prepare for Discharge at time of enrollment)

4. Receive confirmation of the level of care approval from GMCF

5. Review new/ reassessed members by a multidisciplinary team

6. Assignment of the Carepath. Admission is considered complete upon the MD order/signature on the Level of Care and Placement Instrument (Appendix F) which provides the physician order for HCBS services/confirms LOC and RN signature for certification of level of care. Care path completion is required within fourteen (14) days of this date

7. Upon completion of enrollment (synonymous with the PA approval/effective date) and initiation of services, case manager will:
   
   A. Provide the following completed documents to all community service providers:
      
      - MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T) with RN signature and date
      - SOURCE Level of Care and Placement Instrument (Appendix F); must contain required signatures (physician and RN) and date of signatures
      - Level of Care Justification (Appendix I)
      - The Source Carepath
      - Member version of carepath
      - Rights and Responsibilities
      - Authorization for Release (no longer required)
      - Member Referral Form
      - Member Information Form, if applicable
      - Advance Directives (See Section 903, Procedure (j)
      - Directions to the member’s home, starting from the local SOURCE site to the member’s home address (See Section 902, Procedures (k)
      - Prior Authorization numbers (may write on transfer or Carepath form, Appendix F or I)

Rev. 04/11 Note: All services ordered must be listed on Appendix F. The exception to this is if the member is not due for a reevaluation and the new service ordered does not require a reevaluation/ reassessment; in the case of new services ordered without full reassessment, the services are added on the Carepath and indicated as ordered by physician by signature and date on the Carepath.
B. Provide the following completed documents to the member:

- Member participation form
- Carepath-Member Version

Process for Routine admissions:

For HCBS provider billing, SOURCE members are enrolled in the program after Prior Authorization LOC approval is given by GMCF. The Prior Authorization effective date is considered the date of GMCF approval and serves as the date of SOURCE lock in. However, services may not be reimbursed until the SOURCE physician signature authorizes approval of the HCBS services including enhanced case management. The R.N. signs the ILOC form after concurrence is provided by GMCF or DCH review.

Process for members who meet eligibility:

Eligibility requires GMCF approval for any initial SOURCE clients or SOURCE member reassessments on or after 9/30/2013. Services may not be delivered until a GMCF approval and a valid Appendix F ordering HCBS services is in place.

Routine Admission Overview:

- The Case Management Agency makes an appointment with the member for a face to face interview. (g)
- The Case Manager may complete the Assessment Addendum (h)
- A nurse completes the MDS HC. (i)
- When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs Appendix T to indicate supervisory review. (j)
- Appendix T is a signature page that confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment. (k)
- Upon completion of enrollment and initiation of services, case manager will provide the following completed documents to all community service providers: (l)

- MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T) with RN signature and date
- SOURCE Level of Care and Placement Instrument (Appendix F); must contain required signatures (physician and RN) and date of signatures
- Level of Care Justification (Appendix I)
- The Source Carepath
- Member version of carepath
- Rights and Responsibilities
- Member Referral Form
- Member Information Form, if applicable
- Advance Directives (See Section 903, Procedure (j)
PART II – CHAPTER 900
SOURCE Member ENROLLMENT

- Directions to the member’s home, starting from the local SOURCE site to the member’s home address (See Section 902, Procedures (k))

m) All sites shall maintain in the front of each chart for each active member a current Face Sheet with basic demographic information, to include at least the following:

- Name
- Date of Birth
- Address/Phone
- Male/Female
- Medicare/Medicaid or SSN numbers
- Directions to member’s home
- Responsible party information (phone, address) if applicable
- Emergency contact information (phone, address)
- SOURCE PCP
- SOURCE Case Manager
- Date of SOURCE enrollment
- Diagnosis
- Advance Directives- Yes/No
- Discharge date

n) Case managers will provide the following completed documents to the member:

- Member Participation form
- Carepath-Member Version

o) The Case Manager submits documentation via the web portal to GMCF. Exceptions, if the member has a current Prior Authorization that is not expiring within 3 months, it is not necessary to submit to GMCF. GMCF reviews the assessment package and confirms Level of Care. Documents to be submitted via web portal include:

- Appendix F: Level of Care and placement Form (filled out in entirety)
- Appendix I: LOC justification for Intermediate Nursing Facility Care
- MDS-HC form
- SOURCE Assessment Addendum
- Medication Record
- Case Notes (6 months of Case notes for reassessment including Appendix U)
- DON-R Screening Tool for initial assessments
- Current physician or PCP medical documentation that supports level of care such as history & physical, medical progress notes and/or office visit notes, specialist consult notes (or form approved by DCH for this purpose)
PART II – CHAPTER 900
SOURCE Member ENROLLMENT

GMCF may request additional information if needed for confirmation of diagnosis or care level (i.e., dementia diagnosis that is not supported by documentation or suggestive of mental health issues).

p) Following level of care approval by GMCF, the member assessment and care path recommendation are reviewed by the multidisciplinary team.

q) Case Managers will use the following format in presenting newly eligible members to the weekly admissions meeting of the multidisciplinary team:

1. Member name, age and diagnoses
2. Caregiver information, if applicable
3. ADL/IADL impairments from MDS-HC Assessment
4. Current medications
5. SOURCE physician selected from panel
6. Factors complicating Carepath planning (lack of informal support, recent hospitalization, etc.)
7. Recommended SOURCE services
8. Other community services planned or in place
9. ADH level recommended

ADH LEVEL 1. Client Profile:

2. Requires watchful oversight to ensure safety and/or
3. Requires medical monitoring on a weekly basis or more often.
4. Requires minimal to maximal assistance with activities of daily living (Refer to Section 1103.4C for a list of task).
5. May require assistance with self-care or verbal cues to perform self-care (e.g., safely entering and existing a shower or assistance with toileting).

ADH LEVEL 2. Client Profile:

1. Oversight needs to ensure safety.
2. Medical monitoring needs.
3. Level of Need for assistance with personal care such as transfers, ambulation, bathing, or eating.
4. Any Need for specialized therapy.
5. Need for specialized nursing services such as bowel or bladder retraining, catheter care, dressing changes, or complex medication management.
6. Disease Management Needs (if required due to poor outcomes on medical parameters and/or variances)

The team reviews information to ensure that:

1. Informal support is analyzed and maximized
2. Services recommended are logical and cost effective
3. Key health status issues are identified, with urgent problems addressed
r) Following discussion of information presented, the multidisciplinary team reviews the Level of Care, MDS-HC and other SOURCE approved assessment tools for development of the care path and service plan.

s) The Medical Director and/or member’s primary care physician confirms that the member meets eligibility requirements for the SOURCE Program and orders specific services on the SOURCE Level of Care and Placement Instrument (Appendix F) by signature. His/her signature on the Carepath confirms the service level. Medical Director or PCP must sign the Level of Care Placement form within 90 (90) calendar days of the member signature.

t) Once the physician signature is on the level of care form, then a Service Prior Authorization can be created in the Medicaid information System.

u) If applicable, the team also assigns the ADH level of service.

v) GMCF communicates level of care approvals to DCH weekly for admission.

Rev. 10/08

Ineligible members

Ineligible Initial Clients (New Clients)

Process for new clients who do not meet admission criteria due to incomplete information / application (technical denial)

- GMCF does not validate/does not confirm Level of Care and eligibility
- GMCF sends out a certified letter to the member (uses the address listed in the MMIS)
- GMCF notifies by email and sends a letter to the SOURCE agency
- The SOURCE agency notifies the member and makes sure any questions are answered
- The member does not have appeal rights with an incomplete application
- The agency Medical Director and R.N. DOES NOT sign Appendix F, Level of Care and
- SOURCE Agency reviews the discharge plan with community supports, adding information as needed, giving it to member when complete (See Discharge Appendix BB and Z7)
- The SOURCE Case Manager follows the instructions on Appendix Z8 and ensures completion

Rev. 07/15

Process for established members who do not meet continued eligibility at reassessment

a) If a member no longer meets Level of Care (and does not appeal) or is discharged for any other reason, the site will notify all service providers and end all lines on the service Prior Authorization.

b) Except in cases where member meets immediate discharge criteria (i.e. threatening behavior), the agency should attempt to determine if the member is going to appeal and give the member 30 days before ending the service Prior Authorization.

c) Service Prior Authorizations should be ended in 30 days by the Case Management agency if member has not appealed.

Rev. 10/15
d) The appropriate forms should be placed in the member’s chart.

### 904 Routine Reevaluations/Reassessments (Complete Re Evaluation Packets)

Source members are evaluated for continued eligibility at least annually, and more often as necessary (e.g. improvements, as directed by GMCF, as directed by DCH). Reevaluations are to be completed by a licensed nurse (currently licensed in the state of Georgia). Reevaluations completed by an LPN must be reviewed and approved by a supervising RN. Reevaluations are sent to GMCF to obtain approval. The SOURCE case management agency confirms that the member continues to meet criteria for:

- Eligibility using the definition in section 801.3 including Intermediate Level of Care for nursing home placement.
- Continued eligibility, appropriateness, and need for SOURCE services
- Allows for adjustment of the CarePath goals and service plan

Note: All services ordered for member at the time of reevaluation must be listed on Appendix F, Line 23.

Procedures:

- a) RN or LPN schedules face to face meeting with member
- b) Review with member/member representative all documents
- c) Complete MDS-HC (v9) Assessment
- d) Complete SOURCE Level of Care Placement Instrument (Appendix F)
- e) Discuss with member continued eligibility or if indicated possible ineligibility
- f) Initiate the development of a new CarePath with input from member/member representative
- g) Obtain GMCF approval as of 9/30/2013 on all annual reassessments with MDS
- h) Present member information and documentation at multi-disciplinary team meeting
- i) Complete certification of LOC and continued participation in SOURCE
- i) Provide copies of reassessment documents to community service providers before LOC certification end date. The following documents are maintained as part of the SOURCE member clinical record:
  - The MDS-HC, Source Assessment Addendum, and MDS-HC signature page (Appendix T), with RN signature and date
  - SOURCE Level of Care and Placement Instrument (Appendix F), with required signature(s) and date(s)
  - Level of Care Justification (Appendix I)
  - The SOURCE Carepath
  - Member Version of the Carepath
  - Member Referral Form
  - Member Information Form (if applicable)
  - Rights and Responsibilities
  - Advance Directive (See Section 903, Procedure (j)}
PART II – CHAPTER 900
SOURCE Member ENROLLMENT

- Directions to the member’s home, starting from the local SOURCE site to
  the member's home address (See Section 902, Procedures (k)

k) If member is not approved for SOURCE during the Reevaluation/Reassessment process, and the
member appeals, a copy of the GMCF notice of appeal or the member’s copy of DCH Legal
Services Division acceptance of member’s appeal, will extend the LOC currently in place

NOTE: If members no longer meet eligibility criteria for SOURCE participation refer to Section 1405
and 1406 of this manual.

905 Modified Reevaluation/ Readmission into SOURCE

Modified Reevaluation Process may be used for members with Current PA greater than 3 months
from expiration. Such as:

- Members returning to SOURCE from Nursing Home
- Member returning to SOURCE from a Prolonged Institutional Stay
- Internal or External Case Management Agency transfer or
- Member has changes in functioning that significantly affects how care is delivered

This policy is for Medicaid members who have an active SOURCE Prior Authorization. That authorization
must have an expiration date greater than 3 months or more into the future. This may be used for
members who have been in Nursing Homes or have had hospital stays. Inappropriate use would be for
members who have improved in their health and can care for self.

Interview of member for this process may be conducted by LPN, RN, or Case Manager. Cases involving
complex wound care, complex equipment such as IV infusions, peritoneal dialysis, new insulin pumps or
new insulin administration should be conducted by nurses. Cases involving children should be conducted
by nursing staff.

Procedure:

Using the: “Modified Reevaluation Contact Sheet for Members with Active Prior Authorizations/Approvals”
in Appendix QQ. (This form was developed to give all the information needed in a concise format.)

1. Complete: Modified Re Evaluation Contact Sheet for Members with Active Prior
   Authorizations/Approvals (or see Box 1 if case note is preferred)
2. Complete for readmissions to SOURCE
   a. APPENDIX D CONSENT FOR ENROLLMENT/ RIGHTS AND RESPONSIBILITIES,
   b. APPENDIX E AUTHORIZATION FOR RELEASE (IF NOT PREVIOUSLY IN
      PLACE)
   c. APPENDIX F SOURCE LEVEL OF CARE and PLACEMENT INSTRUMENT
   d. Pull Sentinel Event (IF RELATED TO THIS REEVALUATION) and place with packet
      when in office.
3. Send to GMCF:
   a. If an internal or external agency transfer, a SOURCE Member Transfer Form (Appendix
      X) from admitting agency indicating who member transferred from and the new agency
      identification number. The PA number.
4. Send to DCH;
   a. DMA 59 if member is discharged from Nursing Home
PART II – CHAPTER 900
SOURCE Member ENROLLMENT

RN reviews and Signs MODIFIED REEVALUATION CONTACT SHEET for Members with ACTIVE PRIOR AUTHORIZATIONS/APPROVALS or MODIFIED READMISSION CASE NOTE before services begin. RN supervisory review indicates that medications and treatments are consistent with diagnosis and appropriate to be given at home. RN checks box yes or no next to need for Disease Management. RN documents recommendation for home care, educational needs, and disease management. (or documents “no recommendation”) If a sentinel event led to this Nursing Home admission, RN reviews the sentinel, documents recommendations under action plan and/or process improvement and signs/dates the form. All urgent Information is directly communicated to Case Management staff and documented. The RN signs the appendix F.

Case Management and Case Management Supervisors: Assure that all documents are completed. Assure Care path is updated. Assure resources are in place for a smooth, safe transition home.

Review member during Team and Quarterly Case Management meetings. Assure that urgent needs were addressed. Update any sentinel event that lead to this admission under action plan and process improvement (with new dates and data). Resend Sentinel to DCH with UPDATE written on top.

Procedure for Community Service Providers:

COMMUNITY SERVICE PROVIDERS should receive this information for readmissions:

(Note! This is an amended list for these members)

1. SOURCE MODIFIED REEVALUATION CONTACT SHEET for Members with ACTIVE PRIOR AUTHORIZATIONS/APPROVALS (or Case note with complete documentation from Box 1); 2. APPENDIX F; SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT; must contain required signatures (physician and RN) and dates;
3. Appendix F will have current PA expiration date as the end of LOS
4. APPENDIX I LEVEL OF CARE JUSTIFICATION form, with noted Readmission Reason written on bottom of form;
5. Source Updated Care Path with current dates;
6. Member Version of Care Path;
7. APPENDIX D Rights and Responsibilities; Consent for reenrollment
8. APPENDIX E Authorization for Release of Medical Information; (no longer required)
9. APPENDIX W Member Information Form;
10. ADVANCE DIRECTIVES (if not previously acquired);
11. Directions to the member’s home, starting from the local SOURCE site to the member’s home address
12. SOURCE Member Transfer Form (Appendix X) if applicable;
13. Copy of this policy (optional if provider is familiar with policy)

Box 1: Information needed if Modified Readmission using Case Notes to capture information is desired (note, will also need to use Appendix C):

Member Information: Name, DOB, (and any agency specific information)

Purpose of this documentation: Readmission into SOURCE with current PA

Interviewer Info: Name and title of person conducting interview. Date time and location interview occurred.
Interview Contributors: who all was present during interview? Who gave information

Body of Documentation: Reason for Admission to Nursing Home or Discharge from SOURCE services

If reason for admission was due to a fall, head injury, overdose, accident, or suicide event, please document this information. This will be needed later in the process.

New diagnosis, any therapies, all medications.

Mobility: Has there been a significant decrease in mobility?

Has there been a significant change in ability to care for self?

New equipment: what member needs or will be going home with (continued)

Medications can be listed on agency specific sheet or print off of home medications from Institution. RN signs and dates when reviewed.

Next scheduled visit for: Specialist, PCP, and any therapists

Will skilled nursing visits be needed? If so list why.

Will prolonged skilled nursing care be needed?

Case manager or Nurse Interviewer: Signs and date:

2) Complete Appendix C1-6. AND Appendix T: Note on Appendix C6 and T that this is an MODIFIED REEVALUATION per policy guidelines (this does not replace annual full re assessment.)

3) Complete
   a. APPENDIX D RIGHTS AND RESPONSIBILITIES, CONSENT FOR ENROLLMENT
   b. APPENDIX E AUTHORIZATION FOR RELEASE (if not previously in place)
   c. APPENDIX F SOURCE LEVEL OF CARE and PLACEMENT INSTRUMENT
   d. Pull sentinel event and place with packet when in office if related to stay

Follow Guidelines for RN’S, CASE MANAGERS AND COMMUNITY SERVICE PROVIDERS UNDER SECTION 905.

906 SOURCE Member External Transfers:

Transfers from one case management agency to a different case management agency do not require a DON-R Score. As of Oct 1 2015 a complete re-evaluation is only necessary by the receiving agency within 10 business days, if the GMCF Level of Care is expiring in 3 months or less. Otherwise only a modified reevaluation is necessary within 10 days.

If a complete reassessment is needed, submit to GMCF to confirm Level of Care. Clearly indicate that this is a transfer with an expiring Level of Care through contact us or an agency note GMCF will issue a new Level of Care or denial.
The transfer agency will work with the admission agency to set the service Prior Authorization end dates so that the member has a seamless transfer process with minimal interruption in service.

Appendix F submission to DCH for SOURCE admission by the receiving agency is no longer required.

DCH reserves the right to request the evaluation packet and determine LOC.

Agencies should work together for a transition that allows time for GMCF approval.

Members transferring to another SOURCE EPCCM provider will be provided informed choice of providers/program prior to request for admission. One method used to secure informed choice is to involve the member, the previous agency/program staff, and the new agency to admit the member via conference call in order that all parties hear the member’s choice directly.

Please note the information below:

Current federal policy stipulates that persons may not be enrolled in more than one Medicaid case management program at the same time. Current DCH policy stipulates that persons may opt out of one case management program to enroll in another—it’s preferable at the end of a calendar month. SOURCE screening staff is responsible for review of member program participation through the HP web portal prior to initiation of the member face to face assessment. The member will be educated about services available in SOURCE versus his/her current case management program during the face to face assessment with the SOURCE nurse.
Carepaths

SOURCE utilizes Carepaths for a standardized sets of goals and expected outcomes, to develop a plan of care for SOURCE members. Carepaths, designed around indicators associated with chronic illness and impairment, are individualized plans written and implemented for each member. Carepaths, while not disease-specific, address risk factors held in common by people at the SOURCE Nursing Home Level of Care. The SOURCE Assessment nurse, with input from the case manager, is responsible for development of the member carepath at initial assessment and at each re evaluation.

Members and informal caregivers, service providers, Primary Care Provider staff, RN's/LPN's and Case Managers, together, implement the Carepath, adjusting the plan when necessary to meet key outcomes and goals.

The program uses Carepaths to:

a) Standardize case management practices
b) Identify roles for specific players
c) Identify gaps in self-care/informal support, creating a framework for paid SOURCE services
d) Target and analyze problem areas for individual members and across the entire program

SOURCE promotes member independence, self care and assistance from informal care givers. When appropriate, the case manager may coordinate education or training for members or informal care givers to teach direct care, patient education, and monitoring of chronic conditions. Self Care and informal support are reflected in the development and implementation of each carepath. At minimum, the member Carepath will address the following:

- Community residence (related to care path outcomes ie. keeping medical appointments, member satisfaction with services
- Nutrition/weight
- Skin care
- Key clinical indicators (blood pressure, blood sugar, weight monitoring and lab studies)
- Medication compliance
- Performance of ADLs and IADLs
- Transfers and mobility
- Problem behavior(s), if applicable
- Informal care giver support

Carepath addendums are available for care planning to meet housing goals/ outcomes to address incontinence issues. These additional care planning tools can be used with all members regardless of care path level. Agencies are to create their disease management profiles to meet member’s needs.
1002 Carepath Development and Completion

Carepath development requires that the CM/LPN/RN use information gathered from many sources to produce and maintain a consensus between members/caregivers and Primary Care Providers in order to meet individual and program goals. The Source assessment nurse and case manager will evaluate the member’s need for assistance with performance of hFis/her activities of daily living and instrumental activities of daily living, monitoring of chronic medical conditions and other areas which impact the member’s ability to continue living in the community. Evaluation begins with the referral and screening process through the initial assessment and continues for the duration of the member’s length of stay in the program. Assessment nurses and case managers will:

- Determine member formal and informal support, availability and reliability (Whenever possible, nurses/CM’s will meet with informal caregivers to discuss care planning)
- Add to SOURCE Carepath profiles when information is obtained from the member/family during the assessment
- Effective date and expiration date of the Carepath will be taken from the Prior Authorization dates given by GMCF.
- A new Effective date that services were restarted may be documented by a Case Management agency on the carepath if service is interrupted during an active Prior Authorization.
- Short term hospitalizations (less than 2 weeks), temporary moves, member initiated internal transfers, member need for different services, may be documented with a Carepath update and case note. Document service change on the Carepath with Physician Signatures
- A prolonged Span for hospitalization, nursing home stay, rehab stay, may meet requirements for a modified reevaluation. See section 905 Modified Reevaluation/Readmission into SOURCE
- Prior Authorization expiration dates are only given by GMCF
- Complete the Carepath within fourteen (14) days of the completion of the enrollment process which includes determination of level of care, physician signature, and is finalized by the RN signature. Present the Carepath at the Inter-Disciplinary Team (the Medical Director reviews the completed Carepath, recommends changes, as needed, and signs indicating approval). sign the cover page of the carepath with the date the carepath is completed
- Case management or Physician may add or delete services (with explanation) for the member on the carepath. Physician must indicate approval with signature and date.

See instructions for completing the Carepath document at the end of Chapter 1000.

NOTE: When a new service is required as the result of a change in member support or functional capacity; the physician signature and date on the Carepath will confirm his or her review and approval of the new plan of care.

1003 Completed Carepaths

Completed SOURCE Carepaths will have understanding and agreement from the member/care giver and the Primary Care Provider staff. The Case Manager will formally review the carepath goals every quarter.

Initial review of the carepath with the member confirms that:

Service Options Using Resources In Community Environments April 1 2016
member understands expected outcomes
- plan accurately describes self-care capacity and informal resources
- reimbursed services are offered at the appropriate level
- Information on community services that will enhance member’s wellbeing are provided as available and included on Care Path.

Case managers will review carepath goals during regularly scheduled contacts with the member to ensure that the plan is current and continues to support the member’s ability to remain in the community.

During the initial review of the individualized member carepath with the PCP or designee (PA, NP or RN), the following exchange of information will occur:

- PCP role in patient education and treatment
- monitoring of chronic conditions at home
- self care capacity/informal supports identified
- reimbursed services ordered

Upon completion of the PCP review, the CM will obtain the PCP’s signature on the completed carepath during the member’s first PCP conference following member enrollment /re evaluation. CM documents in case notes PCP recommendations. Subsequent PCP conferences will include review of variances of carepath goals.

Service provider review of Carepath allows provider agencies to:
- confirm the authorized service levels
- understand and acknowledge service provider role in supporting member carepath goals
- understand the member and caregiver role(s) in meeting carepath goals

Carepaths are discussed with provider on new enrollment/reassessments and with changes during provider meetings to ensure provider awareness of their role. MIF, referral, or other documented communication will be amended by the case notes as indicated to reflect changes in the carepath.

During regular monthly case management supervision conference, the SOURCE case management supervisor will review and sign completed carepaths for new members, reassessed members or those members with Carepath level changes.

1004. Carepath Formal Review

Case Managers formally review Carepaths each quarter with members and with Primary Care Providers. Formal reviews are conducted face to face. Based on Case Manager’s observation and information received from members or caregivers, Primary Care Providers, providers and/or other parties involved, goals are recorded as “met” or “not met.” For all members, every goal that is not met requires corrective action by the Case Manager (see Policies III A-E, Concurrent Review and Policy II F, Carepath Variances).

1005. Member Version

Each SOURCE Carepath is accompanied by an abbreviated Member Version that lists desired outcomes and the plan for achieving them. The member version includes formal/informal support caregivers. The document serves as an educational tool for members/informal caregivers throughout their participation in
SOURCE. Case Manager/LPN/RN will complete the member version carepath within (14) days of completion of the enrollment process.

Upon a new member’s admission, the Member Version will be faxed or mailed with the referral information to the service provider along with all other documentation as specified in 1401.

The member version carepath is reviewed with the newly admitted member at the first face-to-face visit. During that visit, the member signs this version, acknowledging understanding and agreement. Case manager signs to indicate explanation of the document and its contents.

Instructions for completion of Carepath document:

1. Complete member name and the effective date of the carepath. Effective date of the Carepath is the effective date of the PA.
2. Complete each page of the carepath by documenting which tasks will be performed.
3. Document the name of the individual responsible for performance of the task in the “responsible party” section.
4. Additional information for meeting goals is documented in the “Notes” section found on each page.
5. For issue specific goals, outside the scope of the carepath; CM will fully document the goals, plan and responsible party, using the final page of the care path document. Additional goals, outside the established Carepath outcomes must be approved by the Case Management supervisor, by signature and date. Each outcome/goal must be reviewed and progress documented at quarterly intervals.

When utilizing an additional carepath such as incontinence (Appendix R), the case manager or assessment nurse determines the need for its use and creates a plan. The effective date for an additional carepath is the date that the CM or nurse is adding the addendum.

Changes in the carepath must be documented in the Case Manager’s notes and on the Carepath document by drawing a single line through the previous entry with CM/nurse initials and date.
1100 Reimbursed Services

To implement the Carepath, the Case Manager will refer the new member for reimbursed services, if applicable. Information provided to the agency must be sufficient to allow for effective service delivery and accurate billing.

Procedures:

a) The Case Manager will follow rotation procedures as outlined in Appendix HH.

b) Due to the complexity of care involved, Case Managers will discuss new referrals by phone or in person, for the following service categories:

(1) Personal support/extended personal support
(2) Adult Day Health
(3) Alternative Living Services
(4) Home Delivered Services

d) Home delivered meals and emergency response system referrals will not require a phone call prior to making the referral in writing.

e) The Case Manager will complete the SOURCE Referral Form.

f) In addition to demographic information, the Referral Form must include specific units of service requested and the Authorization Number.

g) Additional information pertinent to service delivery for an individual member will be noted in the “Comments” section at the end of the Referral Form.

h) All providers will also receive copies of the following which are maintained as part of the SOURCE member clinical record:

   o The MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T)
   o SOURCE Level of Care and Placement Instrument (Appendix F)
   o Level of Care Justification (Appendix I)
   o The SOURCE Carepath
   o Member Version Carepath (unsigned version maybe sent initially, CM must send signed version within 10 days of signature procurement)
   o Rights and Responsibilities
   o Authorization for Release

i) Providers will send the Case Manager a Member Information Form confirming the service level and the date services will begin.
j) If the Member Information Form does not match the Initial Referral Form, the Case Manager will call the provider to clarify the referral.

k) Changes in service level will require the following steps:
   (1) The Case Manager will confirm the appropriate service level by assessment to determine that a different service level is required to meet Carepath goals.
   (2) The Case Manager will review the recommended service change(s) with his/her supervisor.
   (3) If the supervisor approves the change, the Case Manager will authorize the new service level in writing, by completing the Member Information Form and sending a copy to applicable providers.
   (4) The original Member Information Form is filed in the member's chart.
   (5) The Case Manager will amend the Carepath and the Member Version as indicated, forwarding an updated copy to the member/caregiver and the Primary Care Provider

NOTE: Member Information Forms (Appendix W) are acknowledged, in writing by the receiving agency and returned to the initiating agency within three (3) business days.

l) Changes in paid assistance will be documented in the Case Manager's notes and on the Carepath, by drawing a single line through the earlier Carepath entry, and initialing and dating the current entry. See also Section 1405, Right to Appeal (regarding decreasing or terminating services).

All HCBS providers must first be enrolled as a CCSP provider for the same services for 6 months prior to providing SOURCE services. SOURCE providers must provide the community based services that are listed on their SOURCE Referral Form from the SOURCE Enhanced Case Management. Any altering of this form is subject to dismissal as a SOURCE or Medicaid provider or may hinder reimbursements.
1200. Carepath Variances

Simply stated, a variance is when an expected outcome doesn't occur. In SOURCE, a variance describes a Carepath goal not met by a member at any point during a quarterly review period. For any goal not met, corrective action by the Case Manager is required. The Case Manager will act quickly to help members resolve variances, to prevent further complications that may jeopardize health or functional status.

Procedures:

a) Case Manager will identify the variance, recognizing problematic issues as goals not met and uncovering the source(s) of the problem.

b) Case Manager will act to resolve the variance. Specific steps taken will depend on the member’s individual circumstances, and on which goal was not met and why. Examples of corrective action may include:
   - Arranging patient education for the member or informal caregiver
   - Scheduling an appointment with Primary Care Provider
   - Increasing service levels or changing service categories
   - Coordinating with provider on service delivery issues

c) The Case Manager will document all variances appropriately:
   (1) The Case Manager will indicate “not met” in the Carepath quarterly review column for that goal.
   (2) The Case Manager will complete a Variance Report form to indicate the source of the variance and specific corrective actions taken.
   (3) If the variance was discovered or noted before the quarterly home visit, the Case Manager will also indicate the variance on the Contact Sheet in the Monthly Contact section as applicable.
   (4) If the variance was discovered or noted at the quarterly review home visit, indicate the variance on the Contact Sheet Quarterly Review section.
   (5) If the variance was discovered at the Primary Care Provider conference, indicate the variance on the Contact Sheet Primary Care Provider conference section.

d) The Case Manager will further document corrective actions in the member’s case notes, on the Member Information Form to providers approving service level changes, on the Carepath if a change to the plan was made, etc., as applicable.

e) The Case Manager will discuss and document variances with the PCP on the quarterly contact form and other service providers as applicable.
f) For variances repeating for a second quarter or longer, the Case Manager – in conjunction with the case management supervisor or program administrator– will increase efforts and resources employed to resolve the variance.
1300. **Concurrent Review**

Communication is key to the SOURCE concept of integration. Defined formally in the program as concurrent review, there are four fundamental principles to SOURCE communication:

- Preventive efforts will be effective and current
- Problems will be quickly identified
- Action will be promptly taken by the appropriate parties to resolve problems
- Resources will be appropriately targeted for maximum results and cost efficiency

Case Managers and Carepaths are at the core of concurrent review in SOURCE. To reach the program’s stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Primary Care Providers, program supervisors, and if applicable, providers; Carepaths provide guidance and formal structure for the concurrent review process.

All key players in SOURCE may possess information on the member’s current condition and on Carepath variances; however, by virtue of increased contact, familiarity or specific skills, each contributes unique perspectives as well:

**Members/CG:** current condition (primarily self-report); preferences; capabilities; household dynamics/informal support

**Primary Care Providers:** clinical condition, recommended treatments and compliance; information from diagnostic procedures, specialist visits, etc.

**Providers:** current condition as observed by trained staff; household dynamics/informal support as observed externally

In addition to the program’s key players, concurrent review includes other entities as appropriate, on an individual basis (example: dialysis center patients) or for a limited period of time (example: hospitalizations).

The job of the Case Manager and his or her supervisor is to analyze and use all information received to help the SOURCE member stay as healthy as possible and to meet Carepath goals.

Communication with key players falls into two categories: scheduled or PRN (as needed in response to recognized triggers). Scheduled contacts serve as an overview for key players, an opportunity to spot patterns or trends and respond preventively. PRN contacts more typically address individual issues as they arise.

1301. **Scheduled Contacts with Members**

The Case Manager will regularly initiate contact with the members/caregivers, and will make follow up contacts as needed with providers, Primary Care Providers, etc., on a member’s behalf.
The Case Manager will also respond to calls initiated by SOURCE members/caregivers or on behalf of members, again taking follow-up steps as necessary. While minimum standards for contact are described below, the Case Manager will communicate with or on behalf of members as often as necessary to meet Carepath goals and to stabilize or improve health status.

Direct contact between members/caregiver and providers or Primary Care Providers also occurs frequently in the model; the Case Manager encourages engagement of the members/caregivers to the fullest extent possible in working toward optimal health and functional status.

Scheduled contacts with members/caregiver will occur according to the following timetable, at a minimum. The Contact Sheet and the Carepath will be used to record scheduled member contacts, appended by member case notes as necessary.

Monthly case notes must reflect what type of contact the Case Manager had with the member and a summary of what was discussed. Quarterly case notes must reflect review of member’s Carepath, which will include goals not met, and a plan of improvement/correction. Case notes must reflect follow up to assure the plan is working, and resolution of identified problems.

1302. Procedures for Scheduled Contacts:

a) SOURCE Service Confirmation: The Case Manager will confirm initiation of services with the SOURCE member within two weeks of referral. The CM will take any follow-up steps required if services have not begun. Service referrals and confirmation will be indicated in case notes, on a Member Information Form (MIF) or on a SOURCE Referral Form.

b) Monthly Contacts: The Case Manager will contact all members a minimum of once each month, to be documented on the Contact Sheet and in case notes if necessary.
   (1) The Case Manager will indicate the method of contact (phone, home visit, other).
   (2) The Case Manager will review goals of the Carepath with the member/caregiver and will ask the member/caregiver to report any additional health or functional status issues, including initial PCP visit as applicable. On the Contact Sheet goals that are met will be checked; goals not met (variances) will be circled.
   (3) For Carepath outcomes with multiple goals, the Case Manager will indicate which particular goal was not met.
   (4) The Case Manager will take appropriate follow-up actions as indicated.
   (5) The Case Manager will sign and date the Contact Sheet for each monthly contact.
   (6) Monthly contacts will be documented by the Case Manager on the contact sheet, appended by case note entries if required for complete
c) **Quarterly Reviews:** The Case Manager will formally review Carepath goals every quarter.

1. At the member’s home, the Case Manager will review goals of the Carepath with the member/caregiver. Goals will be documented as “met” or “not met” and dated in the third column of the member’s Carepath. On the Contact Sheet, goals that are met will be checked; goals not met (variances) will be circled.

2. The Case Manager will review the existing Carepath plan, making updates as indicated due to changes in health/functional status of the member, informal support changes, etc.

3. For a goal not met, the Case Manager will discuss with the member/caregiver options on how best to resolve variance.

4. The Case Manager will ask the member/caregiver to report any other issues potentially jeopardizing health or functional status.

5. The Case Manager will observe the member’s household for cleanliness and safety.

6. Quarterly contacts will be documented by the Case Manager on the contact sheet, appended by case notes if necessary.

7. Following the home visit, the Case Manager will review additional information from Primary Care Providers, providers, etc., on Carepath variances for individual members. It is recommended at the 3rd quarterly visit the Case manager works with member and PCP to have a functional assessment exam scheduled, completed and documented. Submit to GMCF for annual re-evaluations.

8. The Case Manager will follow policy for Carepath variances.

9. The Case Manager will take any additional follow-up actions indicated by the quarterly review.

10. Changes to the Carepath plan will be documented, dated and signed by the Case Manager on the Carepath and the Member Version.

11. New copies of the amended Member Version will be provided to:
   - The member
   - The Primary Care Provider
   - All Providers

Re-evaluations: A formal re-evaluation will be completed for all members annually at minimum. These will be submitted to GMCF following instructions in section 904:

1. RN/LPN will complete the MDS-HC (V9) level of care assessment and the Case Manager/RN/LPN will complete the SOURCE Assessment form or another DCH approved Assessment tool. A new Records Release Authorization and Member Rights and Responsibilities must be signed and dated.

2. The Case Manager will review the existing Carepath plan, services and any issues jeopardizing the health or functional status of the member at the re-evaluation, following the procedures for quarterly reviews.
A new Carepath will be developed and reviewed for each member, following procedures from Policies II A, Self-care and Informal Support, II B, Completing the Carepath Document and II C, Initial Review of the Carepath.

The level of care will be reviewed by the Case Manager and confirmed by the Primary Care Provider or the Medical Director signature on the new Carepath, attesting to the member’s current health and functional status. A new Level of Care form is initiated for the new member and member’s who are due reevaluation (annually or more often as needed) by the RN/LPN with the use of the MDS-HC (v9) (see Appendix S) and Level of Care Justification form.

GMCF or DCH will validate Level of Care with the complete assessment package submitted by the Case Management Agency as of 9/30/2013.

Recommended changes in the Level of Care will be reviewed by the site’s multidisciplinary team as determined by the MDS-HC assessment as conducted by the RN/LPN.

The R.N. and Medical director signature on the Level of Care form (Appendix F) should follow (as of 9.30.2013) after GMCF validation with multidisciplinary team review and confirmation.

The re-evaluation will be further documented on the Contact Sheet by completing the annual re-evaluation section.

The Case Management Supervisor will review and sign the new Carepath at the next monthly supervisory conference for each member.

Annual evaluation packets on members determined by the RN and the multidisciplinary team NOT to meet LOC do not have to be submitted to GMCF. An Appendix Z Reduction... termination and denial form should be sent as soon as possible and if no legal action is taken. All service Prior Authorization lines should be ended if no legal action is taken. As always, the SOURCE Case Manager follows the instructions in Appendix Z and ensures completion, the SOURCE agency notifies the member and makes sure any questions are answered.

It is strongly recommended that at the Case Management 3rd quarter F2F visit, the Member is assisted to make a functional assessment appoint with their PCP. The functional assessment document should be given with explanation to the PCP for this visit and upon completion, submitted to GMCF. See appendix NN for approved form.

1303. **Scheduled Contacts with Primary Care Provider**

**Case Manager-PCP**

Primary care providers will routinely conference with the Case Manager to exchange information on the current status of the member, identifying problems quickly and targeting resources (informal and paid) effectively to resolve them.
Areas discussed and PCP recommendations are to be documented on the contact form or in the case notes. Special attention should be given to any problems, variances and all sentinel events the member may have had since the last quarterly meeting. If the member has an Annual reevaluation scheduled in the next 3 months, concurrence with diagnosis, medications, and functionality should be discussed and documented with the PCP.

**Procedures**

Rev. 10/12

For all SOURCE members, formal conferencing between the Case Manager and the primary care provider will take place at least quarterly. The conference may take place at any point during the quarter for an individual member. Members/caregivers do not typically attend the conferences but may in the case of member compliance problems as a strategy to improve compliance with the medical or HCBS care plan.

**NOTE:** A Primary Care Provider may utilize physician assistants (PA) and/or nurse practitioners (NP) within the scope of his or her practice to manage and treat patients. If PA provides routine medical care to the SOURCE member assigned to the practice, under the supervision of a PCP, the PA is permitted to participate in the quarterly conferencing.

A. The site will provide a list of the patients due for conferencing, with sufficient time for the PCP office to schedule and prepare for the conference.

B. The Primary Care Provider office will have patient charts pulled for the conference and will have ancillary staff (typically nursing staff) attend.

C. For established members review the following, noted by PCP or Case Manager or RN/LPN since last conference, as applicable:

- Changes in health or functional status (including LOC changes)
- Sentinel events with PCP recommendations documented
- Carepath variances, with corrective actions discussed
- Changes in Carepath since last conference
- Equipment/supply needs
- Other factors jeopardizing continued community residence
- Repeated hospital encounters, inpatient or emergency department
- Administration of flu or pneumonia vaccines, when applicable
- PCP concurrence with level of care within 3 months of annual reevaluation

D. For new members: Review Carepath and significant findings from the initial PCP visit.

E. PCP will sign and date new member Carepaths.

F. Recommendations by the Primary Care Provider – including changes to Carepath plan – will be noted by the Case Manager in the PCP Conference section of the Contact Sheet for discussion with the member. Extensive comments will be noted in the member’s case notes. Notes from PCP conferences may also be kept in a separate notebook.

G. Variances noted will be marked by circling the appropriate goal in the
PART II - CHAPTER 1300

CONCURRENT REVIEW

1. Primary Care Provider Conference section of the Contact Sheet / sentinel events that have occurred since the last discussion with the PCP will be reviewed and documented.

H. The Primary Care Provider and the Case Manager will sign and date the
   i. Contact Sheet in the PCP Conference section for all members.

I. Participating Primary Care Provider, PA, NP, or RN will attend conferences in person; additional PCP office staff (typically nursing personnel) may attend as indicated.

J. The Case Manager Supervisor will decide staffing at Primary Care Provider conferences; all Case Managers may attend PCP conferences, or a representative from the case management staff may be designated if information is provided on current status of members from all caseloads.

K. The Case Manager designated will review all PCP recommendations with appropriate case management staff, following the conference.

L. The Case Manager working with a member having chronic Carepath variances will attend the PCP meeting in person to discuss possible resolution, as applicable.

1305. Scheduled Contacts with Service Providers

In addition to the four principle themes of concurrent review described earlier, scheduled contacts ensure that the SOURCE Enhanced Case Management and providers share the same understanding of service levels and responsibilities.

1306. Procedures for Scheduled Contacts with Direct Service Providers

Member initial referrals, discrepancies, discharges:

a) Initial Referrals: see SOURCE-Reimbursed Services.

b) All providers with members will submit to the site monthly reports of actual services delivered.

c) For members with services not delivered as ordered by the Case Manager, providers will include a brief explanation (hospitalization, service canceled by member or Case Manager, transportation problem, agency failure, etc.).

d) Each month, the site will reconcile the report with the actual services ordered.

e) Discrepancies will be identified and the site will follow-up as indicated with the provider, member/caregiver, etc.

f) For services over the level ordered or authorized by the site, the provider will complete an Adjustment Request Form to accompany refunds to the State for any
PART II - CHAPTER 1300
CONCURRENT REVIEW

reimbursement for unapproved services (Note: CM may temporarily authorize community support services differing from the ordered hours, for a specific period of time and documented on a MIF; see SOURCE-reimbursed Services).

g) The provider will copy the Adjustment Request Form to the SOURCE Enhanced Case Management.

h) The site will send a correction in writing to the provider (using a MIF), listing the actual level of services authorized.

i) Due to complexity of care involved, . Monthly conferences will take place with new services providers (as listed below) rendering services to a SOURCE agency’s members for less than or equal to 6 months and who actively provide the following services to a member:

- Adult Day Health
- Personal Support/Extended Personal Support
- Alternative Living Services

j) Quarterly conferences will take place with providers serving a site’s members for greater than 6 months of service delivery, unless otherwise specified on the SOURCE Case Management Internal/External Complaint Log, for these services

- Adult Day Health
- Personal Support/Extended Personal Support
- Alternative Living Services

NOTE: With the agreement of both the SOURCE Site (EPCCM) and the provider, conferences may take place either face to face or by a mutually agreed upon electronic method. . Provider conferences will include for members served by the agency, efforts to resolve:

- Member Carepath variances and sentinel events
- Potential nursing home placement
- Member service issues and service delivery complications
- Discrepancies in services ordered/authorized
- Provider performance issues
- Provider training and education needs
- Review of documentation needs for the service provider’s member record and provision of same

j) The site will maintain written minutes from the conferences. Minutes will be maintained in one central location and sites may choose to document individual member’s file for additional information as well.

k) The Case Manager will provide follow-up action necessary following provider conferences (examples: communicating with family to ensure that adequate food or supplies are available, following up with members not home for service, discussing with Primary Care Provider a referral for behavioral care for an ALS resident, etc.)
l) Following completion of the annual re-evaluation for each SOURCE member, the case manager will send to each provider the updated Member Version of the Carepath. Changes in service units or schedules or significant changes in responsible parties will be accompanied by a MIF to provider affected.

m) For discharges initiated by the SOURCE Enhanced Case Management, the provider will confirm notice of a service discharge by sending a completed Member Information Form (see Appendix W) to the Case Manager.

n) For discharge of a member initiated by the provider, the provider will notify the site of a discharge using the Member Information Form. Discharge by a provider should ONLY occur after:

1. The provider has exhausted all possible avenues to resolve issues complicating service delivery
2. The provider has included the site in attempts to resolve issues complicating service delivery, from the initial identification of a problem
3. The provider has followed waiver requirements for giving notice prior to a discharge date

1307. Scheduled Contacts with Case Management Supervisor

A formal supervision process supports the Case Manager in negotiating complex situations among multiple parties. Case Management supervision serves four main functions, ensuring that:

- The Case Manager has benefit of the supervisor’s additional experience and perspective
- The Case Manager has administrative support in making difficult decisions
- Individual member’s Carepath goals are met
- The program’s direction is sustained

1308. Procedures

a) The status of high risk members will be reviewed by the Case Manager and Case Management Supervisor at least monthly, to:

- Discuss Carepath variances and subsequent corrective actions
- Update support service plans as necessary to meet Carepath goals
- Analyze repeat hospital encounters
- Resolve other issues possibly jeopardizing health or functional status
- Review and sign Carepaths for new and re-assessed members
PART II - CHAPTER 1300

CONCURRENT REVIEW

b) The site will maintain written minutes from the conferences. Minutes will be maintained in one central location and site may document on the individual member’s charts.

c) Recommendations on changes of the Carepath level or Level of Care will be included in supervisory meetings.

(1) The Case Manager will request the RN/LPN complete a new Level of Care Assessment using the MDS-HC.

(2) The Case Manager will present the LOC change for review and approval by the multidisciplinary staff committee; the SOURCE medical director or PCP will sign the Carepath, confirming the new service level or the APPENDIX F to demonstrate the interdisciplinary team’s agreement that the member does not meet LOC.

d) Recommendations for changes in Carepaths will be reviewed at supervisory meetings. The Case Management Supervisor will approve all changes in service plans (see SOURCE-Reimbursed Services).

e) The Case Management Supervisor will sign the Contact Sheet within thirty days following the quarterly home visit.

1309. PRN Contacts

Problems complicating the lives of people with chronic illness may not coincide with scheduled monthly or quarterly Case Manager contacts. The SOURCE model places responsibility on Case Managers to ensure that communication with or between the right players happens at the right time to meet program and Carepath goals.

Communications with members (and subsequent follow-up actions) that fall between scheduled contacts are made in response to member need. While most such contacts fall into areas related to clinical/functional status or service delivery, members may also contact Case Managers about eligibility, housing, items not covered by third party payers, etc. – in short, any issue potentially jeopardizing their ability to continue living in the community.

Access to Primary Care Providers – as needed to manage clinical or behavioral complications of members – is a cornerstone of the program. Effective Primary Care Provider participation is key in helping Case Managers extend the limits for chronically ill people living safely in the community. Given the vulnerable nature of the population SOURCE serves, Primary Care Provider response to unscheduled interactions must be characterized by promptness, creativity and perseverance in problem solving.
Providers (particularly PSS/EPS, ADH and ALS) frequently develop a close relationship with members/CG for several reasons:

- The frequency with which they encounter members/CGs
- The intensely personal nature of community services
- The social isolation of some members

Given these factors, participating providers are in an unrivaled position – and have an unrivaled responsibility – to assist members by ensuring that communication channels stay open.

Communication with the Case Manager Supervisor around identified triggers is also critical, allowing the Case Manager to share the substantial responsibility of making decisions and taking actions that best support members in community living.

**Procedures:**

1. All key players in the program will be encouraged to report to Case Manager’s any issues that threaten a member’s health status or ability to live in the community.

2. All key players will be educated on using the SOURCE 24-hour phone number for case management and primary care assistance offered from the site.

3. All key players will identify a key contact person to facilitate communication for SOURCE members (may be the actual member, as indicated).

4. The individual SOURCE CM assigned to a member is the contact person identified for key players.

5. Triggers for PRN communication between players are:
   - Carepath variances
   - Potential nursing home placement
   - Hospital encounters—inpatient or emergency department
   - Acute illness/exacerbation of chronic condition
   - Significant change in function—physical or cognitive
   - Suspected abuse or neglect
   - Service delivery complications
   - Housing/other residential issues
   - Family dynamics/informal support changes
   - Transportation needs
   - Member’s desire to appeal a Case Manager decision Other factors jeopardizing health/functional status or community residence

   Additional PRN communication with PCPs includes:

   - New patients with SOURCE (review Carepath; file copy on chart)
PART II - CHAPTER 1300

CONCURRENT REVIEW

- Episodic/acute illness or exacerbation of chronic illness
- Medical triage/advice
- Referral to/communication with specialists (or ancillary services, diagnostic, etc.)
- Scheduling appointments
- Urgent equipment/supply needs
- Pharmacy/prescription needs

6. Triggered information will always flow from other key players to the CM.

7. If a specific CM is unavailable, the key player can relate information to the CM on call or to a CM supervisor.

8. Triggered information will flow from the CM to key players as indicated to resolve problems and achieve Carepath goals; in the interest of member privacy and staff energy, care will be taken to involve only player’s essential in resolving/preventing a specific problem.

9. Case Manager’s will document PRN contacts and follow-up actions in a member’s case notes, on Contact Sheets or on Carepaths as indicated.

10. Case Manager’s will take any follow-up actions indicated to resolve outstanding issues (see also Policy II F, Carepath Variances), facilitate services or prevent further complications. Examples of follow-up actions includes:
   - Changing Carepath levels, increases or decreases
   - Evaluating functional changes by a home/hospital visit
   - Scheduling a medical appointment
   - Arranging a family conference to resolve care giving responsibilities
   - Making transportation arrangements
   - Referral for DME
   - Assisting member in obtaining non-covered supplies
   - Changes in Level of Care as determined by MDS-HC

11. Changes in service level will require approval by the Case Manager and the Case Manager supervisor or program manager.

12. The Case Manager will communicate changes to the provider on the MIF (see Appendix W); a return MIF from the provider confirming the new service level is required.

13. For communication with or on behalf of members falling between scheduled monthly or quarterly contacts, the Case Manager will use a case note narrative format with the contact’s name, date and manner of exchange (phone, home visit, etc.) and a brief description of the exchange (see Definitions, Case Notes). Examples include contact regarding service delivery, arranging transportation, etc. Problems, follow-up
1310. Disease State Management

The SOURCE Disease Management design primarily employs Carepath variances to identify high-risk patients within the program, and incorporates traditional DM protocols of tracking, education and self-management into the existing SOURCE structure and processes. DM principles are consistent with the SOURCE focus on outcome measures, primary medical care, regular feedback to all key players and the inclusion of informal support in providing care.

DISEASE MANAGEMENT STRATIFICATION/INTERVENTIONS:

1. SOURCE will primarily identify members requiring the new level of disease management using two criteria: diagnosis and variances. (Additional avenues into disease management will be noted at the end of the stratification section.)

2. All sites will have an internal mechanism for indicating on member charts the current DM stratification level.

3. Disease states targeted include diabetes and hypertension, with additional conditions as identified by the Department of Community Health.

4. Variances targeted:

   All Disease States
   - Clinical indicators (BS, BP, weight as indicator of illness, lab values)
   - Nutrition Goal B. (diet recommended by PCP)
   - Medication compliance

   Dementia/Mental Health – additional variance
   - Behavior Goal B. (problem behavior management)

   Obesity – additional variance
   - Nutrition Goal A. (weight posing critical health risk)
PART II - CHAPTER 1300

CONCURRENT REVIEW

Members identified for high-risk disease management must meet both the diagnosis criteria and the variance criteria described below.

5. SOURCE uses three levels of stratification (low, medium and high) based on variances. Each level of stratification will involve applying escalating resources. While the first two levels (low and medium) will receive patient education around their disease states, only the third level (high risk) will be included in the full disease management program.

   A. **Low risk** – well managed (i.e., meeting Carepath goals, no variances)

   **PLAN:**
   - Conventional SOURCE enhanced primary care case management for preventive measures

   **INTERVENTIONS:**
   - Protocols
   - Carepath development
   - Concurrent review
   - Member education on targeted disease states
   - Time frame – at first quarterly home visit following enrollment

   **TRACKING:**
   - Carepath outcomes
   - Hospital encounters
   - Time frame – formally recorded each quarter

   **DURATION:**
   - Preventive efforts - ongoing for length of stay in SOURCE

   B). **Moderate risk** – occasional variances of targeted Carepath goals

   **PLAN:**
   - Conventional SOURCE enhanced primary care case management with PRN response to individual variances. Review of variance and options for corrective action by case management supervisor and SOURCE PCP. Adjustment of Carepath plan as indicated.

   **INTERVENTIONS:**
   - Protocols
   - Carepath
   - Concurrent review
   - Variance protocols (corrective action)
   - Member education on targeted disease states
PART II - CHAPTER 1300
CONCURRENT REVIEW

- Time frame – at or before next quarterly home visit

TRACKING:

- Carepath outcomes
- Hospital encounters
- Time frame – formally recorded each quarter

DURATION:

- Corrective actions - until resolution of Carepath variance; preventive efforts - ongoing for length of stay in SOURCE

C). High risk – members with three consecutive variances of the same targeted goal*

PLAN:

Conventional SOURCE EPCCM; review by case management supervisor, PCP and medical director for chronic variances; disease management for targeted conditions

INTERVENTIONS:

- Protocols
  Carepath
  Concurrent review
  Variance protocols
  Evidence-based practice protocols/tracking logs
  Self-management goals
- Member education
  Time frame: additional home visit at next monthly contact (replaces phone contact) following identification of consecutive variance

TRACKING:

- Carepath outcomes – formally recorded each quarter
- Hospital encounters
- Clinical outcomes specified by EBP protocols on tracking logs for targeted condition

DURATION:

Resolution of variance(s) and/or recommendation by PCP

*Sites may also choose – on a case by case basis – to review members for high-risk disease management of targeted conditions under the following circumstances.
Hospitalizations – repeat encounters, within 30 days

New admissions into SOURCE, based on history of poorly managed chronic condition

New onset of a targeted condition

PCP recommendation based on poor management of a targeted condition.

Targeted variances other than three consecutive variances of the same goal, with site recommendation (example: sequential variances but not of the same goal; simultaneous variances within a quarter, etc.)

Prior to implementing high-risk DM under any of the alternative routes described above, the DM referral shall be reviewed by the CM supervisor and the site Medical Director.

HIGH-RISK DISEASE MANAGEMENT:

1. In addition to meeting established stratification criteria, the member’s PCP must also concur that the member is appropriate for high-risk DM. At any point during high-risk disease management, the PCP may also recommend DM disenrollment based on non-compliance or other clinically complicating factors.

2. Tracking logs will be completed to the best of the CM/PCP team’s ability. Information requested that is not available will be so indicated on the tracking log, in the appropriate section. To indicate that a protocol was not followed (example: no foot exam performed at an office visit on the diabetes log), a straight line should be drawn across the appropriate section.

3. Self-management goals are educational materials that do not require PCP signature but are considered generically applicable to all SOURCE members on high-risk DM.

4. PCPs will indicate review of any applicable DM tracking logs by signature on the SOURCE contact sheet in the PCP conference section (amended contact sheets will include a statement to that effect).
5. SOURCE Case Management Provider will promote use of evidence-based practices by key players in the following ways:

a). Track key protocols – SOURCE DM tracking logs for targeted conditions
b). Track key clinical measures – SOURCE tracking logs for targeted conditions
c). Track self-management goals for targeted conditions
d). CM and PCP are a team in monitoring indicators. Tracking tool will be kept in CM chart, optionally in PCP chart as well
e). Medical Director/PCP blanket sign off on education plan/self management goals – CMs to reinforce PCP recommendations with educational material; clinical questions referred to PCP
f). Education initiatives for CMs
   Basic explanation of disease process
   Education on materials to be used
   Commonly asked questions
   Education on protocols
g). Standardized education materials written for potentially low-literacy population:
   Brief, Simple, Large type
   Emphasize small changes in lifestyle
   Meaningful in laymen’s terms

6. To facilitate self-management of condition, sites will, as feasible:

a). Include key players in education and management of condition
   Member
   Informal caregivers
   SOURCE providers
   Provide PSS/ALS/ADH providers with education recommendations
b). Ensure proper equipment

Examples: 1-Touch
log book
scales       diet/food diaries
exercise logs

7. Routine reporting and feedback will be accomplished in SOURCE by incorporating DM issues and protocols into the conventional concurrent review process - scheduled and PRN.

- Member/caregiver contacts
  Additional education visit at outset of DM
  Monthly contacts
  Quarterly home visits
- Weekly medical director meetings as indicated
- Quarterly PCP meetings (including clinical measures and protocol reviews)
- Monthly provider meetings
- PRN contacts as needed with all key players re: adherence to protocols, education issues, other follow-up

8. Collaboration among providers will be ensured via:

a). Incorporating disease management into existing concurrent review processes (see above)
   Key players
   Ad hoc players (skilled nursing, hospital CM or d/c staff, etc.)

b). Considering as appropriate use of skilled nursing in patient education and tracking (Medicare, Medicaid or waiver HDS)
c). Incorporating meeting DM goals into concurrent review, as well as Carepath outcomes

9. The following outcomes measures will be employed through SOURCE disease management:

a). Carepath outcomes (targeted goals – see Section 1310, No. 4)
b). Clinical measures from tracking logs for targeted conditions
1400. Provider Performance Monitoring

To function effectively and assist members in meeting program goals, all key players in SOURCE must provide accessible, effective and reliable service. Enhanced Primary Care Case Management providers will comply with all monitoring and reporting activities as required by the Department of Community Health/Division of Medical Assistance. Sites are responsible for routinely monitoring the performance of network providers, both Primary Care Providers and HCBS agencies.

Procedures:

SOURCE Case Management Sites

DCH Long Term Care Unit may require a Corrective Action Plan (CAP) for non-compliance in the following areas. Please see the referenced sections for compliance requirements:

- Source Programmatic Report (See Appendix JJ). (monthly)
- SOURCE Case Management Team Meetings Documentation (See section 806)
- Management of Community Service Provider Performance (See section 807)
- Program admission procedures: submitting all documentation to GMCF (See section 903)
- Program admission procedures: documents submitted to providers (See section 903)
- Care Path Formal Review Documentation (See section 1004)
- Member Forms in Chart; forms present and documentation complete (See section 1300)
- Scheduled Contacts with Primary Care Providers (See section 1305)
- Disease State Management Initiation and Tracking and Intervention Logs (See section 1308)
- Maintaining 24 hour call system: documentation and maintaining system (See section 1402)
- Hospital tracking and intervention Logs (See section 1308 and 1403)
- Utilization Management oversight documentation (See section 1401)
- Standards of Promptness (See Appendix H)
  Including submissions to GMCF are prior to level of care expirations (timely)
- Discharge planning documents: Complete and Comprehensive discharge planning documentation (See appendix Z6-8 and section 806)
- Guardian notification occurs as outlined (See 902 Procedures (d) and 1406 Right to Appeal)

DCH may require a Corrective Action Plan (CAP) for non-compliance. Sites must submit a CAP within 14 calendar days of notice of non-compliance and Corrective Action Plan. If an approved CAP is not properly applied or executed, DCH may impose additional sanctions ranging from new member suspensions up to suspension of participation as a Case Management Agency. The areas listed above are frequently requested areas, SOURCE Case Management Companies are still required to follow all SOURCE policy.
**HCBS Providers (Home and Community Based Services Providers) will be monitored by SOURCE Case Management for the following (including information found in Appendix HH as of 7.01.2013):**

- Services delivered as ordered by the case manager, including – as applicable – units of service, service schedule, tasks, time frame, personal preferences as feasible, etc.
- Prompt and effective communication with sites and members/informal caregivers, at all points during a member's tenure with a provider, as described in Concurrent Review Policies No. 1306 and 1309
- Commitment to serve members with challenging personal situations or diagnoses
- Demonstrated efforts to serve manpower shortage areas
- Willingness to flex service levels as authorized by the case manager, in response to the complex or unpredictable status of individual members
- Customer satisfaction standards that exceed basic licensing requirements; specific areas of accountability include:
  - Reliability of service
  - Competency, compatibility and consistency of staffing (where applicable)
  - Responsiveness to member and staff concerns, including Carepath variances
  - Complete and timely submission of monthly service delivery reports and resolution
  - Continued status in good standing as a Medicaid provider
  - Adequacy of on-call arrangements for after-hours and weekends

**Note:** More Information on Provider Performance Monitoring and Corrective Action by CM agency to HCBS providers, including removal or suspension from the rotation list can be found in Appendix II

Monitoring methodologies for HCBS providers include but are not limited to the PSS/EPS service delivery score, the Case Management Complaint log and the quarterly Carepath goal related to satisfaction with all HCBS services.

**PCPs will be monitored by sites for the following:**

- Appointments – ease of scheduling, initial visit and ongoing appointments
- Conference logistics – scheduling, preparation, wait time, space
- Conference – adequate time allotted quality of PCP participation in discussion and grasp of SOURCE, etc.
- PRN contacts – accessibility (response time of PCP and/or office staff); effectiveness of PCP and office response; on-call response; appropriately identifies existing patients needing referral to SOURCE
- Disease management – accessibility of clinical data required and quality of participation in discussion

4. HCBS providers or PCPs not performing in accordance with standards set by the site or by the DCH SOURCE policy and procedure manual may be subject to review for continued participation with the site.
1401. **Utilization Management**

As stewards of significant state funding via the authorization of HCBS services, SOURCE Case Management Provider must ensure that the value of Medicaid’s long-term care dollars is maximized. Sites will develop an internal system of monitoring and managing utilization of authorized home and community based services.

**Procedures:**

1. Case managers will capitalize on self-care capability and informal support whenever feasible, and family care will be supplemented rather than replaced. Case managers will facilitate informal support with training and equipment as necessary.

2. At the site’s admission committee, the case management team (including the medical director) will review recommendations to ensure the appropriateness of each service category; generally, least restrictive setting or service to achieve goals is preferred by members and is often less costly.

3. Sites will work to maintain function and overall health by addressing areas that may lead to increased impairment and higher HCBS costs – effective medical care, adequate housing, Carepath goals (nutrition, medication adherence, etc.).

4. Case managers will use creativity in developing Carepath plans, employing community resources other than Medicaid-reimbursed services that will contribute to meeting Carepath goals.

5. Sites will maintain case manager awareness of the relationship between age and/or progressive illnesses and the increased need for paid services; case managers will develop initial Carepath that are sufficient to meet goals but do not have extra capacity, to ensure that members may receive additional services if their level of impairment or informal support changes.

6. Sites will benchmark service plan costs by level, according to site averages or using information provided by the Department of Community Health for all SOURCE Case Management Provider.

7. Upon admission, sites will calculate service plan costs for comparison to the benchmarked standards.
8. Outliers will be reviewed further by the medical director, site manager and case management supervisor. Adjustments to service plans will be made when appropriate; balancing costs of care with achieving program and Carepath goals.

9. Sites will develop an internal method for the ongoing identification of outliers that exceed benchmarked standards established by the site or by DCH. Triggers may be service costs, units of service, etc.

Rev. 07/09, 10/09
10. Upon completion of enrollment and initiation of services, case manager will provide the following documents to all community service providers:

- The MDS-HC with Medication List, and Appendix T
- SOURCE Assessment Addendum C1-5,
- SOURCE Level of Care and Placement Instrument (must contain required signatures and date of signature)
- Level of Care Justification (Appendix I)
- The SOURCE Carepath detail (Appendix J, L, or N)
- Member Version of the Carepath (initial paperwork may be an unsigned version, signed versions must be sent after member signature procurement)
- Rights and Responsibilities
- Advance Directives if available to Case Management (See Section 903 (j)
- Directions to the member’s home, starting from the local Source site Office to the member’s home address (See Section 902, Procedures (k))
- Consent for Enrollment (Appendix C7) for initial and annual enrollment
- Referral Form (Appendix V) for initial and annual enrollment and when member has notable changes
- SOURCE Member Information Form (MIF) (only when member has notable changes)

1402. **24-Hour On Call**

SOURCE Case Management Provider will maintain a 24-hour a day/seven days per week/365 days per year on-call system that will:

- Optimize primary medical care for members by offering prompt attention to clinical complications or illness
- Assist members and informal caregivers in addressing after-hours service delivery issues promptly
- Help members avoid unnecessary emergency room visits by medical triage and advice

All sites will maintain a 24-hour phone line answered by a live voice.
PART II - CHAPTER 1400

a) At assessment, the case manager will leave for the member written information on how to contact the SOURCE Enhanced Case Management, including the 24-hour phone number.

b) Education for members by the Case Manager on using the 24-hour line will be included at the assessment home visit.

c) Access to the following services will be provided or facilitated via the 24-hour phone line:
   (1) After hours medical triage and advice
   (2) After hours medical consultation by SOURCE Primary Care Provider or designated qualified medical professional
   (3) Assistance in resolving service delivery complications, after hours
   (4) Authorization of medical services

d) Authorization of community services including increase or decrease in service (also using the site specific SOURCE number) must be approved by Case Management staff, with confirmation on the appropriate forms.

1403. Health System Linkages

SOURCE differs from conventional HCBS in Georgia in part by including primary care providers as partners in case management. To meet program and Carepath goals, SOURCE Case Management Provider assume responsibility for coordinating overall healthcare services for members. Sites must work with local healthcare facilities in collaborative arrangements to reduce conflicting and duplicative efforts. Sharing information on current health conditions, assistance needed and resources available benefits the members and promotes program goals. Coordination between the site and healthcare organizations (particularly hospitals) ensures that decisions for nursing home placement of members will not occur without:

- Exploration of all possible routes to a community-based plan
- Primary Care Provider consultation
- Advocacy efforts by CM, in coordination with family/informal caregivers

For all services delivered by non-reimbursed organizations, the Case Manager must take three steps: identify when a service is in place, coordinate efforts with the staff and track the service until discharge.

Procedures:

1. Hospital Linkages:
a) SOURCE Case Management Provider will maintain ongoing coordination with acute care facilities, ensuring hospital coverage of the entire service area.

b) Areas included for coordination are:
   (1) Communication with family members around hospitalizations
   (2) Discharge planning, emphasizing community plans over institutionalization and referral to SOURCE-affiliated providers
   (3) Treatment conferences for extended LOS patients
   (4) Preventive efforts re: repeated hospital encounters

c) Case Manager will educate members/caregiver on using hospitals affiliated with the SOURCE Enhanced Case Management, upon enrollment and throughout the member’s length of stay.

d) Sites will track inpatient admissions, by following protocols of the Hospital Tracking Form (see Appendix), facilitating discharge. The Hospital Tracking Form may replace a case note regarding the hospitalization for that member.

e) Hospitals coordinating with SOURCE are requested to communicate with the SOURCE site relative to hospitalized members for collaboration in discharge planning.

2. Home Health Services

a) SOURCE Case Management Provider will maintain ongoing coordination with home health agencies, ensuring effective and non-duplicative home health services for members indicated.

b) Areas for coordination include:
   (1) Services provided by agency and by SOURCE
   (2) Communication with Primary Care Providers
   (3) Resolution of Carepath variances
   (4) Preventive efforts to meet Carepath goals
   (5) Discharge planning

c) Case Manager will educate members/caregiver and hospital staffs on using home health agencies affiliated with SOURCE, upon enrollment and throughout the member’s length of stay.

3. Dialysis Centers:

a) SOURCE Case Management Provider will maintain ongoing coordination with area dialysis centers, ensuring effective and non-duplicative dialysis services for all members indicated.

b) Areas included for coordination include:
   (1) Provision of primary care services
   (2) Authorization of healthcare services
(3) Case management responsibilities
(4) Resolution of Carepath variances
(5) Preventive efforts to meet Carepath goals
(6) Hospitalizations

c) A dialysis center physician may serve as a participating Primary Care Provider, if he or she agrees to perform the functions described under “SOURCE Primary Medical Care” and in the Scheduled Contacts – Primary Care Providers and Policy, PRN Contacts.

1404. **Member Discharge**

**Discharge Planning Policy Statement:**

Discharge planning is instituted at the beginning of the SOURCE participation to assist a client in making the transition from one service environment to another.

Discharge planning is conducted to: Plan for continuity of an individual's health care; Maintain the individual's level of functioning; Lower an individual's readmission rates to medical facilities (for example: hand rails in bathroom to prevent falls)

**Process for Discharge Planning:**

Complete the following activities at enrollment to ease planning at discharge:

- Begin to develop the discharge plan during the initial assessment (document what the member will need if discharged)
- Reflect discharge planning in care plans by utilizing the steps in 1401 that ensure maximize funding (i.e. keep family resources in place, use community resources)
- Coordinate discharge planning in consultation with the client’s physician, other involved service agencies, and other local resources available to assist in the development and implementation of the individual’s discharge plan. (Track key providers in member’s well-being, consult with them as necessary)

See Appendix BB and Z6 and Z7-8 for more Information on operationalization of discharge planning.

**Discharge Policy Statement:**

SOURCE Members can be discharged for a variety of reasons. Voluntarily or Involuntarily. SOURCE supports and when possible improves the member’s functioning. If evaluation or occurrences support discharge, SOURCE will work to make the transition as smooth as possible.

**Process for Discharge:**

The Case Manager will exhaust all means to ensure that members continue their enrollment in the program, for several key reasons:

- Members constitute a vulnerable population due to chronic illness, disability, advanced age and low-income
Managing non-compliance is a core function of the CM/Primary Care Provider team

DCH expects sites to meet or exceed consumer expectations

Discharge from the program may be either voluntary or involuntary. Reasons for discharge include:

- Member moves from the site’s service area
- Member enters a facility or institution
- Member does not meet eligibility using the definition in section 801.3 disability and Intermediate Nursing Home Level of Care Criteria
- Member is no longer eligible for full Medicaid
- Member death
- Member transfers to another waiver program
- Member is admitted to a nursing home (with expectation of Medicaid reimbursement for the nursing facility services.)
- Member Choice
- Member is chronically non-compliant
- Member health and safety needs cannot be met in the community
- Member’s health and functionality is not confirmed by the Primary Care Provider’s documentation or other appropriate physician specialist

This section is appended by Section 1406, Right to Appeal.

a) Voluntary Discharge

Enrollment in SOURCE is strictly voluntary. Case Managers will make all feasible efforts to meet the reported and observed needs of persons in service. However, a voluntary discharge will be effective immediately as of the date requested by the member, guardian or custodial caregiver.

Procedures:

Rev. 07/16

10/12

(1) A Case Manager’s efforts to reconcile the source(s) of a member’s dissatisfaction with the program may include as indicated:
- Conferences with providers, Case Manager and members/Caregivers
- Changing provider, PCP or Case Manager
- Discontinuing an individual service or otherwise altering the Carepath plan
- Involvement of the supervisor, Primary Care Provider or program management

(2) If efforts to resolve a member’s or caregiver’s dissatisfaction with SOURCE are unsuccessful, the consequences of disenrollment from SOURCE will be explained:
- Case Management services from site discontinued
- Community services reimbursed by SOURCE discontinued
- PCP services coordinated through site discontinued
(3) If other HCBS programs are enrolling the member following discharge from SOURCE, the Case Manager will work to make the transition happen smoothly.

(4) Services reimbursed by SOURCE will be discontinued effective on the date so requested by the member, or the date the member becomes ineligible.

(5) Upon learning of an effective discharge date, the Case Manager will notify:
   - SOURCE providers, by completing the Discharge section of the Member Information Form (MIF)
   - Providers not reimbursed through SOURCE
   - The SOURCE PCP office

(6) The member’s PCP may continue providing primary care services following discharge from the program if requested by the member and agreed to by the PCP.

Rev. 7/06

(7) Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix Z (7) to be filed in the member’s chart.

1405 SOURCE MEMBER INVOLUNTARY DISCHARGE

Involuntary Discharge

Effectiveness of SOURCE services depends heavily on the participation of members/caregivers in developing and implementing the Carepath plan. A prolonged or repeated pattern of deliberate non-compliance may result in involuntary discharge from SOURCE.

Discharge from SOURCE, however, does not end a member’s Medicaid eligibility. Only after thorough efforts by the site to resolve patterns of non-compliance will SOURCE members be involuntarily discharged. Examples of non-compliance include but are not limited to:

- Failure to keep scheduled Primary Care Provider appointments
- Avoiding or refusing Case Manager visits or other contacts
- Refusal to allow or facilitate the delivery of community services as agreed on in the Carepath plan
- Failure to provide essential information affecting SOURCE’s ability to help members live in healthy and functionally independent ways
- Refusing to participate in problem solving discussions and efforts with Case Manager’s, PCP’s, physicians or providers around Carepath variances, delivery or clinical issues
- Failure to use designated SOURCE providers or affiliates for services

Rev.01/09, 10/09

Discharge occurs when:

10/09
PART II - CHAPTER 1400

1. The case manager determines that the member is no longer appropriate or eligible for services under SOURCE

2. DCH Program Integrity staff recommend in writing that a member be discharged from service

3. Member/member’s representative consistently refuses service(s)

4. Member's physician orders the member's discharge from SOURCE

5. Member enters a nursing facility. The provider must send the notice of discharge immediately upon the member’s placement in a nursing facility in the case of nursing facility admission expected to be of a long term nature (greater than 21 days) or if the member has no payor source other than Medicaid for nursing facility services.

NOTE: All member services are discharged and Appendix Z is sent to member via Certified Mail. Please refer to Section 1406 of this manual. The fifteen day waiting period does not apply to discharge based on admission to a nursing facility.

6. Member exhibits and/or allows illegal behavior in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days.

7. Member/member’s representative or case manager requests immediate termination of services. The provider must document in the member’s record the member’s request for a change in provider.

8. Member moves out of the planning and service area to another area not served by the provider. (If needed a transfer of services needs to be coordinated by case management to ensure continuity of care)

9. Member expires.

10. Provider can no longer provide services ordered on the Carepath. (see also section 1306 Discharge… initiated by the provider)

11. Member is non compliant. Examples of non-compliance includes:
   - Failure to keep scheduled Primary Care Provider appointments
   - Avoiding or refusing Case Manager visits or other contacts
   - Refusal to allow or facilitate the delivery of community services as agreed on in the Carepath plan
   - Failure to provide essential information affecting SOURCE’s ability to help members live in healthy and functionally independent ways
- Refusing to participate in problem solving discussions and efforts with Case Manager’s, PCP’s, physicians or providers around Carepath variances, delivery or clinical issues
- Failure to use designated SOURCE providers or affiliates for services

**Procedures:**

1. The assigned Case Manager will communicate clearly at admission the program’s expectations of members/caregiver.

2. The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program.

3. Single, minor or isolated instances of non-compliance will not result in formal action; the Case Manager will address these issues with members/caregiver as they occur.

4. The Case Manager will take action steps indicated for repeated instances of non-compliance, involving as indicated the member’s PCP, supervisor or program manager (see Policy II F, Carepath Variances).

5. Issues of non-compliance and efforts at resolution will be documented in the member’s case notes, on the Carepath, in Variance Reports, etc.

6. The multidisciplinary team staffing the admissions process will be the entity to hear, explore and decide issues of pending discharge due to non-compliance.

7. The Primary Care Provider will be informed of pending involuntary discharge prior to the disenrollment’s effective date.

8. Prior to discharge, a member (or custodial caregiver or guardian) will receive from the Case Manager – following approval by the site’s multidisciplinary group – written warning of potential discharge with a suggested course of action required to avoid discharge.

9. For members/caregiver unable to read, the Case Manager will read the letter over the phone or in person; the letter will also be mailed to the member’s house.

10. Should the first written warning fail to resolve a pattern of non-compliance, members (or custodial caregivers or guardians) will receive from Case Manager (with approval from the multidisciplinary group) a written deadline for the course of action necessary to avoid discharge.

11. If the member fails to meet the letter’s deadline, the Case Manager will initiate steps to discharge.
(12) The Case Manager will make referrals to other programs or agencies if the dis-enrolling member so requests.

(13) The Case Manager will facilitate the transition to other agencies in all ways possible.

(14) Members will be informed in writing of the formal date of discharge from SOURCE.

(15) Members may further seek to appeal an involuntary discharge through the Department of Community Health’s appeal process.

(16) Members may be involuntarily discharged immediately from SOURCE by the site’s multidisciplinary staff group for criminal activities by member or in the home, and physical aggression toward providers, CM or PCPs, by member or in the home environment bypassing procedures 3 through 13.

(17) Upon discharging the member, the CM will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB) and Appendix Z(7-8), to be filed in the member’s chart.

1406. **Right to Appeal**

The DON-R Score, Failure to meet eligibility including Nursing Home Level of Care, Reduction in Services or other SOURCE Terminations

A. SOURCE members and applicants have the right to appeal the following actions of a SOURCE Enhanced Case Management site:

- The DON-R score (but may not appeal agency refusal to screen assess based on initial information)
- Denial of eligibility (category of eligibility other than SSI or Public Law or no category; failure to meet nursing home level of care; refusal based on other factors like service area, available housing, safety concerns, etc.)
- Reduction in services (any reduction in service, even resulting from a temporary increase)
- Termination of services (discharge from SOURCE)

The Department of Community Health will notify sites when a request for an appeal is made, and when a request is made to maintain services at the current level. Agencies are not to reassess a client while the client is under an appeal request or Request for Fair Hearing (RFH) unless;

A) Greater than 9 months since last assessment (waiver requires annual assessment)
PART II - CHAPTER 1400

a. Notify GMCF and submit with information on circumstances in contact us

B) Reassessment has been approved by DCH.
   a. Notify GMCF and submit with information on circumstances in contact us

Sites should note that this policy applies only to SOURCE-reimbursed services.

Procedures for Issuing Discharge Notice from Case management Agency:

Case managers and CM supervisors will attempt to reach consensus with members and potential members (or legal guardians if applicable) on decisions made about the member’s care. SOURCE sites will involve the primary care physician and/or Medical Director in all decisions resulting in adverse action.

Members who fail to meet the eligibility criteria including Nursing Home Level of Care will be reviewed by the Interdisciplinary team prior to issuance of the Appendix Z (notification of adverse action). The assessment nurse will present, or, at a minimum, be available to answer questions about the member’s MDS-HC assessment, additional assessments and any other documents used in the LOC determination, to the interdisciplinary team for review and discussion.

If the team agrees that the member does not meet eligibility, the Medical Director and/or PCP will indicate same in item 34 of Appendix F and sign his/her name as required.

1. Following discussion of an action falling into any of the categories described above, the site will inform the member clearly of the action to be taken.

2. Unless GMCF issues the written notice, sites will give the member written notice, sent via Certified Mail, of actions for any of the categories, using the Appendix Z-1 letter, NOTICE OF DENIAL, TERMINATION, REDUCTION IN SERVICE. The form will be dated the day the form is mailed.

3. Sites are not to issue a discharge letter (Appendix Z form) if GMCF has issued the decision. Sites may download GMCF’s written notice from the GMCF web portal and take to client if client is not aware of notice, or has not received notice through mail.

4. The original Z-1 letter is mailed to the SOURCE member via Certified Mail, along with the Appendix Z-2 Notice of Right to a Hearing form.
After conferring to the member Appendix Z 7 is completed. A copy is kept in the SOURCE chart.

5. For members concurring with the intended action, the Appendix Z-1 letter and the Appendix Z-2 and Z-7 form will also be completed and provided to members as described above.

6. Members have 30 days from the date of their Appendix Z-1 letter to request a hearing in writing; in cases of decreasing or terminating services, members may retain their services at their current level by notifying DCH in writing within thirty days of the Appendix Z-1 letter’s date. Services remain in place pending the outcome of the Administrative Hearing.

(Discharge to nursing home requires immediate discharge of without Thirty day (30) waiting period. Refer to Section 1405-Involluntary Discharges)

7. Case managers should follow up the Appendix Z-1 letter with a call within 15 days to determine if the member (or legal guardian if indicated) has any questions concerning the adverse action notice. (See Step 3 if member has not received notice)

8. If the member wishes to appeal, the case manager should assist with their request for a hearing as appropriate.

9. If the discharge was agency issued and the member appeals, a complete assessment packet is uploaded to GMCF to maintain the Prior Authorization and maintain member services. The packet should be clearly identified as involuntary termination with appeal. (if GMCF concurs, no new discharge notice is issued.)

10. The case manager should ensure the member has information on obtaining assistance in appealing an action (see Appendix Z-2 Notice of Your Right to a Hearing form).

11. The Case Manager will check with the member and/or family representative regarding the notice of adverse action and whether a hearing request has been filed with DCH before formally discharging the member from the program.

12. Members requesting discharge from SOURCE are exempt from the 30-day waiting period. Case managers should immediately send in a APPENDIX F form with the date requested for discharge by the member. The member will no longer receive SOURCE EPCCM or community based services as of the date indicated on the APPENDIX F. See also Policy No.1405 (a) Voluntary Discharge.

13. A SOURCE member has the right to represent him/herself or have an attorney, paralegal or any other person to represent him/her. Case managers should notify
members of the availability of local services for legal assistance to older or low-income persons.

14. If an appeal is filed by the members, the site will present information at the appeal supporting the adverse action taken.

15. CM will notify member of the planned discharge and provide the member with information regarding the appeal process, as directed in Medicaid Part I Policy and Procedures section 500.

NOTE: Prior to review by the Interdisciplinary team, the nurse (R.N. or L.P.N.) shall review the member’s diagnoses, medications, treatments with the member’s PCP to ensure concurrence with Member’s health and functional status as documented on the MDS-HC.

Procedures after decision of non-eligibility:

1. SOURCE assessment nurse (R.N. or LPN) will carry out the MDS HC assessment and the RN will make a preliminary determination if the member meets eligibility. If determined by the Case Management agency or GMCF that the member does not meet eligibility, an appendix Z form will be sent to the member by the denial agency. The Appendix Z Form states why the member does not meet the LOC criteria, and cites applicable policy. The member has thirty (30) days to request a hearing.

2. Discharge planning information/resources are sent to the member within 15 days of denial.

3. As of April 2016, GMCF will reference a 2nd level review option on the discharge Appendix Z letter to members who have a GMCF issued denial. This means that:
   a. If the member provides new information in the 10 days, they will either be accepted by GMCF for LOC, or they will receive a 2nd and final denial letter.
   b. The member will have 10 business days to provide new information to GMCF through their Case Management agency.
   c. If the member provides new information in the 10 days, they will either be accepted by GMCF for LOC, or they will receive a 2nd and final denial letter.
   d. If the member does not give new information, no new denial letter will be issued from GMCF. The member continues to have the right to ask for an appeal 30 days from issuance of the original denial letter.

4. If the member requests a hearing, the member will send his/her hearing request to DCH Legal Services.
5. Upon receipt of the hearing request, DCH Legal Services will decide to accept or reject the request for hearing. If accepted DCH will:

6. Send the member a confirmation letter that the hearing will be granted and

7. Contact the SOURCE Program Site and/or GMCF to request a copy of the file/records used to make the eligibility determination.

8. Documentation of paperwork from steps 4 or 5, GMCF confirmation, or a memo from DCH SOURCE confirming the hearing request was granted will confirm that Level of Care is to be continued under the DCH Legal Services authority (and services are to continue) for Utilization Review or Program Integrity.

9. SOURCE Program site or GMCF will provide a copy of the records to DCH Legal Services.

10. The benefits must continue.

11. If member's Prior Authorization has expired, GMCF will extend the LOC PA if they have denied the member. If this is an agency denial, Agency must upload reassessment packet to GMCF with explanation that member is in appeal and needs a Prior Authorization number to continue benefits.

12. Upon receipt of the records, DCH Legal will assign the case to an attorney and transmit the case to OSAH for a hearing. OSAH will issue a notice of hearing setting a specific hearing date, time, and location.

13. While waiting for the hearing to occur, the benefits must continue, and reevaluations/reassessments should occur if:
   a. Greater than 9 months since last assessment
   b. Approved by DCH.

14. During this waiting period, if the member decides that he/she does not want to proceed with the hearing, it is the member or the member's representative's duty to inform DCH And OSAH that the member no longer wishes to proceed with the hearing. SOURCE does not represent the member. SOURCE is not an agent of the state. The right to a hearing belongs to the member.

15. If the member decides to proceed with the hearing, the administrative hearing will occur and the administrative law judge will issue a decision. Continue member benefits pending the judge's decision.

16. If the judge rules in favor of DCH, the member’s benefits will be reduced or terminated. The member can appeal to the next level. Keep ruling with member file.

17. If the judge rules in favor of the member, the benefits will continue and DCH can appeal to the next level. Maintain a copy of the ruling with the most current Appendix F. Reference on the appendix F the court ruling. Annual Reassessment following an appeal.
is determined by the Prior Authorization dates. The time spent in hearing will count to the annual review.

Note: In the case of SOURCE terminations upheld through hearing, or in the case of voluntary terminations, SOURCE case management agencies notify all HCBS provider agencies involved in the provision of services to the member in order to avoid continuation of services not reimbursable under Medicaid.

1407. Confidentiality of Member Information

Integration of care for chronically ill people requires significant sharing of information between key players. To a greater extent than conventional HCBS, SOURCE Case Management Provider access, review and maintain patient records of all types, due to:

- Increased accountability standards for CM, across all treatment settings
- Coordination with participating primary medical care providers
- Formal linkages with health system providers

Ensuring appropriate access to medical and case management information by individuals involved in direct care or in monitoring care must be balanced with concern for member privacy. Offenses of confidentiality fall into two categories: unauthorized access of confidential data (looking at a member’s chart or other data when there is no “need to know”), and the unauthorized use, dissemination or communication of clinical or other confidential data.

SOURCE Case Management Providers are required to act in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Procedures:

a) Each site will maintain a confidentiality policy specific to the organization.

b) The site-specific policy will include an “Employee Statement of Confidentiality” with disciplinary actions described for policy violations.

c) Upon admission, all members will sign a consent form to permit the release of information, as necessary to individuals or entities participating in the program.

d) Only case management, medical records and administrative staff will have direct access to member charts, excluding regulatory agency staff.
e) Charts will be maintained after hours in a secure environment.

f) Release of information to participating providers will be only on an as needed basis, and according to the policies and procedures of the site and DMA.

g) All charts will be maintained per the guidelines as specified in Part I Policies and Procedures for Medicaid/Peachcare for Kids.

1408. Non-Reimbursed Items and Services

In helping members continue residing in the community, CM will frequently discover needs for items or services not covered by conventional third-party payers like Medicaid or Medicare or by other traditional community resources. Often these items or services are critical to achieving Carepath outcomes for members, but the costs may be far out of reach for the member/caregiver to pay for privately. Sites will develop or have access to funds to bridge gaps in coverage for essential items or services. Typical examples include incontinence supplies, nutritional supplements and certain prescription medications; other examples are moving expenses, pest control, specific pieces of DME, etc.

If funds for non-covered items or services do not exist in the local community, a site may consider applying to local charitable foundations, accepting donations from civic organizations, individuals, churches and other faith-based organizations, etc., to build a fund. Sites must comply with all applicable local, state and federal requirements.

Payment for such items or services by the site does not set a precedent for such funding for all members. Consideration should be on an individual, case-by-case basis and will depend on the amount of funding and guidelines established.

Procedures:

a) The Case Manager will review any available options to cover a needed item or services, including the member/caregiver’s own resources.

b) When other potential sources are ruled out, the Case Manager will submit a request in writing to the Case Manager Supervisor documenting specifically the service or item needed a time frame if applicable and a brief rationale.

c) The Case Manager Supervisor or Program Manager will have authority to approve the expenditure and will maintain a record of all items/services covered.

d) The Case Manager will forward the approved request to the organization or staff member (if internal) in charge of dispersing funds.
e) If the items/services are not approved, the Case Manager will continue to work with the SOURCE member/Caregiver to attempt to obtain the item or services from other sources or to find a suitable substitute.

f) For items/services funded on an ongoing basis, the Case Manager assigned will be responsible for reviewing every quarter the need for continued assistance.

g) Non-reimbursed services for members will be documented, for potential analysis of service packages.

1409. Due Process for SOURCE HCBS providers

SOURCE providers have the right to an Administrative Review should they be removed from a SOURCE Enhanced Case Management’s rotation list of providers. Sites must notify providers in writing of the action. The provider shall have ten (10) days from the date of the written notice of removal from the DCH SOURCE referral list from the SOURCE Case Management Provider to submit a written request for the Review. All requests for reviews must be submitted to the address specified in the corrective action notice to the provider. The written request for an Administrative Review must include all grounds for appeal and must be accompanied by any supporting documentation and explanations that the provider wishes the Department of Community Health to consider. Failure of the provider to comply with the requirements of administrative review, including the failure to submit all necessary documentation, within ten (10) days shall constitute a waiver of any and all further appeal rights, including the right to a hearing, concerning the matter in question.

The Division of Medicaid shall render the Administrative Review decision within thirty (30) days of the date of receipt of the provider’s request for an Administrative Review.

Following an evaluation of any additional documentation and explanation submitted by the provider, a final written determination regarding removal from the SOURCE rotation list will be sent to the provider. If the provider wishes to appeal this determination regarding removal from the list, the provider may appeal the decision of the SOURCE Enhanced Case Management. The appeal must be in writing and received by the Commissioner’s office within ten (10) business days of the date the Administrative Review decision was received by the provider. The appeal shall be determined within forty-five (45) days of the date on which the Commissioner’s office received the request to appeal.
The request for the appeal must include the following information:

- A written request to appeal the decision of the Administrative Review
- Identification of the adverse administrative review decision or other SOURCE action being appealed
- A specific statement of why the provider believes the administrative review decision or other SOURCE action is wrong; and
- Submission of all documentation for review

An appeal shall state the action appealed.

The Department of Community Health and the Division of Medicaid will reach a decision within thirty (30) days of receiving the appeal. If the Commissioner’s decision upholds that of the SOURCE Enhanced Case Management, removal from the SOURCE provider list shall remain in effect for the time specified.

The decision of the DCH Commissioner is final. No further appeal rights will be available to the provider.

1410. HIPAA Regulations

A federal law about health care, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides new health privacy regulations.

The Privacy Rule under HIPAA establishes privacy protections that assure Medicaid recipients and all health care patients that their medical records are kept confidential. The rules will help to ensure appropriate privacy safeguards are in place as we manage information technology to improve the quality of care provided to patients. The new protections give recipients greater access to their own medical records and more control over how their personal information is used by their health insurance plans (including Medicaid) and by health care providers.

The DCH Notice of Privacy Practices explains how Georgia Medicaid uses and discloses individuals’ health information and how individuals may access their information. The notice was mailed to all Medicaid recipients with the April 2004 eligibility cards.

1411. SOURCE Sentinel Event Policy
Case Managers will complete the SOURCE Sentinel Event Report in the event of an unanticipated incident that results in death or significant physical, financial or emotional injury of a SOURCE member. Excluded are deaths, injuries or impairments due to acute illness that can be reasonably considered a potential outcome in consideration of a member’s age or health status. These are not events that occur in a hospital or rehabilitation facility.

Reportable Sentinel events include:

- Falls
- Significant physical injuries
- Alleged criminal acts by staff against a member
- Alleged criminal acts which are reported to the police by a person who receives services
- Member missing without authority or permission and without others’ knowledge of whereabouts
- Financial exploitation or mismanagement of client funds
- The intentional or willful damage to property by a client that would severely impact operational activities or the health and safety of the client or others
- Whether by a member or staff person on duty or other person, any threat of physical assaults, or behavior so bizarre or disruptive that it places others in a reasonable risk of harm or, in fact, causes harm
- Inappropriate sexual contact or attempted contact by a staff person (on or off duty), volunteer or visitor, directed at a member
- Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling
- Use of physical or chemical restraints
- Withholding food, water, or medications unless the member has requested the withholding
- Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation)
- Isolating member from member’s representative, family, friends, or activities
- Inadequate assistance with personal care, changing bed linen, laundry, etc.
- Leaving member alone for long periods of time
- Failure to provide basic care or seek medical care

Procedures:

1. In the event of a sentinel event, the Case Manager will complete the Sentinel Event Report (see Appendix for form), in consultation with the Case Management supervisor.

2. The SOURCE PCP or Medical Director will also be consulted as indicated, to accurately complete the report.
3. Sites shall notify the DCH SOURCE Program Specialist of all sentinel events, by mailing or faxing the Sentinel Event Report upon completion (and by a phone call if indicated).

4. Again in consultation with the Case Management supervisor, the Case Manager will implement any follow-up activities indicated.

1412. **Transfers between SOURCE Case Management Agencies**

Transfers between SOURCE Enhanced Case Management can happen for a variety of reasons that may be member initiated or agency initiated. To promote continuity of care and help members meet program goals, DCH has established a protocol to minimize the disruption of support services for members transferring to a new site or a new case management agency. Members should be encouraged to move toward the end of the month if possible, taking into consideration existing lock-in procedures of DCH.

Rev. 07/11

A. **MEMBER Chooses to TRANSER TO A Different CASE MANAGEMENT AGENCY within same Community (External Transfer)**

**Procedures:**

1. The new agency will notify the existing agency of the member’s choice of a planned transfer, to best coordinate provision of services for the member.

2. Upon learning of a member’s choice to be enrolled with a different SOURCE CM agency, the case manager from the existing site will request that the member make the transfer at the end of the month if possible. Original agency is responsible for providing one year of copied records to the receiving agency.

3. The new site may assess the member at any point during the month.

4. The new agency will not be responsible for case management until the member is discharged from the existing site.

5. Until discharge, the existing agency is responsible for all aspects of case management.
6. With the member’s permission and a signed release, the existing site forwards a copy of the member’s chart or the most current year’s documentation to the new agency. (Original agency is responsible for providing one year of copied records to the receiving agency.)

7. Receiving agency uses copied records for historical reference and picks up monthly contacts, service, and care plan reviews from the previous dates and related standards of promptness.

Rev. 10/15

8. The new agency will submit a SOURCE Member Transfer Form (Appendix X) to GMCF if a modified reevaluation is completed. If a full evaluation is needed, submit complete packet to GMCF and indicate that is an external agency transfer.

9. With physician signature on the appendix F and a service PA start date the member is considered enrolled with the new agency.

10. As SOURCE is a voluntary program, the existing CM agency will discharge the member according to the date requested by the member.

11. Members transferring to another site will be subject to existing SOURCE lock-in procedures for HCBS. (Lock in are scheduled to end 10/1/2015 and SOURCE moves to Prior Authorizations for service.

Rev. 07/11

B. MEMBER must RE-LOCATE or TRANSFER to different Case Management Agency

Procedures:

When a member needs to transfer CM agencies (for instance, the member is relocating to an area that is not served by the existing case management company, or the existing case management company cannot serve the member and must transfer the member), the existing Case Manager (CM) and the existing Case Management Supervisor (CMS) will begin the transfer process.

Note: If this is a case management company initiated transfer, DCH must be notified and give approval.
1. The Case Manager or supervisor will offer the member a list of case management agencies that provide service in the area (use Appendix Z-12 in the SOURCE DCH manual).

2. The member will select a site and notify the Case Manager of their choice.

3. The Case Manager will notify the CMS, who will contact the new agency to make a referral, give the new agency an anticipated relocation or transfer date if possible and coordinate discharge and admissions processes to best serve the member.

4. Members will be counseled by case management staff to plan moves (and discharge from the existing site), in order to lessen the member’s time without HCBS.

5. With the member’s permission and a signed release, the existing agency forwards a copy of the member’s chart or the most current year’s documentation to the new agency. (Original agency is responsible for providing one year of copied records to the receiving agency.)

6. Receiving agency uses copied records for historical reference and picks up monthly contacts, service, and care plan reviews from the previous dates and related standards of promptness.

7. Upon moving, the new agency will work to expedite the assessment process to the extent possible, to determine any changes in status (caregiver/informal support, HCBS and primary care needs) related to the move, in order to lessen the member’s time without HCBS. Assessment (may use Modified Reevaluation as directed in section 905) is required within 10 days in the case of a change of address that impacts caregiver availability, environmental issues related to service delivery, or needs of the member.

8. The new agency will submit a SOURCE Member Transfer Form (Appendix X) to GMCF if a modified reevaluation is completed. If a full evaluation is needed, submit complete packet to GMCF and indicate that is an external agency transfer.

9. Members transferring to another agency will be subject to existing SOURCE procedures for HCBS.

C. MEMBER TRANSFER TO ANOTHER SOURCE Site Location within Same CASE MANAGEMENT AGENCY (Internal Transfer)
Procedures:

1. Original site notifies the new site of member’s upcoming transfer.

2. Original site is responsible for providing one year of copied records to the receiving site.

3. The new site may determine a need to reassess the member. Modified reassessment (see section 905) is required within 10 days in the case of any of the following changes:
   - circumstances that impact caregiver availability
   - environmental issues related to service delivery
   - Changes in the needs of the member.

4. Complete Reassessment is required if Level of Care Expires within 90 days. A complete Packet is uploaded to GMCF.

5. If the LOC does not expire within 90 days, the new agency may complete a modified reevaluation and will submit only a SOURCE Member Transfer Form (Appendix X) to GMCF.

6. Until transfer, the existing site is responsible for all aspects of case management.

7. Receiving site uses copied records for historical reference and picks up monthly contacts, service, and care plan reviews from the previous dates and related standards of promptness.

1413. Case Management Reimbursement Hierarchy

Note: Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for repetitive case management services to more than one agency or Medicaid provider that renders case management services to an individual. (Guidelines for dual enrollment in SOURCE and acceptable non-repetitive Case Management are in section 701 Member Exclusions)

- A hierarchy (see below) for case management services was established to prevent payment of more than one case management services per month.
  1. COS 830 – CMO
  2. COS 851 – SOURCE CM (COS 851 ends 10/1/2015)
  3. COS 680 - MRWP/NOW
  4. COS 681 - CHSS/COMP
  5. COS 660 – ICWP
  6. COS 590 – CCSP
  7. COS 764 – Child Protective Services Targeted Case management
  8. COS 800 – Early Intervention Case Management
9. COS 765 – Adult Protective Services Targeted Case Management
10. COS 763 – At Risk of Incarceration Targeted Case Management
11. COS 762 - Adults with AIDS Targeted Case Management
12. COS 790 – Rehab Services/DSPS
13. COS 100 – Dedicated Case Management – Non-Waiver Members
14. COS 840 – Children’s Intervention Service

Effective for dates of service on and after January 1, 2009, the Case Management agency or Medicaid Provider submitting claims for the same member in the same calendar month:

Rev 04/09

- If two claims are submitted for CM services the hierarchy determines which provider will be paid.
- If the lower hierarchy provider has been reimbursed the claim amount will be recovered and payment made to the CM provider first in the hierarchy.
Appendix A
SOURCE Screening Form

SCREENER ____________ REFERRAL DATE __________ SCREENING DATE ____________________

NAME ______________ DOB ___/___/___ SEX ____ MEDICAID __YES/__ NO

SSN _______ MEDICAID NUMBER ____________ MEDICARE NUMBER ____________

SSI: YES / NO IF NO, IS MONTHLY INCOME SSI LEVEL OR BELOW?

ADDRESS: __________________________ PHONE __________________

HOUSING: ALONE____ WITH RELATIVE/FRIEND____ HOSPITAL ____
PERSONAL CARE HOME ____ NURSING HOME ____ OTHER ______

PHYSICIAN ______________ DATE OF LAST VISIT ______________
DIAGNOSES ________________________________

INITIAL CALLER __________ REFERRED BY ______________________

REFERRAL/SCREENING NOTES ______________________________
______________________________
______________________________
______________________________

PRIMARY CAREGIVER/RELATIONSHIP __________________________

PHONE __________ ADDRESS ____________________________

WILLING TO USE SOURCE PCP: ___ YES ___ NO

REFERRED FOR SOURCE ASSESSMENT ____________________________
NOT ELIGIBLE/REASON ____________________________
REFERRED FOR OTHER SERVICES ____________________________
OTHER ____________________________
SERVICE OPTIONS USING RESOURCES IN COMMUNITY ENVIRONMENTS
SOURCE PROGRAM PARTICIPATION

DATE__/__/____

DEAR_______________________

WELCOME TO THE SOURCE PROGRAM. THE SOURCE MULTIDISCIPLINARY TEAM REVIEWED YOUR SITUATION AND RECOMMENDED COMMUNITY–BASED SERVICES THROUGH SOURCE.

SERVICES WILL BEGIN AFTER THE PROVIDERS LISTED BELOW HAVE VISITED YOU. SOMEONE FROM THE FOLLOWING AGENCY(S) WILL BE CONTACTING YOU.

<table>
<thead>
<tr>
<th>PROVIDER AGENCY</th>
<th>PROVIDER AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td>CONTACT PERSON</td>
<td>CONTACT PERSON</td>
</tr>
<tr>
<td>TELEPHONE NUMBER</td>
<td>TELEPHONE NUMBER</td>
</tr>
<tr>
<td>PROVIDER AGENCY</td>
<td>PROVIDER AGENCY</td>
</tr>
<tr>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td>CONTACT PERSON</td>
<td>CONTACT PERSON</td>
</tr>
<tr>
<td>TELEPHONE NUMBER</td>
<td>TELEPHONE NUMBER</td>
</tr>
</tbody>
</table>
APPENDIX B

AS A PARTICIPANT IN THE SOURCE PROGRAM:

YOU WILL NOT LOSE ANY MEDICAL ASSISTANCE BENEFITS THAT YOU ARE CURRENTLY RECEIVING BY PARTICIPATING IN THE SOURCE PROGRAM.

YOU MAY WITHDRAW FROM SOURCE AT ANY TIME.

PLEASE CONTACT THE CASE MANAGER LISTED BELOW OR YOU MAY HAVE SOMEONE CALL ON YOUR BEHALF IF YOU HAVE QUESTIONS OR NEED ADDITIONAL INFORMATION.

__________________________  ______________________________
CASE MANAGER                  TELEPHONE NUMBER
**1. Home Assessment:**
List people who live in the home:

<table>
<thead>
<tr>
<th>Name/Relationship</th>
<th>Age</th>
<th>Work: FT, PT, Night</th>
<th>Status: Permanent, Temporary, Intermittent</th>
<th>School: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Is there usually someone with you at night? Y _____ N ______
Do you have someone who could stay with you if you were sick? Y _____ N ______

If yes, provide name and contact information: _______________________________________
_____________________________________________________________________

Plans for evacuation or disaster: ________________________________________________
_____________________________________________________________________

**2. Physical Environment:**

<table>
<thead>
<tr>
<th>Features:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrical hazards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stove/refrigerator on premises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signs of careless smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washer/dryer on premises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other fire hazards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pets (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with living situation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Features:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space heater(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke detectors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indoor toilets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate ventilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning to move</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: ___________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**3. Medications:**

Pharmacy name and telephone number: ____________________________________________
How do you get your medications? ______________________________________________
Member: ___________________________ Date: ________________

4. Psychosocial:
In the past year have there been any significant changes in your life, such as:

<table>
<thead>
<tr>
<th>Change</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness/injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in job, residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losses or deaths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in marital status</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Victim of crime or Exploitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Advance Directives:
Do you have a signed Advance Directive? Yes ____ No ____
If yes, where is the copy kept? ____________________________________________________
Does the family know of the Advance Directive? Yes ____ No ____

6. Proxy Decision Makers:
Name: ___________________________ Relationship: ___________________________
Telephone: ___________________________
Type: guardian _____ payee _____ power of attorney _____

7. Financial Information:
Monthly Income $____________
  Social Security ________
  SSI ________
  Other ________
  Checking Account? Yes ___ No ___
  Savings Accounts? Yes ___ No ___
Who manages money for member? __________________________________________________

8. Nutrition:
Has your doctor told you to eat a special diet? ___________________________
Are you compliant with your diet order? Yes ____ No ____
Do you use alcohol? Yes ____ No ____; tobacco? Yes ____ No ____; or recreation drugs? Yes ____ No ____
If yes, what drugs? _____________________________________________________________

9. Home Monitoring:
If applicable, in addition to your doctor, who is responsible for monitoring ___ BS ___ BP
____ weight? ____ self care ____ others assisting ____________________________

Service Options Using Resources In Community Environments April 1 2016
APPENDIX C
SOURCE ASSESSMENT ADDENDUM

How often? _________________________________________________________________
Member: ___________________________ Date: __________
Member: ___________________________ Date: __________

List any monitoring equipment and supplies you have (blood pressure cuff, One-Touch type machine, scales, etc.)
_________________________________________________________

10. Labwork:
Do you currently require any ongoing labwork/diagnostics or other medical procedures (blood machine, scales, etc)?
_________________________________________________________

Procedure __________________________ Frequency __________________
Reason __________________________ Provider __________________

11. IADL/ADL:

Instrumental Activities of Daily Living

<table>
<thead>
<tr>
<th>Category</th>
<th>WHO helps and WHEN? (include ALL assistance – family/friends AND formal services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td></td>
</tr>
<tr>
<td>Food preparation</td>
<td>Breakfast/Lunch/Supper</td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
</tr>
<tr>
<td>Mode of Transportation</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Finances</td>
<td></td>
</tr>
</tbody>
</table>
Member: _______________________________ Date: ________________

Basic Activities of Daily Living – If assistance is required:

<table>
<thead>
<tr>
<th>Category</th>
<th>WHO helps and WHEN? (ALL informal AND paid support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed mobility:</td>
<td></td>
</tr>
<tr>
<td>Transfer:</td>
<td></td>
</tr>
<tr>
<td>Locomotion:</td>
<td></td>
</tr>
<tr>
<td>Dressing:</td>
<td></td>
</tr>
<tr>
<td>Eating:</td>
<td></td>
</tr>
<tr>
<td>Toilet use:</td>
<td></td>
</tr>
<tr>
<td>Personal hygiene:</td>
<td></td>
</tr>
<tr>
<td>Bathing:</td>
<td></td>
</tr>
<tr>
<td>Continence:</td>
<td></td>
</tr>
</tbody>
</table>

Are existing caregivers willing/able to continue providing assistance at current levels?
Yes ____ No ____ Comments: ______________________________________________________
_____________________________________________________________________________

12. Physician Information

Doctor’s Name ___________________________ Phone No. (____) ____________
Reason _______________________________________________________________________

Doctor’s Name ___________________________ Phone No. (____) ____________
Reason _______________________________________________________________________

Service Options Using Resources In Community Environments April 1 2016
13. Medical Treatment

Do you currently receive any of the following medical treatments? (If yes, list who provider and telephone number.)

<table>
<thead>
<tr>
<th>Treatments</th>
<th>Provider/Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure sore treatment</td>
<td></td>
</tr>
<tr>
<td>Wound or other skin care treatment</td>
<td></td>
</tr>
<tr>
<td>Skilled therapy (PO/OT/speech)</td>
<td></td>
</tr>
<tr>
<td>Colostomy/ostomy care</td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

14. Other Programs

Cross reference with other programs:

15. Education

What is the highest grade completed in school? _______________________________________

16. Special Equipment

___ Bed Rail ___ Hospital Bed ___ Incontinence pads
___ Catheter ___ High toilet seat ___ Glasses
___ Brace (back) ___ Prosthesis ___ Cane/walker
___ Blood glucose monitor ___ Adaptive eating equipment ___ Grab bars
___ Bathing equipment ___ Bedside commode ___ Other vision
___ Lift (manual/electric) ___ Wheelchair (manual/electric) ___ Dentures
___ Other ___

____________________________________  __________________________
Care Manager Signature                 Date
### SOURCE SERVICES RECOMMENDED

<table>
<thead>
<tr>
<th>Issues Noted</th>
<th>Services Recommended</th>
<th>Provider Assigned</th>
<th>Frequency</th>
<th>Participant Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MC PC RL</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>MC PC RL</td>
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<td>MC PC RL</td>
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<td>MC PC RL</td>
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<td></td>
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<td>MC PC RL</td>
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</tbody>
</table>

______________________________

Member Signature

______________________________

Date

______________________________

Case Manager Signature

______________________________

Date
SOURCE Consent for Enrollment

I, ______________________________, voluntarily agree to enroll in SOURCE. I understand that SOURCE will provide primary medical care, case management and support services, under the Georgia Better Health Care program.

I understand that I will be required to use a doctor or nurse practitioner participating in SOURCE, who will provide or coordinate all medical care I may need. Any support services I may need will also be arranged and monitored by SOURCE. If I am currently enrolled in another Medicaid waiver program, my enrollment and services will be changed to SOURCE.

I further understand that SOURCE staff will be coming to my home to evaluate my current status and my need for support services, on an ongoing basis. SOURCE will also provide information to participating SOURCE providers, as needed for effective service delivery.

Information gathered on the type and amount of service I receive and on my medical condition may also be used in evaluating this program or to develop future healthcare programs and guidelines in Georgia. MY NAME OR OTHER IDENTIFYING INFORMATION WILL NOT BE USED FOR THIS PURPOSE.

________________________________________  ____________________________
Person giving consent                       Date

________________________________________  ____________________________
Relationship to SOURCE member if not member  Date

________________________________________
Witness
SOURCE Manual
Member Rights and Responsibilities

In order for you to have a positive and healthy experience in SOURCE, the staff must ensure that your rights are respected.

Your rights, in the SOURCE program:

You have the right to receive:

- Considerate and respectful care, without discrimination as to race, religion, sex or national origin.
- Clear and current information about your health, medical treatments and Carepath plan.
- The name of any doctor, Case Manager or other SOURCE Enhanced Case Management staff member involved in your care.
- Information necessary to give consent before any procedure and/or treatment, and information on potential alternatives.
- Privacy and confidentiality of your treatment and medical records. Information about you will be released only as necessary for providing effective care, and only with your consent (see attached Consent for Enrollment Form).
- Information on how to make a complaint or an appeal about care received through the SOURCE Enhanced Case Management.
- You have the right to reasonable participation in decisions involving your care.
- You have the right to refuse treatment to the extent allowed by law, and to be informed of the likely medical consequences.
- You have the right to choose a primary care doctor from the SOURCE Enhanced Case Management’s list of participating physicians.
- You have the right to choose from the SOURCE Enhanced Case Management’s list of participating providers, for support services indicated by your Carepath plan.

The SOURCE program is designed to help you stay as healthy and independent as possible.
To achieve these goals, you must be an active partner in working with your Case Manager and SOURCE doctor.

Your responsibilities, in the SOURCE program:

You are responsible for providing clear and complete information regarding your overall health and healthcare, including illnesses/injuries, hospitalizations, medications or anything else that may affect how SOURCE delivers medical and supportive services.

You are responsible for helping to develop and carry out your SOURCE plan by:

- Giving complete and timely information to your Case Manager about your own abilities and those of your family or friends who are caregivers
- Carrying out assigned responsibilities as you agreed with your Case Manager
- Letting your Case Manager know if you or others (including paid providers) are not able or willing to carry out responsibilities as agreed, so the Case Manager can help make other arrangements
- Working with SOURCE staff to solve problems in key areas, identified by your Case Manager as goals during your enrollment in the program
- Using providers (hospitals, home care and home health agencies, etc.) who participate in the SOURCE program.

You are responsible for keeping all medical appointments as part of your SOURCE plan, or for notifying SOURCE if you cannot keep an appointment.

You are responsible for maintaining a safe and healthy home environment. Your Case Manager may assist you in finding help with home repairs or in moving to a new home, if necessary.

You are responsible for treating your Case Manager, doctors and service providers in a courteous and respectful manner.

___________________________________  ____________________
SOURCE Member/Caregiver  Date

___________________________________  ____________________
SOURCE Case Manager  Date
AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS/MEDICAL INFORMATION

I hereby authorize SOURCE to receive information from the medical records of:

Patient _______________________________ SSN__________________________
Date of Birth__________________________ Date(s) of Service: ______________

Information requested: _____________________________________________________
________________________________________________________________________

Requested by: __________________________ Phone No._____________________

Purpose or need for information: Enrollment in SOURCE “Enhanced Case Management”

All information I hereby release to be obtained will be held strictly confidential and cannot be
released without my consent. I understand that this authorization will remain in effect for one year,
unless I specify an earlier date here: __________________________

____________________ ____________________
Signature of Patient or Authorized Person Date

________________________
Relationship if Not Patient

____________________ ____________________
Signature of Witness Date

Please send all information to:______________________________________

________________________________________________________________________
________________________________________________________________________

________________________________________________________________________
## APPENDIX F Level of Care

<table>
<thead>
<tr>
<th>LOC PA Number:</th>
<th>Effective/End Dates</th>
<th>Patient's Name (Last, First, Middle Initial):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SOURCE TEAM NAME &amp; ADDRESS</td>
<td></td>
<td>2. Patient's Name (Last, First, Middle Initial):</td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
<td>3. Home Address:</td>
</tr>
<tr>
<td>Provider ID#</td>
<td></td>
<td>4. Telephone Number;</td>
</tr>
<tr>
<td>5. County:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Number</th>
<th>Social Security Number</th>
<th>Mother's Maiden Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Medicaid Number</td>
<td>7. Social Security Number</td>
<td>8. Mother's Maiden Name:</td>
</tr>
</tbody>
</table>

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Resources with necessary information including medical data.

16. Signed ____________________________ (Patient, Spouse, Parent or other Relative or Legal Representative) 17 Date ________________________

### Section B. Physician’s Examination Report, Recommendation, and Nursing Care Needed

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary __________________________</td>
<td>1. Initial _____ 2. Reassessment</td>
</tr>
<tr>
<td>2. Secondary _________________________</td>
<td>1. Initial _____ 2. Reassessment</td>
</tr>
<tr>
<td>3. Other _____________________________</td>
<td>1. Initial _____ 2. Reassessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications (including OTC)</th>
<th>Diagnostic and Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Name</td>
<td>Dosage</td>
</tr>
</tbody>
</table>

### 22. SOURCE SERVICES ORDERED: ECMS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Regular</td>
<td>□ Intake □ IV</td>
<td>□ Improving</td>
<td>□ Good</td>
</tr>
<tr>
<td>□ Diabetic</td>
<td>□ Output □ Bedfast</td>
<td>□ Stable</td>
<td>□ Fair</td>
</tr>
<tr>
<td>□ Formula</td>
<td>□ Catheter Care</td>
<td>□ Fluctuating</td>
<td>□ Poor</td>
</tr>
<tr>
<td>□ Low Sodium</td>
<td>□ Colostomy Care</td>
<td>□ Deteriorating</td>
<td>□ Cooperative</td>
</tr>
<tr>
<td>□ Tube Feeding</td>
<td>□ Sterile Dressings</td>
<td>□ Critical</td>
<td>□ Confused</td>
</tr>
<tr>
<td>□ Other</td>
<td>□ Suctioning</td>
<td>□ Terminal</td>
<td>□ Violent</td>
</tr>
</tbody>
</table>

### Decubiti

<table>
<thead>
<tr>
<th>28. Decubiti</th>
<th>29. Bowel</th>
<th>30. Bladder</th>
<th>31. Indicate Frequency Per Week of the following services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No □ Infected</td>
<td>□ On Admission</td>
<td>Surgery Date______</td>
<td>➷ Physical Therapy</td>
</tr>
</tbody>
</table>

| □ Continent | □ Occas Incontinent | □ Incontinent | □ Colostomy | □ Continen t | □ Occas Incontinent | □ Incontinent |

### 32. Record Appropriate Legend

<table>
<thead>
<tr>
<th>IMPAIRMENT</th>
<th>Record Appropriate Legend</th>
<th>Activities of Daily Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Severe</td>
<td></td>
<td>1. Dependent</td>
</tr>
<tr>
<td>3. Mild</td>
<td></td>
<td>3. Independent</td>
</tr>
<tr>
<td>4. None</td>
<td></td>
<td>4. Not App</td>
</tr>
</tbody>
</table>

### 33. This patient’s condition

| □ SOURCE | □ Home Health Services: |

34. I certify that this patient provided by a nursing facility requires or does not require the intermediate level of care

35. I certify that the attached plan of care addresses the client’s needs for Community Care

36. Physician’s Signature:

37. Physician’s Name (Print)

38. Address:

39. Date Signed By Physician

40. Physician’s Licensure No

41. Physician’s Phone No

### ASSESSMENT TEAM USE ONLY

42. Nursing Facility Level of Care? □ Yes □ No

43. L.O.S. Certified Through Date

44. Signed by person certifying LOC: Title Date Signed Phone
DCH FORMS NEEDED FOR HEARING REQUESTS

SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT-INSTRUCTIONS

Purpose: The Level Of Care (LOC) page summarizes the client’s physical, mental, social, and environmental status to help determine the client’s appropriateness for SOURCE services. In addition, the LOC page represents the physician’s order for all waivered services provided by SOURCE.

Who Completes Form: Initial assessments are completed by a licensed nurse (RN or LPN), case manager. The LOC is always signed by the RN. The agency medical director or client’s physician participates in all assessments and reassessments by completing designating sections of the LOC page and signing the form.

When the Form is Completed: The case manager completes the LOC page at initial assessments and reassessments, and transfers from one SOURCE site to another. Include the transfer date.

Instructions:

Indicate whether this is an initial admit, discharge, or transfer and date agency would like change to occur. May write any other helpful information in the box or at top of page.

SECTION I  A. IDENTIFYING INFORMATION

Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address, telephone number, including area code, and Medicaid provider identification number of care coordination team.

2. Enter client’s last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.

3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.

4. Enter client’s area code and telephone number.

5. Enter client’s county of residence.

6. Enter client’s Medicaid number exactly as it appears on the Medicaid card.

7. Enter client’s nine-digit social security number.

8. Enter client’s mother’s maiden name.

9, 10, 11. Enter client’s sex (“M” or “F”), age, and date of birth (month/day/year).

12. Enter client’s race as follows:
   A = Asian/Pacific Islander  H = Hispanic  W = White
   B = Black  NA = Native American

13. Enter client’s marital status as follows:
   S = Single  M = Married  W = Widowed
   D = Divorced  SP = Separated

14. Check (✓) appropriate type of recommendation:
   1. Initial: First referral to SOURCE or re-entry into SOURCE after termination
   2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.

15. Enter referral source by name and title (if applicable), or agency and type as follows:
   MD = Doctor  S = Self  HHA = Home health agency
   NF = Nursing facility  FM = Family  PCH = Personal Care Home
   HOSP = Hospital  ADH = Adult Day Health

Service Options Using Resources In Community Environments April 1 2016

Z-9
O = Other (Identify fully)
16, 17. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to Case Manager regarding level of care determination.

SECTION IB. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION

Section B is completed and signed by licensed medical person completing medical report.

18. The physician or nurse practitioner enters client's primary, secondary, and other (if applicable) diagnoses. (Nurse assessor may enter client diagnoses, but through review and signature on Appendix F, the physician or nurse practitioner confirms the diagnoses)

NOTE: When physician, nurse practitioner or Medical Director completes signature, the case management team indicates ICD codes. Enter ICD codes for “primary diagnosis”, “secondary diagnosis” or “third diagnosis” in the appropriate box. Case management teams secure codes from ICD code book, local hospitals or client's physician.

19. The physician or nurse practitioner or Medical Director checks “yes” box to indicate if client is free of communicable diseases; if the member has a communicable disease or it is unknown, check “no”.

20. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.

21. List all diagnostic and treatment procedures the client is receiving.

22. List all waivered services ordered by case management team.

23. Enter appropriate diet for client. If "other" is checked (✓), please specify type.

24. Enter number of hours out of bed per day if client is not bedfast. Check (✓) intake if client can take fluids orally. Check (✓) output if client’s bladder function is normal without catheter. Check (✓) all appropriate boxes.

25. Check (✓) appropriate box to indicate client’s overall condition.

26. Check (✓) appropriate box to indicate client’s restorative potential.

27. Check (✓) all appropriate boxes to indicate client’s mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.

28. Check (✓) appropriate box to indicate if client has decubiti. If “Yes” is checked and surgery did occur, indicate date of surgery.

29. Check (✓) appropriate box.

30. Check (✓) appropriate box.

31. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.

32. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.

33. Case Management team with the Medical Director (admitting physician) indicates whether client’s condition could or could not be managed by provision of Home and Community Services or Home Health Services by checking (✓) appropriate box.
NOTE: If physician indicates that client’s condition cannot be managed by provision of Home and Community Services and/or Home Health Services, the member will not be admitted to SOURCE and should be referred to appropriate institutional services.

34. Medical Director, admitting physician with Multidisciplinary Team certifies that client requires or does not require level of care provided by an intermediate care facility and signs on #36, confirming the GMCF review and LOC determination.

35. Admitting/attending physician certifies that CarePath, plan of care addresses patient’s needs for living in the community. If client’s needs cannot be met with home and community based services, the member will not be admitted to SOURCE and will be referred to appropriate services.

36. This space is provided for signature of admitting/attending physician indicating his certification that client needs can or cannot be met in a community setting. Only a physician (MD or DO) or nurse practitioner may sign the LOC page.

37, 38, 39, 40, 41. Enter admitting/attending physician’s name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided.

NOTE: The date the physician signs the form is the service order for SOURCE services to begin. UR will recoup money from the provider if date is not recorded.

42, 43, 44. REGISTERED NURSE (RN) USE ONLY

42. The registered nurse checks (✓) the appropriate box regarding Nursing Facility Level of Care (LOC). When a level of care is denied, the nurse signs the form after the “No” item in this space. The RN does not use the customized “Approved” or “Denied” stamp.

43. LOS - Indicate time frame for certification, i.e., 3, 6, 12 months. LOS cannot exceed 12 months.

# Certified Through Date - Enter the last day of the month in which the length of stay (LOS) expires.

44. Licensed person certifying level of care signs in this space, indicates title (R.N.), date of signature, and contact information.

NOTE: Date of signature must be within 60** days of date care coordinator completed assessment as indicated in Number 17. Length of stay is calculated from date shown in Number 43#. The RN completes a recertification of a level of care prior to expiration of length of stay.

Distribution: The original is filed in the case record. Include a copy with the provider assessment/reassessment packet.
Note: If services are ordered between annual reviews and at such a level that it does not require the member to have a reassessment, the service(s) can be documented on the Care Path, and the physician signs and dates the Carepath. As of July 1, 2015 members who have a complete reassessment will all be on SOURCE Level I carepath.

### SOURCE Care Path Level (OPTIONAL)

All patients must have a medical condition which requires physician monitoring.

Check what the patient Requires.

- [ ] Patient requires skilled nursing services daily  
  - Yes  
  - No
- [ ] Patient requires assistance with a documented mental problem (cognitive loss)  
  - Yes  
  - No
- [ ] Patient requires assistance with a documented physical problem  
  - Yes  
  - No

AND if there is another problem that contributes to member’s care:

- [ ] Other ______________________________

Circle any problems below that require medical monitoring:

- Nutritional status; skin care; catheter use; therapy services; clinical indicators/lab studies; restorative nursing care; or medication management.
Case Managers complete SOURCE activities within the standards of promptness guidelines

### Standard of Promptness for Care Coordination

<table>
<thead>
<tr>
<th>IF ACTIVITY IS</th>
<th>THEN STANDARD OF PROMPTNESS IS WITHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding to telephone inquiry regarding SOURCE admission</td>
<td>3 business days after telephone inquiry</td>
</tr>
<tr>
<td><strong>SCREENING</strong></td>
<td></td>
</tr>
<tr>
<td>Screening a referral</td>
<td>3 business days after telephone inquiry</td>
</tr>
<tr>
<td>Notifying client referral source of client denial/eligibility</td>
<td>Within 3 business days after decision of non-eligibility</td>
</tr>
<tr>
<td><strong>INITIAL ASSESSMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Nurse completion of face to face assessment for new admissions</td>
<td>within 30 business days of notification of slot availability</td>
</tr>
<tr>
<td>RN review of the assessment</td>
<td>10 business days following the assessment visit</td>
</tr>
<tr>
<td>Sending assessment /reassessment package to GMCF for LOC review</td>
<td>No later than 60 days from assessment completion date</td>
</tr>
<tr>
<td><strong>REASSESSMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Send Reassessment package to GMCF for LOC review</td>
<td>At least 45 days before expiration of the current Level of Care and no sooner than 89 days before LOC expiration</td>
</tr>
<tr>
<td>RN review of the assessment</td>
<td>10 business days following the assessment visit</td>
</tr>
<tr>
<td>Medical Director/PCP signature confirming LOC</td>
<td>Within 90 days of member signature on LOC*</td>
</tr>
<tr>
<td>Completing reassessments when requested by:</td>
<td>See Section 1406</td>
</tr>
<tr>
<td>• SOURCE service provider</td>
<td></td>
</tr>
<tr>
<td>• Utilization Review analyst</td>
<td></td>
</tr>
<tr>
<td>• Legal Services Office</td>
<td></td>
</tr>
<tr>
<td>• Administrative Law Judge</td>
<td></td>
</tr>
<tr>
<td>• Member</td>
<td></td>
</tr>
<tr>
<td>Brokering services for new client</td>
<td>10 business days after reassessment request</td>
</tr>
<tr>
<td>Telephone follow-up with a client after service brokered to assess service compliance, client satisfaction</td>
<td>10 business days after service initiation</td>
</tr>
<tr>
<td>Sending member a Participation Form and Member Care Path</td>
<td>5 business days after service initiation</td>
</tr>
</tbody>
</table>
## APPENDIX H
### Standards of Promptness

<table>
<thead>
<tr>
<th>IF ACTIVITY IS (cont’d.)</th>
<th>THEN STANDARD OF PROMPTNESS IS WITHIN (cont’d.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sending referral packet to provider</td>
<td>Before service provider begins services</td>
</tr>
<tr>
<td>Completing and returning Member Information Form (MIF) to provider</td>
<td>3 business days after receipt from provider 2 business days if involving a sentinel event</td>
</tr>
<tr>
<td>Telephone contact with member</td>
<td>Monthly</td>
</tr>
<tr>
<td>Face to Face Care Path review</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Provider meeting for the coordination of care</td>
<td>Monthly</td>
</tr>
<tr>
<td>(Applies to all ALS, ADH, and PSS providers)</td>
<td>Note: may be conducted face to face, telephone or electronically</td>
</tr>
<tr>
<td>Reporting Sentinel events to DCH, Adult Protective Services, local law enforcement, and Long Term Care Ombudsman</td>
<td>Within 1 business day of the notification or discovery of the event</td>
</tr>
<tr>
<td>Transfer of client record when client moves to another SOURCE site with the same provider (copy of records is acceptable)</td>
<td>5 business days after notification of transfer</td>
</tr>
<tr>
<td>Submitting Monthly Statistical Reports to DCH</td>
<td>By the 15th of the month following the month subject to report</td>
</tr>
</tbody>
</table>

### Involutionary Discharge

| Complete and provide a copy of the discharge plan with specific resources to the member | No later than 15 days following a SOURCE involuntarily discharge (day of notification by GMCF or date the CM agency issued letter to member) |
| Follow up call or visit to member and or family to confirm understands information on discharge and discharge planning resources | 7 to 10 work days after discharge plan is given |
Appendix I: Intermediate Nursing Home Level of Care

Rev. 07/11 USE SECTION 801.3 FOR INTERPRETIVE GUIDELINES AND USE INSTRUCTION /GUIDE (FOLLOWING PAGE).

To meet an intermediate nursing home level of care the individual must meet:

Item # 1 in Column A  AND one other item (2-8) in Column A,

PLUS at least one item from Column B or C (with the exception of #5, Column C)

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Status</strong>&lt;br&gt;(If #1 is circled, please document etiology)</td>
<td><strong>Mental Status</strong>&lt;br&gt;(If #1-4 is circled, please document etiology)</td>
<td><strong>Functional Status</strong>&lt;br&gt;(If #1-5 is circled, please document etiology)</td>
</tr>
<tr>
<td>In addition to the criteria in # 1 below, the patient's specific medical condition must require any of the following plus one item from Column B or C &lt;br&gt;The mental status must be such that the cognitive loss is more than occasional forgetfulness</td>
<td>Functional Status &lt;br&gt;One of the following conditions must exist (with the exception of #5)</td>
<td></td>
</tr>
<tr>
<td>1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician</td>
<td>1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement</td>
<td>1. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist.</td>
</tr>
<tr>
<td>2. Nutritional management; which may include therapeutic diets or maintenance of hydration status</td>
<td>2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/care plan for continued placement.</td>
<td>2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals.</td>
</tr>
<tr>
<td>3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions or healing decubiti (continued)</td>
<td>3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention (continued)</td>
<td>3. Requires direct assistance of another person to maintain continence.</td>
</tr>
<tr>
<td>4. Catheter care such as catheter change and irrigation</td>
<td>4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia</td>
<td>4. Documented communication deficits in making self-understood or understanding others.</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Service Options Using Resources in Community Environments July 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy, (3 times per week or less)</td>
</tr>
<tr>
<td>6. Restorative nursing services such as range of motion exercises and bowel and bladder training</td>
</tr>
<tr>
<td>7. Monitoring of vital signs and laboratory studies or weights</td>
</tr>
<tr>
<td>8. Management and administration of medications including injections</td>
</tr>
</tbody>
</table>
INSTRUCTIONS/GUIDE for Determination of ILOC

Intermediate Level of Care Criteria: SOURCE Applications

Rev. 07/11

The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE and all other eligibility requirements listed in 801.3. The Intermediate Level of Care Criteria is recommended by the Site’s Registered Nurse, using assessment information reported via the MDS-HC assessment, case notes, physician notes, history & physical, and other assessment tools. The R.N. circles all relevant items from Column A, B & C to support the level of care. If additional notes such as related diagnoses are required, such information is noted on the document.

Specific criteria as below:

I. Medical Status: Must satisfy Question #1 and any one of #2 through #8

<table>
<thead>
<tr>
<th>SOURCE LOC CRITERIA</th>
<th>PRIMARY LOC APPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Has at least one chronic condition . . .”</td>
<td>Examples: HTN, diabetes, heart disease, pulmonary disease, Alzheimer’s, spinal cord injury, CVA, arthritis, etc.</td>
</tr>
<tr>
<td>2. Nutritional management . . .”</td>
<td>Medical record reflects status as underweight or morbidly obese; need for therapeutic diet d/t exacerbation chronic condition (HTN, diabetes, skin condition, etc.); dialysis patients (hydration); others at risk of dehydration.</td>
</tr>
<tr>
<td>3. “Maintenance and preventive skin care . . .”</td>
<td>Diabetics; SRC members spending significant time in wheelchair or bed; existing wound care/skin issues or history of; members with incontinence</td>
</tr>
<tr>
<td>4. “Catheter care . . .”</td>
<td>Self explanatory</td>
</tr>
<tr>
<td>5. “Therapy services . . .”</td>
<td>Self explanatory</td>
</tr>
<tr>
<td>6. “Restorative nursing services . . .”</td>
<td>Self explanatory</td>
</tr>
<tr>
<td>7. “Monitoring of key clinical indicators, laboratory studies or weights . . .”</td>
<td>Diagnosis requiring ongoing monitoring of clinical indicators: hypertension, pulmonary disease, diabetes, cardiovascular disease, etc. (key clinical indicators)</td>
</tr>
</tbody>
</table>
include but are not limited to blood pressure, pulse, respiration, temperature, weight, blood sugar for diabetics; medications indicating ongoing laboratory studies (Coumadin, Dilantin, Tegretol, Digoxin, Phenobarbitol, liver profiles, certain cholesterol medications, etc.); CHF and dialysis patients for monitoring of weight.


SRC members needing assistance with management OR administration of medications (d/t cognitive or physical impairments). May be paid care or informal support providing assistance.

### II. Cognitive Status that includes cognitive loss. Must Satisfy one of #1 through #4

*(Note: Always involves cognitive loss with etiologic diagnosis not related to a developmental disability OR mental illness for SOURCE Waiver eligibility)*

<table>
<thead>
<tr>
<th>SOURCE LOC CRITERIA</th>
<th>PRIMARY LOC APPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Documented short or long-term memory deficits . . . “</td>
<td>Linked to a diagnosis (CVA, TBI, dementia, Alzheimer’s, etc.) documented in medical record; review MMSE score.</td>
</tr>
<tr>
<td>2. “Documented moderately or severely impaired cognitive skills . . . “</td>
<td>Same as above. Allow for eccentricities.</td>
</tr>
<tr>
<td>4. “Undetermined cognitive patterns which cannot be assessed by a mental status exam . . . “</td>
<td>Rarely used. Aphasia listed as example.</td>
</tr>
</tbody>
</table>

### OR

### III. Functional Status: Must satisfy one of #1 through #4 (with the exception of #5)

*(Note: Always involves impairment with etiologic diagnosis not related to a developmental disability OR mental illness for SOURCE Waiver eligibility)*
### SOURCE LOC CRITERIA

<table>
<thead>
<tr>
<th></th>
<th>PRIMARY LOC APPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Transfer and locomotion performance requires limited/extensive assistance . . . “</td>
<td>“One person physical assist” is key indicator. Not someone who lives alone with no support (paid or informal) in place or planned. “Locomotion” viewed as primarily in home.</td>
</tr>
<tr>
<td>2. “Assistance with feeding.”</td>
<td>May be due to significant physical or cognitive impairment. Cueing and set-up help required together (i.e., not just an IADL issue).</td>
</tr>
<tr>
<td>3. “Direct assistance . . . to maintain continence.”</td>
<td>“Assistance of another person” is key indicator (i.e., not just using incontinence products). May be due to physical (transfers, etc.) or cognitive impairments.</td>
</tr>
<tr>
<td>5. “Assistance . . . dressing/personal hygiene”</td>
<td>Self-explanatory. See “another deficit” requirement described.</td>
</tr>
</tbody>
</table>
APPENDIX I

Level of Care
Worksheet

The mental status for this column must be cognitive loss and more than occasional forgetfulness.

**Medical Status**

1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician
   - Etiology
2. Nutritional management, which may include therapeutic diets or maintenance of hydration status
   - Etiology
3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions or healing decubiti
   - Etiology
4. Catheter care such as catheter change and irrigation
   - Etiology
5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (3 times per week or less)
   - Etiology
6. Restorative nursing services such as range of motion exercises and bowel and bladder training
   - Etiology
7. Monitoring of vital signs and laboratory studies or weights
   - Etiology
8. Management and administration of medications including injections
   - Etiology

**Mental Status**

1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement
   - Etiology
2. Documented moderately or severely impaired cognitive skills with etiologic diagnoses for daily decision making. Cognitive loss addressed on MDS/care plan for continued placement
   - Etiology
3. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention
   - Etiology
4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia
   - Etiology

**Functional Status**

If #15 is circled, please document functional etiology. Circle where supported on MDS

1. Transfer and locomotion performance of resident requires limited/extend assistance by staff through help or one-person physical assistance
2. Continuously stand-by supervision, encouragement or cueing required and set-up help of meals
3. Requires direct assistance of another person to maintain continence
4. Documented communication deficits in making self-understood or understanding others
5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene

**Functional Etiology**

**Column C Functional Status**

The Functional Status impairment must not be related to a developmental disability or mental illness.

**Worksheet**

Signature of R.N. __________________________ Date ________
(Must be present)

Signature of Other __________________________ Date ________

This is a preliminary review of patient. Final determination is made with the Level of Care and Placement Instrument (Appendix F).
APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____________________________________________ Medicaid #__________________________________ Date:_________________

Service Options Using Resources In Community Environments

LEVEL I – CAREPATH

Rev. 10/15

Circle what the patient has:

1) a documented mental problem (with cognitive loss)
2) a documented physical problem

Prior Authorization Dates: ________________ to ________________ PA # ________________

Disease(s) that require DM Plan? ________________________________

SOURCE Case Manager ________________________________ Signature ________________________________ Date ________________

SOURCE Case Mgmt Sprvsr ________________________________ Signature ________________________________ Date ________________

SOURCE PCP _______________________________________ Signature ________________________________ Date ________________

SOURCE Medical Director ________________________________ Signature ________________________________ Date ________________

Care Path additions: Document Reason for Care Path changes and signatures as needed below for members who have Care Path changes but don’t require a full reevaluation.
<table>
<thead>
<tr>
<th>KEY MEMBER OUTCOMES</th>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>QUARTERLY REVIEWS</th>
</tr>
</thead>
</table>
| Member resides in community, maintaining maximum control possible over daily schedule and decisions. Sentinel events are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into action. | **Stabilize chronic conditions** and promptly treat episodic/acute illness through long-term management by a SOURCE PCP/Case Manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness. | **GOALS:**

1st review period (__/__/__):
A. __met  __not met
B. __met  __not met
C. __met  __not met

Sentinel events?

2nd review period (__/__/__):
A. __met  __not met
B. __met  __not met
C. __met  __not met

Sentinel events?

3rd review period (__/__/__):
A. __met  __not met
B. __met  __not met
C. __met  __not met

Sentinel events?

4th review period (__/__/__):
A. __met  __not met

PCP: ________________________________ Case Mgr. ________________________________

**SOURCE PCP role:**
- Evaluate and treat episodic /acute illness
- Manage chronic disease, including:
  - Risk factor modification/monitoring of key clinical indicators
- Coordination of ancillary services
- Education for members/informal caregivers
- Medication review and management
- Conference/communicate regularly with Case Manager
- Review support service plans
- Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services
- Promote wellness, including immunizations, health screenings, etc.

**SOURCE Case Manager role:**
- **A. Member/caregiver contributes to the design and implementation of community-based services plan.**
  - Key member responsibilities:
    - Accept services as planned with manager;
    - Provide accurate information on health status and service delivery; and
    - Maintain scheduled contact with case manager.

- **B. Member keeps scheduled medical appointments.**
### C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and Case Managers.

Key provider performance areas:

- Reliability of service
- Competency and compatibility of staffing;
- Responsiveness to member concerns and issues; and
- Coordination with Case Manager.

Maintain contact with member, for ongoing evaluation:

- Monthly by phone or visit (minimum)
- Quarterly by visit (minimum)
- PRN as needed

Educate members on patient responsibilities

Encourage/assist member in keeping all medical appointments

Conference/communicate regularly with PCP; assist patients in carrying out PCP orders

Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work

Coordinate with informal caregivers and paid providers of support services

Educate or facilitate education on chronic conditions

Assist members in ALL issues jeopardizing health status or community residence

**NOTES:**

- __________________________________________________________
- __________________________________________________________
- __________________________________________________________

(Providers and units/schedules listed on Member Version)

---

**B.** __met  __not met

**C.** __met  __not met

Sentinel events?

__________
### Key Member Outcomes

| A member’s diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions |

### Goals:

#### A. SOURCE member’s body mass supports functional independence and does not pose a critical health risk or progress is made toward this goal (PCP, ADH or other report).

#### B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by Case Manager or provider, self- or caregiver report).

### Member Education:

- **SOURCE PCP/PCP staff**
- **SOURCE educational material**
- **Other**

### Meal Preparation:

- **Self-care (total)**
- **Assistance by informal caregiver(s)**
- **Home delivered meals**
- **ALS (alternative living service)**
- **PSS aide (includes G-tube)**

### Meal Preparation Schedule: (Indicate SELF, INF, HDM, PSS or ALS):

#### Quarterly Reviews:

1st review period (**/**/**):  
- **met**
- **not met**

2nd review period (**/**/**):  
- **met**
- **not met**

3rd review period (**/**/**):  
- **met**
- **not met**

4th review period (**/**/**):  
- **met**
## APPENDIX J
### Level 1 Carepath Rev. 10/2015

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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</table>

NOTES: __________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

(Providers and units/schedules listed on Member Version)

[Providers and units/schedules listed on Member Version]
**Member’s skin will be maintained in healthy condition, avoiding breakdowns and decubiti.**

**GOALS:**

Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.

### MEMBER/CAREGIVER EDUCATION:

- **SOURCE PCP/PCP staff**
- **SOURCE educational material**
- **other _____________________**

### MONITOR SKIN for integrity:

- **SOURCE PCP**
- **self care**
- **informal caregiver _____________________**
- **ADH**
- **specialist _____________________**
- **PSS aide/PSS RN every 62 days**
- **ALS**
- **skilled nursing**

Provider: ________________________________

Dates of Service: ________________________________

### QUARTERLY REVIEWS

**GOALS:**

1st review period (__/__/__): __met __not met

2nd review period (__/__/__): __met __not met

3rd review period (__/__/__): __met __not met

4th review period (__/__/__): __met __not met
### Assistance required:

- [ ] turning/repositioning (see page _____)
- [ ] continence (see page _____)
- [ ] nutrition (see page _____)

### NOTES:

---

(Providers and units/schedules listed on Member Version)
**KEY MEMBER OUTCOMES**

Key clinical indicators and lab values will regularly fall within parameters acceptable to SOURCE PCP or treating specialist.

**NOTE:** Key clinical indicators and lab values deemed applicable are determined and monitored for each member by the SOURCE PCP, according to the member's diagnosis and current medical condition. The CM role is to assist the member in carrying out PCP orders, to facilitate achieving this goal.

The PCP will advise on any additional monitoring required for each member.

Additional monitoring required, if applicable:

- **blood glucose**
- **blood pressure**

**PLAN/RESPONSIBLE PARTY**

MEMBER/CAREGIVER EDUCATION:

- SOURCE PCP/PCP staff
- SOURCE educational material
- other

MONITOR CLINICAL INDICATORS:

- SOURCE PCP (OV)

ADDITIONAL MONITORING REQUIRED:

- self care
- other

**QUARTERLY REVIEWS**

GOALS:

1st review period (__/__/__):

- met
- not met

2nd review period (__/__/__):

- met
- not met

3rd review period (__/__/__):

- met
- not met

4th review period (__/__/__):

- met
- not met
Member _____________________________________________ Medicaid # __________________________ Date:_________________

___ weight (as indicator of illness, for CHF patients, etc.)

___ labs

___other ________________________________

____ LMP ____________________________

last menses for women of child bearing age

___ other ________________________________

___________________________

___________________________

___________________________

___________________________

NOTES:_______________________________________

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(Providers and units/schedules listed on Member Version)
<table>
<thead>
<tr>
<th>KEY MEMBER OUTCOMES</th>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>QUARTERLY REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member/caregiver understands and adheres to medication regimen (self- or caregiver report, physician/RN report or observation by Case Manager). Sentinel events around medications are discussed with appropriate responsible parties.</td>
<td>MEMBER/CAREGIVER EDUCATION:</td>
<td>GOALS:</td>
</tr>
<tr>
<td></td>
<td>___SOURCE PCP/PCP staff</td>
<td>1st review period</td>
</tr>
<tr>
<td></td>
<td>___SOURCE educational material</td>
<td>(<em><strong>/</strong></em>/___):</td>
</tr>
<tr>
<td></td>
<td>___other</td>
<td>_ met  _ not met</td>
</tr>
<tr>
<td></td>
<td>MEDICATION ADMINISTRATION/MANAGEMENT:</td>
<td>Sentinel events?</td>
</tr>
<tr>
<td></td>
<td>___self care</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___informal caregiver</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___ADH/DHC</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___ALS</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___PSS aides (cueing)</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___RN provider</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>Dates of Service:</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>OBTAINING MEDICATIONS:</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___self care</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___informal caregiver</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___pharmacy delivery</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>___other</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>PHARMACY:</td>
<td>______</td>
</tr>
<tr>
<td></td>
<td>NOTES:</td>
<td>______</td>
</tr>
</tbody>
</table>

Service Options Using Resources In Community Environments April 1 2016
<table>
<thead>
<tr>
<th>Member ___________________________</th>
<th>Medicaid # ______________________</th>
<th>Date: ____________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4th review period (<em><strong>/</strong></em>/___):</th>
<th>_ met _ not met</th>
</tr>
</thead>
</table>

Sentinel events?

__________

(Providers and units/schedules listed on Member Version)
<table>
<thead>
<tr>
<th>KEY MEMBER OUTCOMES</th>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>QUARTERLY REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular performance of ADLs and IADLs is not interrupted due to cognitive or functional impairments.</td>
<td><strong>ASSISTANCE REQUIRED:</strong> (S=SELF; INF=informal support; PSS=PSS aide; HDM=home delivered meals; ALS=alternative living service):</td>
<td><strong>GOALS:</strong></td>
</tr>
</tbody>
</table>
| | ____bathing  ____dressing  ____eating  ____transferring  ____toileting/continence  ____turning/repositioning | 1st review period (__/__/__):  
| | ____errands  ____chores  ____financial mgt.  ____meal prep. |  
| | **informal caregiver(s) providing assistance:** | 2nd review period (__/__/__):  
| | |  
| | **home delivered meals** | 3rd review period (__/__/__):  
| | **ADH** |  
| | **ALS** | 4th review period (__/__/__):  
| | **ERS** |  
| | **incontinence Carepath** |  
| | **PSS aide** |  
| | Total hours/week: _____  Indicate no. of hours: |  

**GOALS:**

1st review period (__/__/__):

- __met
- __not met

2nd review period (__/__/__):

- __met
- __not met

3rd review period (__/__/__):

- __met
- __not met

4th review period (__/__/__):

- __met
- __not met

---

Service Options Using Resources In Community Environments April 1 2016
APPENDIX J
Level 1 Carepath Rev. 10/2015

<table>
<thead>
<tr>
<th>Member</th>
<th>Medicaid #</th>
<th>Date: ______________</th>
</tr>
</thead>
</table>

| Service Options Using Resources In Community Environments April 1 2016 |
| Monday _____AM _____PM       | Thursday _____AM _____PM       |
| Tuesday _____AM _____PM      | Friday _____AM _____PM        |
| Wednesday _____AM _____PM   | Saturday _____AM _____PM     |
| Sunday _____AM _____PM      |                                |

NOTES:_________________________________________________________________

___________________________________

_____________________________________

________________________________________________________________________

(Providers and units/schedules listed on Member Version)
<table>
<thead>
<tr>
<th>KEY MEMBER OUTCOMES</th>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>QUARTERLY REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem behavior will not place the Member at risk of social isolation, neglect or physical injury to themselves or others. Diagnosis:</td>
<td>ROUTINE AND PRN MONITORING AND EVALUATION by SOURCE PCP for signs of changes in mental status</td>
<td>GOALS:</td>
</tr>
<tr>
<td>_depression ___ _substance abuse</td>
<td>MEMBER/CAREGIVER EDUCATION:</td>
<td>1st review period (<strong>/</strong>/__):</td>
</tr>
<tr>
<td>_bi-polar disorder ___ schizophrenia</td>
<td>___SOURCE PCP</td>
<td>A. ___met ___not met</td>
</tr>
<tr>
<td>___Alzheimer’s ___ other dementia</td>
<td>___other ____________________________</td>
<td>B. ___met ___not met</td>
</tr>
<tr>
<td>___other ____________________________</td>
<td>_ongoing management of condition by mental health professional provider: ____________<strong><strong><strong><strong><strong><strong><strong><strong>schedule</strong></strong></strong></strong></strong></strong></strong></strong></td>
<td>C. ___met ___not met</td>
</tr>
<tr>
<td></td>
<td>Sentinel events?</td>
<td></td>
</tr>
<tr>
<td>GOALS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Residential arrangements remain stable.</td>
<td></td>
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<tr>
<td>B. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers. Indicators of inadequately managed behavior include:</td>
<td></td>
<td></td>
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<tr>
<td>• hospitalization for condition</td>
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<tr>
<td>• discussion of potential institutionalization</td>
<td></td>
<td></td>
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<tr>
<td>• increased level of caregiver stress</td>
<td></td>
<td></td>
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<tr>
<td>• physical danger to self or others posed by behavior</td>
<td></td>
<td></td>
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<tr>
<td>• discharge from a program or service due to behavior</td>
<td></td>
<td></td>
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<tr>
<td>Examples of problem or symptomatic behavior:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ALS for supervision and monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___PSS aides for supervision and monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___day program for supervision and monitoring of mental status when or if informal support is unavailable</td>
<td></td>
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<td></td>
<td></td>
<td>2nd review period (<strong>/</strong>/__):</td>
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<td></td>
<td></td>
<td>A. ___met ___not met</td>
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<td>B. ___met ___not met</td>
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<td></td>
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<td>C. ___met ___not met</td>
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<td>Sentinel events?</td>
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<td></td>
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<td>3rd review period (<strong>/</strong>/__):</td>
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<td>A. ___met ___not met</td>
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<td>B. ___met ___not met</td>
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<td></td>
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<td>C. ___met ___not met</td>
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<td>Sentinel events?</td>
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<td></td>
<td>4th review period (<strong>/</strong>/__):</td>
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<tr>
<td></td>
<td></td>
<td>A. ___met ___not met</td>
</tr>
<tr>
<td>wandering impaired memory</td>
<td>substance abuse</td>
<td>profoundly impaired judgment</td>
</tr>
<tr>
<td>---------------------------</td>
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<td>------------------------------</td>
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</tbody>
</table>

C. Sentinel events around behavior are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into action.

| provider: ________________________________ |
| schedule: M  T  W  Th  F |

NOTES: ________________________________

______________________________

______________________________

______________________________

______________________________

______________________________

(Providers and units/schedules listed on Member Version)

B. __met __not met

C. __met __not met

Sentinel events?

________
**APPENDIX J**  
**Level 1 Carepath Rev. 10/2015**

<table>
<thead>
<tr>
<th>Member _____________________________________________</th>
<th>Medicaid # ________________</th>
<th>Date: __________________</th>
</tr>
</thead>
</table>

### Service Options Using Resources In Community Environments April 1 2016

#### KEY MEMBER OUTCOMES

- Transfers and mobility will occur safely.

#### GOALS:

- Member has no falls due to unsuccessful attempts to transfer.
- Sentinel events around falls are discussed with responsible parties.

#### PLANNED RESPONSIBILITY PARTY

**MEMBER/CAREGIVER EDUCATION:**
- SOURCE PCP/PCP staff
- SOURCE educational material
- PCP is notified. Member gait, balance assessed, medication reviewed.

- Other ____________________________

#### ASSISTANCE REQUIRED:

- **Informal caregiver(s)** to provide assistance with transfers and mobility:
  - __________________________________

- **PSS aide** for assistance if/when informal support is unavailable
- **ALS**
- **ADH program** for assistance if/when informal support is unavailable

- **Adaptive equipment** as indicated, with training as required (specify):
  - __________________________________
  - __________________________________
  - __________________________________

- **Home modifications** as indicated (specify):
  - __________________________________

#### QUARTERLY REVIEWS

**GOALS:**

<table>
<thead>
<tr>
<th>1st review period (<em><strong>/</strong></em>/___):</th>
</tr>
</thead>
<tbody>
<tr>
<td>_ met _ not met</td>
</tr>
<tr>
<td>Sentinel events?</td>
</tr>
<tr>
<td>__________</td>
</tr>
</tbody>
</table>

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<tr>
<th>2nd review period (<em><strong>/</strong></em>/___):</th>
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</thead>
<tbody>
<tr>
<td>_ met _ not met</td>
</tr>
<tr>
<td>Sentinel events?</td>
</tr>
<tr>
<td>__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3rd review period (<em><strong>/</strong></em>/___):</th>
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</thead>
<tbody>
<tr>
<td>_ met _ not met</td>
</tr>
<tr>
<td>Sentinel events?</td>
</tr>
<tr>
<td>__________</td>
</tr>
</tbody>
</table>

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*Service Options Using Resources In Community Environments April 1 2016*
**KEY MEMBER OUTCOMES**

Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE pt.

**GOALS:**

No reports or other indicators of caregiver exhaustion (self-report, observed by case manager, etc.).

<table>
<thead>
<tr>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>QUARTERLY REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing SOURCE case management/support service plan</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Referral to support group</strong></td>
<td></td>
</tr>
<tr>
<td><strong>In-home respite</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-home respite provider:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Extended Personal Support (EPS) schedule:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ADH for respite purposes for informal caregiver</strong></td>
<td></td>
</tr>
</tbody>
</table>

**NOTES:**

---

(Providers and units/schedules listed on Member Version)

**GOALS:**

1st review period (__/__/__): met not met

2nd review period (__/__/__): met not met

3rd review period (__/__/__): met not met

4th review period (__/__/__): met not met
### KEY MEMBER OUTCOMES

<table>
<thead>
<tr>
<th>GOALS:</th>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>QUARTERLY REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>GOALS:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1st review period (<em><strong>/</strong></em>/___):</td>
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<td>_ not met</td>
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<td></td>
<td></td>
<td>2nd review period (<em><strong>/</strong></em>/___):</td>
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<td></td>
<td></td>
<td>3rd review period (<em><strong>/</strong></em>/___):</td>
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<td>4th review period (<em><strong>/</strong></em>/___):</td>
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<td>_ met</td>
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<td>_ not met</td>
</tr>
</tbody>
</table>

**Member _____________________________________________ Medicaid # ____________________ Date: ____________________**
<table>
<thead>
<tr>
<th>GOALS:</th>
<th>1st review period (<em><strong>/</strong></em>/___):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>_ met</td>
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<tr>
<td></td>
<td>_ not met</td>
</tr>
<tr>
<td></td>
<td>2nd review period (<em><strong>/</strong></em>/___):</td>
</tr>
<tr>
<td></td>
<td>_ met</td>
</tr>
<tr>
<td></td>
<td>_ not met</td>
</tr>
<tr>
<td></td>
<td>3rd review period (<em><strong>/</strong></em>/___):</td>
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<td></td>
<td>_ met</td>
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<tr>
<td></td>
<td>_ not met</td>
</tr>
<tr>
<td></td>
<td>4th review period (<em><strong>/</strong></em>/___):</td>
</tr>
<tr>
<td></td>
<td>_ met</td>
</tr>
<tr>
<td></td>
<td>_ not met</td>
</tr>
</tbody>
</table>

Member _____________________________________________ Medicaid # ______________________ Date: ________________
APPENDIX K MEMBER VERSION FOR LEVEL I

Member: ___________________________ Date: ___________

Welcome to SOURCE!

Our goals are helping you:

Stay as healthy as possible

AND

Continue living in your own home.

Your SOURCE CASE MANAGER:

SOURCE 24-hour Phone: _______________

Your SOURCE DOCTOR:

__________ Phone: ______________

Hospital for emergencies:

Besides treating you when you're sick, your SOURCE doctor will give you ADVICE and TREATMENT in the areas listed on this sheet, areas that are very important for your good health. Also listed are any people who may be helping you with each.

Please call the SOURCE 24-hour phone line before going to the emergency room, unless it is a life-threatening emergency.

Name ___________________________ Date ___________

GOOD NUTRITION

Proper meals

____________________________________

HEALTHY SKIN

Checking skin for problems ________________

____________________________________

KEEPING IT UNDER CONTROL

____ Blood pressure ______ Blood sugar

____ Weight ______ Unsafe behavior

Monitoring each: YOUR SOURCE DOCTOR

Others: ________________________________

____________________________________

NOTES: ______________________________

____________________________________

Member signature/date_____________________

Case Manager signature/date_________________
APPENDIX K MEMBER VERSION FOR LEVEL I

Member: ___________________________    Date: ____________

TAKING MEDICINES PROPERLY
Current medications: Contact your case manager or doctor’s office.
Drug store used _________________________
Picking up medicines _____________________
Help with taking medicines ________________

______________________________

GETTING UP, DOWN AND AROUND SAFELY
EQUIPMENT _____________________________

HELP from another person ________________

______________________________

GETTING HELP IN AN EMERGENCY
Plan for getting help in an emergency:
MEDICAL    CALL 911    FIRE CALL 911
HURRICANE OR OTHER NATURAL DISASTER:

______________________________

TAKING CARE OF MY HOME AND MYSELF
CLEANING

______________________________

ERRANDS _____________________________
LAUNDRY _____________________________
BATHING/DRESSING ____________________

______________________________

OTHER SUPPORT _______________________

______________________________

SOURCE SUPPORT SERVICES

______________________________

NOTES:

______________________________

Level 1

L-2

Service Options Using Resources In Community Environments April 1 2016
APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_________________________________________ DATE ______________________________

SOURCE

HOUSING, INCONTINENCE CAREPATHS
### APPENDIX L HOUSING, INCONTINENCE CAREPATHS

**MEMBER_________________________________________ DATE ______________________________**

**Service Options Using Resources In Community Environments April 1 2016**

<table>
<thead>
<tr>
<th>KEY MEMBER OUTCOMES</th>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>FUNDING</th>
<th>QUARTERLY REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member will reside in housing that is safe, affordable and accessible.</td>
<td>__Member preference is to explore relocating to a new home.</td>
<td></td>
<td>MEASURES:</td>
</tr>
<tr>
<td>Issues identified:</td>
<td></td>
<td></td>
<td>1st review period (<em><strong>/</strong></em>/___):</td>
</tr>
<tr>
<td>___substandard physical structure</td>
<td></td>
<td></td>
<td>_ met</td>
</tr>
<tr>
<td>___unaffordable</td>
<td></td>
<td></td>
<td>_ not met</td>
</tr>
<tr>
<td>___not accessible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___geographic isolation</td>
<td></td>
<td></td>
<td>2nd review period (<em><strong>/</strong></em>/___):</td>
</tr>
<tr>
<td>___family/household dynamics</td>
<td></td>
<td></td>
<td>_ met</td>
</tr>
<tr>
<td>___other ___________________________</td>
<td></td>
<td></td>
<td>_ not met</td>
</tr>
<tr>
<td><strong>GOALS:</strong></td>
<td></td>
<td></td>
<td>3rd review period (<em><strong>/</strong></em>/___):</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>_ met</td>
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<td>_ not met</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>('_ met', color='red')</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>_ met</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>_ not met</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEMBER_________________________________________ DATE ______________________________**
No reports or observations of the above.

| Follow-up on application once submitted (review waiting list if applicable, contact regularly to check) |
| Relocation checklist: |
| Security deposit |
| Utilities |
| Transfer |
| Change of address with Social Security, DFCS, etc. |
| Notification of providers |
### Key Member Outcomes

- Member will reside in housing that is safe, affordable and accessible. (CONT'D, Page 2)

### Plan/Responsible Party

- Moving arrangements:
  - ___ family/informal support
  - ___ PSS aide; provider _____________

- Date moved: ________________
- Date refused to relocate: ________________

- HOME REPAIR, renter:
  - ___ Broadly describe nature of repairs needed:
    - ___ structural
    - ___ electrical
    - ___ plumbing
    - ___ infestation
    - ___ heating/cooling
    - ___ major accessibility modifications
    - ___ other ________________

### Funding

### Quarterly Reviews

<table>
<thead>
<tr>
<th>MEASURES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st review period (<em><strong>/</strong></em>/___):</td>
</tr>
<tr>
<td>_ met</td>
</tr>
<tr>
<td>_ not met</td>
</tr>
</tbody>
</table>

| 2nd review period (___/___/___): |
| _ met |
| _ not met |

<p>| 3rd review period (<em><strong>/</strong></em>/___): |
| _ met |
| _ not met |</p>
<table>
<thead>
<tr>
<th>Service Options Using Resources In Community Environments April 1 2016</th>
<th>L-5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APPENDIX L HOUSING, INCONTINENCE CAREPATHS</strong></td>
<td></td>
</tr>
<tr>
<td>MEMBER_________ DATE ________________</td>
<td></td>
</tr>
<tr>
<td><strong>Identify informal support to provide assistance, if available.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provide SOURCE resources to informal support.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Obtain permission to contact landlord if applicable, if no informal support available for this assistance.</strong></td>
<td></td>
</tr>
</tbody>
</table>
MEMBER_________________________________________ DATE ______________________________

### Key Member Outcomes

<table>
<thead>
<tr>
<th>Member will reside in safe, affordable and accessible housing. (CONT'D, page 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan/Responsible Party</strong></td>
</tr>
<tr>
<td>Identify and contact landlord, describing nature of need repairs.</td>
</tr>
<tr>
<td>One-month follow-up</td>
</tr>
<tr>
<td>Repairs acceptable <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Repairs in progress <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>No repairs initiated <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Notify appropriate authority:</td>
</tr>
<tr>
<td>City Inspection Department <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>(structural, plumbing, wiring)</td>
</tr>
<tr>
<td>Health Department <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>(infestation, sewage)</td>
</tr>
<tr>
<td>Fire Department <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>(electrical, wiring, smoke alarms)</td>
</tr>
<tr>
<td>One month follow-up with Member</td>
</tr>
<tr>
<td>Repairs in progress/completed</td>
</tr>
<tr>
<td>Repairs not initiated</td>
</tr>
<tr>
<td>Re-contact appropriate authority</td>
</tr>
</tbody>
</table>

### Funding

<table>
<thead>
<tr>
<th>Quarterly Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEASURES:</td>
</tr>
<tr>
<td>1st review period (<strong><strong>/</strong></strong>/____):</td>
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<tr>
<td>_ met</td>
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<tr>
<td>_ not met</td>
</tr>
<tr>
<td>2nd review period (<strong><strong>/</strong></strong>/____):</td>
</tr>
<tr>
<td>_ met</td>
</tr>
<tr>
<td>_ not met</td>
</tr>
<tr>
<td>3rd review period (<strong><strong>/</strong></strong>/____):</td>
</tr>
<tr>
<td>_ met</td>
</tr>
<tr>
<td>_ not met</td>
</tr>
<tr>
<td>Final disposition:</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>____ repairs made</td>
</tr>
<tr>
<td>____ repairs not made</td>
</tr>
<tr>
<td>____ Member preference is to relocate (see relocate plan)</td>
</tr>
<tr>
<td>____ Member preference is to remain in home under present conditions</td>
</tr>
<tr>
<td>KEY MEMBER OUTCOMES</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Member will reside in safe, affordable and accessible housing. (CONT'D, page 4)</td>
</tr>
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</tbody>
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Service Options Using Resources In Community Environments April 1 2016  L-8
<table>
<thead>
<tr>
<th>Member</th>
<th>Date</th>
</tr>
</thead>
</table>

---

**APPENDIX L HOUSING, INCONTINENCE CAREPATHS**

___Explore available funding from other sources:

______________________________________

______________________________________

---

Service Options Using Resources In Community Environments April 1 2016 L-9
<table>
<thead>
<tr>
<th>KEY MEMBER OUTCOMES</th>
<th>PLAN/RESPONSIBLE PARTY</th>
<th>FUNDING</th>
<th>Quarterly Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member will reside in safe, affordable and accessible housing. (CONTD, page 5)</td>
<td>__One month follow-up</td>
<td></td>
<td>MEASURES:</td>
</tr>
<tr>
<td></td>
<td>___ repairs acceptable <strong>/</strong>/__</td>
<td></td>
<td>1st review period (/<em>/</em>/) :</td>
</tr>
<tr>
<td></td>
<td>___ repairs in progress <strong>/</strong>/__</td>
<td></td>
<td>2nd review period (/<em>/</em>/):</td>
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<tr>
<td></td>
<td>___ no repairs initiated <strong>/</strong>/__</td>
<td></td>
<td>3rd review period (/<em>/</em>/):</td>
</tr>
<tr>
<td></td>
<td>___ Re-contact appropriate funding source</td>
<td></td>
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<tr>
<td></td>
<td>__Final disposition:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>___ repairs made</td>
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</tr>
<tr>
<td></td>
<td>___ repairs not made</td>
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</tr>
<tr>
<td></td>
<td>___ Member preference is to relocate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(see “Relocation” section)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>___ Member preference is to remain in home under present</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>conditions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Key Member Outcomes

<table>
<thead>
<tr>
<th>Plan/Responsible</th>
<th>Funding</th>
<th>Quarterly Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member's incontinence will be managed to promote skin integrity and adequate personal hygiene.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GOALS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A. Member has no skin breakdowns or decubiti requiring clinical intervention/wound care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Member maintains acceptable personal hygiene (no perceptible odor, etc., and no reports by Member or caregiver/provider/PCP).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Member has no infections/complications OR frequency of infections decreased for persons with catheter.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Plan/Responsible**

___paper continence products
supplier: ___Member/informal caregiver
___Community Benefits
___assistance by informal caregiver
___assistance by PSS aide
proof: schedule:

___catheterization
___in-and-out
___assistance by informal caregiver
___assistance by LPN/RN
proof: schedule:

___in-dwelling
___assistance by informal caregiver
___assistance by RN/LPN
proof: schedule:

___external
___assistance by informal caregiver

**Measures:**

1<sup>st</sup> review period (___/___/___): _A_.
A. ___met _ not met
B. ___met _ not met
C. ___met _ not met

2<sup>nd</sup> review period (___/___/___): _A_.
A. ___met _ not met
B. ___met _ not met
C. ___met _ not met

3<sup>rd</sup> review period (___/___/___): _A_.
A. ___met _ not met
### APPENDIX L HOUSING, INCONTINENCE CAREPATHS

<table>
<thead>
<tr>
<th>Member: ____________________________</th>
<th>Date: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service Options Using Resources In Community Environments</th>
<th>April 1 2016</th>
</tr>
</thead>
</table>

- ___ assistance by PSS aide  
  - provider:  
  - schedule:  
- ___ ostomy  
- ___ Member/caregiver education  
- ___ SOURCE PCP  
- ___ SOURCE RN  
- ___ self-care  

Assistance required:  
- ___ assistance by informal caregiver  
- ___ assistance by PSS aide  
  - provider:  
  - schedule:  
- ___ assistance by LPN/RN  
  - provider:  
  - schedule:  

<table>
<thead>
<tr>
<th>4th review period (<em><strong>/</strong></em>/___):</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. ___ met  ___ not met</td>
</tr>
<tr>
<td>B. ___ met  ___ not met</td>
</tr>
<tr>
<td>C. ___ met  ___ not met</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>A. ___ met  ___ not met</td>
</tr>
<tr>
<td>B. ___ met  ___ not met</td>
</tr>
<tr>
<td>C. ___ met  ___ not met</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>A. ___ met  ___ not met</td>
</tr>
<tr>
<td>B. ___ met  ___ not met</td>
</tr>
<tr>
<td>C. ___ met  ___ not met</td>
</tr>
</tbody>
</table>
Carepath Variance Report

SOURCE Member: __________________________________________________________

Year/Quarter: ____________________ Date: _________________________________

__Comm  __Skin  __Clin  __Meds  __I/ADLs  
__Trans/MOB__

__Nutr’n  __Behavior  __Inf Support  __Incontinence

Corrective Action Taken:

Year/Quarter__________________ Date: ___________________________________

__Comm  __Skin  __Clin  __Meds  __I/ADLs 
__Trans/MOB__

__Nutr’n  __Behavior  __Inf Support  __Incontinence

Corrective Action Taken:
APPENDIX M
CARE PATH VARIANCE REPORT

Year/Quarter______________________ Date: __________________________________
__Comm__Skin __Clin __Meds __I/ADLs
__Trans/MOB
__Nutr’n __Behavior __Inf Support __Incontinence

Corrective Action Taken:

Year/Quarter______________________ Date: ________________________________
__Comm__Skin __Clin __Meds __I/ADLs
__Trans/MOB
__Nutr’n __Behavior __Inf Support __Incontinence

Corrective Action Taken:
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance.

Rev. 04/11  Note: Remember when assessing LOC with the Multi Data Set – Home Care (MDS-HC) that the target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE.)
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance.
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance.

### APPENDIX S

#### MDS-HC Assessment Version 9

**SECTION C. COGNITION**

<table>
<thead>
<tr>
<th>1. COGNITIVE SKILLS FOR DAILY DECISION MAKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making decisions regaining sense of daily life—e.g., when to eat meals, when to take medicine, when to go to sleep. All decisions consistent, reasonable, and safe.</td>
</tr>
</tbody>
</table>

| 2. MODERATE difficulty—Problem hearing normal conversation, requires quiet setting to hear clearly. |
| 3. Severe difficulty—Difficulty in situations e.g., speaker has to talk loudly or speak very clearly, expresses that at times speech is not understood. |

| 4. No hearing |

### VISION

<table>
<thead>
<tr>
<th>Ability to see to adequate light (with glasses or without vision assistance normally poor)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Unable—Cannot see detail, including print in newspapers, books</td>
</tr>
<tr>
<td>B. Moderate difficulty—Sees print, but not regular print in newspapers, books</td>
</tr>
<tr>
<td>C. No difficulty</td>
</tr>
</tbody>
</table>

### SECTION D. COMMUNICATION AND VISION

<table>
<thead>
<tr>
<th>1. MAKING SELF UNDERSTOOD (Expression)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expresses thoughts and ideas using both verbal and nonverbal means.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. ABILITY TO UNDERSTAND OTHERS (Comprehension)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands conversations either verbally or nonverbally.</td>
</tr>
</tbody>
</table>

### SECTION E. MOOD AND BEHAVIOR

<table>
<thead>
<tr>
<th>1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR BAD MOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoids usual activities and interests; 2 or more days in a row negative attitude.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. SELF-REPORTED MOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No in last 3 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. BEHAVIOR SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
</tr>
</tbody>
</table>

---

interRAI Home Care (HC)©

Rev. 07/08

Service Options Using Resources In Community Environments April 1 2016

S-3
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance.

### SECTION 5. PSYCHOSOCIAL WELL BEING

**1. SOCIAL RELATIONSHIPS**
- (a) If living with someone: (Enter name(s))
- (b) Social support from family member or others outside the home
- (c) Other support outside the home
- (d) Voluntary activities outside the home
- (e) orientation

**2. LONELY**
-的身影 indicates the need for loneliness

**3. CHANGE IN SOCIAL ACTIVITIES LAST 30 DAYS**
- (a) Change in social activities
- (b) Change in work or volunteer activities

**4. LENGTH OF TIME ALONE DURING THE DAY/WORKING TIME (HOURS)**
- (a) Total number of hours
- (b) Number of hours alone

**5. MAJOR LIFE STRESSORS LAST 30 DAYS**
- (a) Death of a close family member
- (b) Major health problem
- (c) Major financial problem

### SECTION 6. FUNCTIONAL STATUS

**1. ADL SELF PERFORMANCE AND CAPACITY**
- (a) Meal preparation
- (b) Ordinary household tasks
- (c) Managing finances
- (d) Managing medications
- (e) Using phone
- (f) Stair use
- (g) Shopping

**2. MOBILITY**
- (a) Transportation
- (b) Treadmill

**3. LIVING ARRANGEMENTS**
- (a) Living arrangement
- (b) Housing arrangement

---

**APPENDIX S**

**MDS-HC Assessment Version 9**

---

**REV. 07/08**

**Service Options Using Resources In Community Environments April 1 2016**

---

**S-4**
APPENDIX S
MDS-HC Assessment Version 9

Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance

---

InterRAI Home Care (HC)

**4. PADS OR BRIEFS WORN**
- Yes

**SECTION I. DISEASE DIAGNOSES**

<table>
<thead>
<tr>
<th>Disease Code</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**1. DISEASE DIAGNOSES**

- Musculoskeletal
  - Hip fracture during last 30 days or since last assessment if less than 30 days
  - Other fracture during last 30 days or since last assessment if less than 30 days

- Neurological
  - Alzheimer’s disease
  - Dementia other than Alzheimer’s disease

- Physiological
  - Anxiety
  - Bipolar disorder

- Psychological
  - Depression

- Schizophrenia

**INFECTIONS**

- Pneumonia
  - Urinary tract infection in last 30 days

**OTHER**

- Cancer
  - Diabetes mellitus

**2. OTHER DISEASE DIAGNOSES**

---

**SECTION II. CONTINENCE**

**1. BLADDER CONTINENCE**

- Complete control

**2. URINARY COLLECTION DEVICE (Exclude pads/liners)**

- No
  - 1

**3. DIETARY CONTINENCE**

- No
  - 1

---

**SECTION J. HEALTH CONDITIONS**

**1. FALLS**

- No
  - 1

**2. RECENT FALLS**

- Yes
  - 1

**3. PROBLEM FREQUENCY**

- Not present
  - 1
  - 2
  - 3

---

Service Options Using Resources in Community Environments April 1, 2016

Rev. 07/08
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance.

### APPENDIX S
MDS-HC Assessment Version 9

#### interRAI Home Care (HC)

<table>
<thead>
<tr>
<th>BALANCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Difficult or unable to move self to standing position unassisted.</td>
<td></td>
</tr>
<tr>
<td>b. Difficult or unable to turn self around and face the opposite direction when standing</td>
<td></td>
</tr>
<tr>
<td>c. Dizziness</td>
<td></td>
</tr>
<tr>
<td>d. Unsteadiness</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARDIOVASCULAR</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Chest pain</td>
<td></td>
</tr>
<tr>
<td>1. Difficulty clearing airway secretions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PSYCHIATRIC</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>g. Abnormal thought process—e.g., delusional thinking (false idea, delusional thinking)</td>
<td></td>
</tr>
<tr>
<td>h. Delusions—Fixed false beliefs</td>
<td></td>
</tr>
<tr>
<td>i. Hallucinations—False sensory perceptions</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGICAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pyramidal</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>OTHER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Aspiration</td>
<td></td>
</tr>
<tr>
<td>d. Gl and GU bleeding</td>
<td></td>
</tr>
</tbody>
</table>

### DYSPEA (Shortness of breath)

1. Absence of shortness of breath:
   - During activity
   - During sleep
   - Present while sitting

2. Present at rest, but absent when performing normal Activities

3. Present at rest, but absent when performing normal Activities

### FATIGUE

Frequency of moderate daily activities—e.g., ADLs, ADLs

<p>| |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>No</td>
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<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

### PAIN SYMPTOMS

Frequency with which patient complains or shows evidence of pain (including grimacing, teeth clenched, moaning, withdrawal if touched, or other non-verbal signs suggesting pain)

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<table>
<thead>
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<tbody>
<tr>
<td>No</td>
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<tr>
<td>Yes</td>
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</table>

### CONSISTENCY OF PAIN

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<tr>
<td>No</td>
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<tr>
<td>Yes</td>
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</table>

### INSTABILITY OF CONDITIONS

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<tbody>
<tr>
<td>No</td>
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<tr>
<td>Yes</td>
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</tbody>
</table>

### SELF-REPORTED HEALTH

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<tbody>
<tr>
<td>No</td>
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<td>Yes</td>
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</tbody>
</table>

### TOBACCO AND ALCOHOL

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<tr>
<td>No</td>
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<tr>
<td>Yes</td>
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</tbody>
</table>

### SECTION V. ORAL AND NUTRITIONAL STATUS

### 1. HEIGHT AND WEIGHT IN CHINESE AND POUNDS—COUNTRY SPECIFIC

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<tr>
<th></th>
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<tbody>
<tr>
<td>a. HT in</td>
</tr>
<tr>
<td>b. WT lbs</td>
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</tbody>
</table>

### 2. NUTRITIONAL ISSUES

<p>| |</p>
<table>
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<tbody>
<tr>
<td>a. Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 60 DAYS</td>
</tr>
</tbody>
</table>

### 3. Mode of Nutritional Intake

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a. Nausea</td>
</tr>
<tr>
<td>b. Alcohol intake moderate to high</td>
</tr>
<tr>
<td>c. Fluid intake less than 2,000 cc per day (less than four 8 oz cups/day)</td>
</tr>
<tr>
<td>d. Fluid output exceeds input</td>
</tr>
</tbody>
</table>

---

Rev. 07/08

Service Options Using Resources In Community Environments April 1 2016 S-6
APPENDIX S
MDS-HC Assessment Version 9

Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance

### SECTION I. SKIN CONDITION

1. MOST SEVERE PRESSURE ULCER
   - No pressure ulcer
   - Any areas of persistent skin redness
   - Pitted loss of skin layers
   - Deep cracks in the skin
   - Breakdown of underlying muscle or bone
   - Not cosmetically correctable

2. PRIOR PRESSURE ULCER
   - Yes

3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER
   - Yes

4. MAJOR SIGN PROBLEMS
   - Yes

5. SKIN YEARS OR CUTS
   - Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION
   - Yes

7. FOOT PROBLEMS
   - Yes

### SECTION II. MEDICATIONS

1. LIST OF ALL MEDICATIONS
   - Include all medications and any non-prescribed (over-the-counter) medications taken in the LAST 7 DAYS.
   - For each medication:
     - **Name**
     - **Dosage**
     - **Unit**
     - **Route of Administration**
     - **Frequency**

### SECTION III. TREATMENT AND PROCEDURES

1. PREVENTION
   - Yes
   - Blood pressure measured in LAST YEAR
   - Colorectal test in LAST 5 YEARS
   - Dental exam in LAST YEAR
   - Eye exam in LAST YEAR
   - Hearing exam in LAST 2 YEARS
   - Flu vaccine in LAST YEAR
   - Mammogram or breast exam in LAST 2 YEARS
   - Other (specify):

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 30 DAYS OR SINCE LAST ASSESSMENT IF LESS THAN 30 DAYS
   - Yes
   - Chemotherapy
   - Dialysis
   - Infection control
   - Infusion therapy
   - IV medication
   - Respiratory therapy
   - Radiation therapy
   - Wound care
   - Other (specify):

3. FORMAL CARE
   - Days (A) and Total minutes (B) of care in last 7 days
   - Home health aides
   - Home nurse
   - Homemaker services
   - Meals
   - Physical therapy
   - Occupational therapy
   - Speech-language pathology and audiology services
   - Psychological therapy

---

Rev. 07/08
Service Options Using Resources In Community Environments April 1 2016
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance.

<table>
<thead>
<tr>
<th>4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT</th>
<th>2. LIVES IN APARTMENT OR HOUSE ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)</td>
<td>No</td>
</tr>
<tr>
<td>a. Implant acute hospital with overnight stay</td>
<td>b. Emergency room visit (not causing overnight stay)</td>
</tr>
<tr>
<td>5. PHYSICALLY RESTRAINED—Limits restraints, used physically restrained in chair when sitting</td>
<td>0</td>
</tr>
</tbody>
</table>

SECTION O. RESPONSIBILITY

1. LEGAL GUARDIAN (EXAMPLE: LISA) | 0 | No | 1 | Yes |

SECTION P. SOCIAL SUPPORTS

1. TOWING INFORMATION HELPERS
   a. Relationship to person
      1. Child under age 18
      2. Spouse
      3. Parent or grandparent
      4. Parent of a grandparent
      5. Spouse’s parent
      6. Other relative
      7. Friend
      8. Neighbor:
         a. No informal helper | b. Lives with person | 0 | No | 1 | Yes | 0 | No | 1 | Yes |
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</table>

2. INFORMAL HELPER STATUS
   a. Informal helper(s) unable to continue in caring activity—g. Decline in physical health or mental health to continue
   b. Primary informal helper expresses feelings of distance, anger, or depression
   c. Family or close friends report feeling overwhelmed by person’s illness

3. HOURS OF INFORMAL CARE AND ACTIVITY MONITORING DURING LAST 3 DAYS
   a. Total number of hours of help received from family, friends, and neighbors

4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY
   a. No | b. Yes

SECTION Q. ENVIRONMENTAL ASSESSMENT

1. HOME ENVIRONMENT
   a. Disrepair of the home—e.g., hazardous situation; indication of no lighting in living room, bathroom, kitchen, toilet, condition of holes in floor, leaking pipes
   b. Squatting condition—e.g., extremely dirty, limited by type of living
   c. Inadequate heating or cooling—e.g., too hot in summer, too cold in winter
   d. Lack of personal safety—e.g., fear of violence, lack of preparation for inclement weather, broken glass, frames
   e. Limited access to home or rooms in home—e.g., difficulty entering or leaving home, unable to declutter, difficulty maneuvering within rooms, no windows although needed

INTERRAI Home Care (HC)

3. OUTSIDE ENVIRONMENT
   a. No | b. Yes
   c. Availability of emergency assistance—e.g., telephone, alarm response system
   d. Accessibility to grocery store without assistance
   e. Availability of home delivery of groceries

4. FINANCES
   a. No | b. Yes
   Because of limited funds during the last 30 days unable to pay bills among the following: adequate housing, clothing, prescription medications, sufficient income for housing, necessary health care

SECTION R. DISCHARGE POTENTIAL AND OVERALL STATUS

1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
   a. No | b. Yes

2. OVERALL SELF SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARING TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
   a. Improved | b. No change | c. Determined

CODE FOLLOWING THREE ITEMS IF "DETERIORATED" IN LAST 90 DAYS—OTHERWISE SKIP TO SECTION S

3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION
   a. No | b. Yes

4. NUMBER OF 8 ADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION
   a. No | b. Yes

5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION
   a. Within last 7 days | b. 8 to 14 days ago | c. 15 to 21 days ago | d. 22 to 28 days ago | e. 29 to 60 days ago | f. More than 60 days ago

SECTION S. DISCHARGE

1. LAST DAY OF STAY
   a. No | b. Yes

2. RESIDENTIAL/LIVING STATUS AT TIME OF ASSESSMENT
   a. Private home/rented room | b. Boarding home | c. Assisted living or semi-independent living | d. Mental health residence—e.g., psychiatric group home | e. Group home for persons with physical disability | f. Group home for persons with intellectual disability | g. Residential facility (nursing home) | h. Transitional housing | i. Hospice facility | j. Homeless (with or without shelter) | k. Long-term care facility (nursing home) | l. Psychosocial setting | m. Psychosocial setting

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING/COMPLETING THE ASSESSMENT

1. Signature (print on above line)
2. Date assessment signed as complete

INTERRAI Home Care
# APPENDIX T

**MDS-HC Participants**  
**SOURCE Program**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Agency</th>
<th>Relationship to Applicant</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

RN Who Reviewed MDS HC for Completeness: (Printed)  
RN signature  
Date:

Appendix T needs to be signed and dated by R.N. SOP is within **10 business** days of completion of the MDS-HC.

---

**Service Options Using Resources In Community Environments April 1 2016**  

Rev. 01/09  
Rev. 01/13  
Rev. 07/13
**APPENDIX U1**

**SOURCE MONTHLY CONTACT SHEET**

Use this form for Case management *Monthly Contact Sheet*. May use this form or U2 for *quarterly reviews*. Review these areas with member or member’s caregiver each month. See section 1302. Summarize this info with PCP during quarterly visits by transferring information to PCP contact sheet.

Member’s

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth</th>
<th>Level:</th>
<th>PCP:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Services Ordered: ________________________________________

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROCESS</strong></td>
<td><strong>1st 2nd 3rd 4th (circle quarter)</strong></td>
<td><strong>MONITORING/CASENOTES</strong></td>
</tr>
<tr>
<td>See Policy 1302</td>
<td><strong>QUARTERLY OBJECTIVES</strong></td>
<td>√: if GM goals met. CN: see case notes. NA: not applicable</td>
</tr>
<tr>
<td>Monthly Contacts (Minimum)</td>
<td><strong>Circle Variances</strong></td>
<td></td>
</tr>
<tr>
<td>Circle Specifics below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have Reviewed with the member:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Services:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Appts and Dates:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ PCP or ☐ Specialist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Room Visit or Hospitalizations</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**MONITORING/CASENOTES**

- **Diet and Nutrition Goals:**
  - Weight stable, feeding problems, following diet
- **Skin Integrity Goals:**
  - Details for any skin openings or decubiti: ie stable, worsening, new
- **Clinical Goals:**
  - Is blood pressure, blood sugar or other within goal?
- **ADL/IADL Goals:**
  - Any disruptions in ADL or IADL maintenance?
- **Transfer and Mobility Goals:**
  - Any falls or concerns with Transfers or Mobility?
- **Behavioral Goals:**
  - Any problem behaviors?
- **Care Giver Support Goals:**
  - Informal caregivers maintained in member’s life?
- **Incontinence Goals:**
  - Incontinence issues including supplies
  - Ostomy or Catheter
  - Medications (update list from chart)
  - Adherence issue? Problems?
- **Disease Management (DM):**
  - Is Intervention needed? What will be done?
- **Notes:**
  - (include resolution of last month’s variances, if any, teaching done on DM):

---

**Section D**

- **Any Sentinels this month/Quarter? Yes No # of Sentinels**

- **Appropriate follow up actions/ interventions needed:**

---

**CM Signature and Date**

**Member Signature and Date (if face to face)**

**CM Supervisor Signature and Date (quarterly)**

---

*Service Options Using Resources In Community Environments April 1 2016*
Tips for Appendix U1

Tips for completing Appendix U for Monthly Reviews
Before calling member: fill out Column A. Review chart for any phone calls, notes, variances, sentinel events, service problems. Make notes of any follow up information you may need from the member. Pull most recent medication record. Move back and forth between columns Band C while speaking with member.

Complete section D with thoughtful review on conversation with member taking into consideration variances/sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines.

Tips for completing Appendix U for Quarterly Reviews:
Before visiting member fill out Column A. Review member’s chart for any phone calls, notes, variances, sentinel events, service problems. Make notes of any follow up information you may need from the member. Review Carepath and use columns B and C for short summaries. Take copy of Medication Record to confirm with member.

Complete section D with thoughtful review on conversation with member taking into consideration variances/sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines.

Per Policy: Case Managers and Carepaths are at the core of concurrent review in SOURCE. To reach the program’s stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Primary Care Providers, program supervisors, and if applicable, providers; Carepaths provide guidance and formal structure for the concurrent review process.
Document on this form before and during Carepath review with member. See Policy 1302.

Member’s Name: ___________________________ Level: ___________ PCP: ___________________________
Date of Birth: ___________________________ Significant Diagnosis: ______________________________________

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>MONITORING/CASE NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Review OR Annual Re-evaluation</td>
<td></td>
</tr>
<tr>
<td>No. of Emergency Room visits:</td>
<td></td>
</tr>
<tr>
<td>No. of Hospitalizations:</td>
<td></td>
</tr>
<tr>
<td>Sentinel Events this quarter? Yes No</td>
<td></td>
</tr>
<tr>
<td>Or Number of Sentinels this year#</td>
<td></td>
</tr>
<tr>
<td>See member chart for additional information on:</td>
<td></td>
</tr>
<tr>
<td>Copies of Advance Directives received, if applicable</td>
<td></td>
</tr>
</tbody>
</table>

Does member have / need **Disease Management** (see policy section 1310)? Yes No
If so, information given/ reviewed with patient: __________________________________________ OR
Is skilled nursing, RN or PCP care, or other intervention needed for DM and will be recommended at team meeting? Yes No
(Circle appropriate intervention if needed)

Notes/Additional Follow-up actions indicated by this review: ______________________________________________________
____________________________________________________________________________________________

Δ Confirm/ List medications for Annual Visit:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Who ordered?</th>
<th>Member Compliant?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Δ For Annual Evaluation: **Member Stated Goals** for year: ______________________________________________________
____________________________________________________________________________________________

Member Signature and Date
Case Management Signature and Date
Case Management Supervisor Signature (quarterly) Date
**Tips for Appendix U2**

U2 can be used instead of appendix U for quarterly visits. Always use U2 for Annual contact with members.

**Quarterly visits:**
Before speaking with member, Fill out Column labeled *Process* and Pull/ copy a recent medication list.
- Review chart for any phone calls, notes, variances, sentinel events, service problems. Pull Carepath to review with member. Make notes of any information you may need from the member.

Complete quarterly objectives with member while reviewing Carepath. Complete monitoring notes with thoughtful review with member taking into consideration variances/ sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines.

Per Policy: Case Managers and Carepaths are at the core of concurrent review in SOURCE. To reach the program’s stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Primary Care Providers, program supervisors, and if applicable, providers; Carepaths provide guidance and formal structure for the concurrent review process.

△ **Annual visits:**
See guidelines above for quarterly visits and also complete the areas marked with triangle symbol.
## PCP CONFERENCE

**Member’s Name:** ______________________________________  
**Level:** _______  
**PCP:** ______________________________________

**Date of Birth:** ___________________________  
**Significant Diagnosis:** ___________________________

**Current Services:** ______________________________________  
**ER Visits/ Hospitalizations? Yes NO Why?**  
**PCP recommendations for prevention**

Does member need a SOURCE Disease Management Tracking Log? **Y N**  
If so, was it reviewed? **Y N**

Document all member deficits  
Case Management or RN: prepare as much as possible ahead of time to present to PCP.  
✓ Use Check if Goal is met for Area, Circle if not met, N/A if not applicable. Comments from Agency and PCP are encouraged.

- [ ] Keeping PCP Appointments ___________________________  
  PCP ______________________________________

- [ ] Diet/Weight ______________________________________  
  PCP ______________________________________

- [ ] Behavior Issues ______________________________________  
  PCP ______________________________________

- [ ] ADL/IADL Needs ______________________________________  
  PCP ______________________________________

- [ ] Medication Compliance ______________________________________  
  PCP ______________________________________

- [ ] Falls/Mobility Issues ______________________________________  
  PCP ______________________________________

- [ ] Clinical Indicators – list and give current range  
  (lab, v/s) ______________________________________  
  PCP ______________________________________
  Is Flu/Pneumonia/ Other Vaccine Due? **Y N**

- [ ] Skin Care/Breakdowns____________________________________  
  PCP ______________________________________

- [ ] Caregiver Issues____________________________________  
  PCP ______________________________________

- [ ] Continence Issues____________________________________  
  PCP ______________________________________

**New Diagnoses!**

Review Carepath, record any changes made. ______________________________________

**Confirm/ List medications with PCP office Quarterly. * = new medications:**

Member Health complaints/ risks that may be due to  
Medication actions, list here so PCP may assess.  
Such as Fall/ER/ weakness/Dizziness, other. ______________________________________

- [ ] PCP Notes/Comments/Goals for member at any visit:

- [ ] Major Changes/Concerns in Functional Status: Yes No  
  **Physical or cognitive?**

  ______________________________________  
  ______________________________________  
  ________________  
  ________________  
  ________________  
  ________________  

  PCP Signature  
  MD/PA/NP  
  Date

- [ ] CM received H&P, notes, labs needed __________  
  PCP Signed Care path __________  
  PCP Signed Contact Sheet __________  
  Other __________
Tips for Appendix U3 PCP Conference

Use this form to prepare and summarize before visit with PCP case management areas of interest to medical providers (quarterly visit go back to the beginning of the quarter) (with annual visits go back one year) such as:

1. Circle which quarterly visit or is this the closest date to the member’s Annual visit where member will be reassessed for the program?
2. Document which home and community services member receives (case management is a given)
3. Does the member have or now need disease management tracking? See Policy section 1310.
4. Were the majority of appointments with the PCP kept? Were the majority of appointments with the specialist kept? (Write in N/A if no specialist visits needed).
5. Review member chart and estimate number of emergency department visits and hospitalizations.
6. Review member chart to see if variances occurred. Circle the section and write a brief note on variance (ie. resolved, in progress, etc) under the correct areas.
   - Were diet goals met? Were there any variance? Short note to indicate progress if a variance was reported (ie resolved or ongoing?)
   - Are there any skin breakdowns or poorly healing wounds? Locations and variances are self explanatory.
   - Clinical Goals: if any routine medical tests are followed by the member for health conditions, are they within acceptable ranges for the re-evaluation time period? (BP stands for blood pressure, FSBS stands for fasting blood sugar, O2 is oxygen management) These are common tests followed. Enter tests you and PCP feel are critical.
   - ADL /IADL goals for transfers and mobility. Fill out as indicated.
   - Behavioral Issues: Complete as indicated.
   - Caregiver Support Issues. Fill out as indicated.
7. Please list all current medications.
   a. If member has medications, are they taking them as indicated?
8. Any significant sentinel events this year? If yes, just indicate type ie abuse, fall, neglect etc

II. When meeting with PCP, please encourage provider to jot comments, notes, and goals on form.
9. If any areas not reviewed, document why it was not reviewed.
10. PCP and Case management signs form.
11. If there is an annual re evaluation due for the member within 3 months, go over information in black box with PCP.
   - It’s very important to confirm if PCP agrees that member has ADL and/or IADL deficits and the etiology or diagnosis that is causing the deficits.
   - You may inform the PCP that for SOURCE, those deficits must be due to a physical deficit or a cognitive loss, and rise to Nursing Home Level of Care which is determined by standardized assessment tools, and team review of all pertinent information on the member.
If PCP has questions, have an agency R.N. or supervisor speak to PCP
APPENDIX V
SOURCE Referral Form

Rev. 01/09

SOURCE Member_________________________________ Date____________________
Social Security No._________________________________ Medicaid No.______________
Address__________________________________________ Phone No._________________
__________________________________________ Medicare No.__________________
SOURCE Level_________________ Diagnosis Code_________________
SOURCE Enhanced Case Management Authorization No____________________________________
Directions to home____________________________________________________________________

Primary Contact and Relationship_____________________________________________________
Primary Contact Phone
Number(s)_____________________Address___________________________________________
Service Requested:

Adult Day Health________ Frequency________________________

Level 1 Full Day________ Level II Full Day________
Level 1 Partial Day________ Level II Partial Day________
Physical Therapy_______
Speech Therapy________
Provider________________________

Alternative Living Service________ Provider______________________________

Group Model_______ Family Model_______

Respite Services________ Frequency________________________

Out of Home Respite (12 hours)________
Out of Home Respite (8 hours maximum, 3 hours minimum)________
Provider________________________

Personal Support Services________ Frequency________________________ Extended Personal Support
Services________ (may also be used for in-home respite 2-3 times per week)________

Frequency________________________

Appendix F is good through date:_________________
Member is under administrative review. Please continue services until:_________
Provider__________________________________________________

Emergency Response System________ Provider__________________________

   Installment________ Monitoring Monthly________

Home Delivered Meals________ Provider__________________________

   Frequency________________________________________

Medicaid Home Health (75 units of service)________

   Skilled Nursing Visit ________
   Physical Therapy Visit ________
   Occupational Therapy Visit ________
   Medical Social Services ________
   Home Health Aide ________

Provider____________________________________________

Services to Begin: ___________________________________________

Comments:

SOURCE Site ________________________________________________

Signature________________________ Date________________________

Title______________________________
SOURCE Member Information Form

Provider to Case Manager

Response required?  _YES _NO

Provider Name ______________________________________

Member Name ______________________________________ Medicaid No. ___________________

Service type:  _ADH  _ALS  _ERS  _HDM  _HDS  _PSS  _EPS

Service offered? _YES  Date services initiated

No – Reason ______________________________________

Frequency/Units

Change/FYI

_Recommendation for change in service _Change in frequency/units by case manager

_Change in mbr’s. Health/functional status _Change of physician/CM

_Hospitalization _Other

_Service not delivered _FYI

Explanation: ______________________________________________________________________

_______________________________________________________________________________

__________________________________________ Effective date of change: _________________

Discharge

Discharge Reason _______________________________________________________________

_______________________________________________________________________________

Date of Discharge ________________________________________________________________

COMMENTS:

Prior Authorization Dates: --------- to _____________  PA #___________________

_______________________________________________________________________________

Signature _______________________________________________ Date _________________

Title ________________________________________________ Phone ____________________

Signature _______________________________________________ Date _________________

Title ________________________________________________ Phone ____________________
SOURCE Member Information Form

The SOURCE Member Information Form (MIF) conveys information between the site and participating service providers. The form serves as documentation of interactions on behalf of individual SOURCE members, and may be initiated by either case management or service provider staff. The form confirms key exchanges (new admissions, service level changes, hospitalizations, etc.) but also should be used to identify issues that potentially jeopardize a SOURCE member’s ability to continue living in the community.

MIF Instructions:

1. Indicate entity-initiating MIF (site or provider) with a checkmark.
2. Indicate nature of the communication with a checkmark (Initial, Change, FYI or Discharge)
3. Complete demographic and service type information as indicated.
4. INITIAL: Check either No or yes, with additional information requested.
   If yes, record frequency/units in space provided.
5. CHANGE/FYI: Indicate the nature of the communication with a checkmark.
   Explain and date ALL items checked in the space provided.
6. DISCHARGE: Never complete this section without first communicating by phone or in person with the site or provider to attempt to resolve the issue prompting discharge.
7. COMMENTS: Record any additional relevant information.
8. SIGNATURE: Indicate staff member sending the MIF, the date sent and staff member’s title.

NOTE: The agency receiving the MIF must acknowledge receipt of the MIF in writing, sign, date and return the MIF to the agency which generated the MIF within three (3) business days.
APPENDIX X

SOURCE MEMBER TRANSFER FORM

SOURCE Program: Prior LOC Authorization Number: ____________________________
Expiration Date: __________________

1. Member name
_____________________________ DOB: ______________
(Last, First, M.I.)

2. Social Security number _______________________________
Medicaid number _______________________________

3b. Other Contact Information: ________________________________

3. Member transfer from:
SOURCE Agency Name and Provider ID#

County ________________________________

Care coordinator / Contact person ________________________________
Telephone ( ______ ) ________________________________

Last service day ________________________________

Member’s previous address ________________________________
City ___________________________ State _______ Zip ____________

5. Member transfer to:
SOURCE Agency Name and Provider ID#

County ________________________________

Case Manager/Contact person ________________________________

Telephone ________________________________

Member’s new address ________________________________
City ___________________________ State _______ Zip ____________

Telephone ( ______ ) ________________________________

Rev. 07/11
Instructions

SOURCE MEMBER TRANSFERS

*Purpose:* The member transfer form is used to transfer case records and to notify GMCF of transfer.

*Who Completes/When Completed:* The case manager completes the member transfer form. It accompanies the original case record of the last year of service to the receiving agency. Original agency is responsible for providing one year of copied records to the receiving agency. Receiving agency uses those records for historical reference and picks up monthly contacts, service, and care path reviews from the previous dates and related standards of promptness. Full reassessment is required within 10 days in the case of a change of address that impacts caregiver availability, environmental issues related to service delivery, or needs of the member.

*Instructions:*

1. Enter member’s name (last name, first, and middle initial) and Date of Birth.
2. Enter member’s social security number.
3. Enter member’s Medicaid number.
4. Enter SOURCE Agency and county member is transferring from.
   - Enter the name, area code, and telephone number of the case manager/contact person transferring the case record.
   - Enter member’s last date of service.
   - Enter member’s prior address.
5. Enter SOURCE AGENCY and county member is transferring to.
   - Enter the name, area code, and telephone number of the case manager/contact person receiving the case record. If the new case manager’s name is not known default to the new agency/SOURCE site.
   - Enter member’s new address.
Distribution: The original Member Transfer accompanies the original member case record to the receiving SOURCE agency. A copy is filed in the duplicate case record maintained at the transferring SOURCE agency.

NOTE: This form or a copy of this form is used by the case manager to ensure care continuity.
APPENDIX Y
SOURCE Hospitalization Tracking Form

Patient: _______________________________ Date of admission: ____________

Hospital ______________________________ Date of discharge: ____________

1. ___ Room no. _____ and Case Manager assigned ______________________________

2. ___ Contact Case Manager (beeper or voice mail, etc.)/date(s): _____________________
   ___ Date of actual contact with Case Manager ______________________________
   ___ Follow-up with social worker if indicated/date ______________________________
   ___ Admitting Diagnosis ______________________________
   ___ Discharge diagnosis ______________________________
   ___ Programed date of discharge ______________________________
   ___ REQUEST NOTIFICATION PRIOR TO MEMBER DISCHARGE for coordination
   ___ Fax current SOURCE services and PCP to Case Manager

___ Notify SOURCE PCP of hospitalization _____/_____/_____

3. ___ Contact additional Case Manager if Member moves ______________________________

4. ___ Contact family/informal support date: ______________________________

5. ___ MIF(s) to all providers if indicated ___ ERS ___ PSS/skilled ___ HDM ___HDS

6. ___ Attend Case Conference if indicated

NOTES:

___ Copy of discharge summary received
___ SOURCE notified prior to discharge
___ MIF sent to providers to resume services; ___ service plan adjusted

CHECK ANY “NOT MET” UPON HOSPITALIZATION:
___ COMM ___ SKIN ___ HOUSING ___ I/ADL ___ TRANS/MOB
___ NUTR’N ___ CLIN ___ MEDS ___ BEHAVIOR ___ INF. SUPPOR
___ INCONTINENCE
APPENDIX Z
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

1. To ______________________________ SSN xxx-xxx-________ Date: _________________

Your participation in the SOURCE Program has been given careful consideration. In accordance with the Code of Federal Regulation, 42 CFR 441.301(b) (i) (ii) and 441.302(c) (2), the following determination has been made:

☐ 2. Decision to Reduce Services: you have been determined to require fewer services because __________________________________________________________

OR

☐ 3. Decision to Terminate or Deny Services: You do not meet the eligibility requirements as found in the Elderly and Disabled 1915-c Home and Community Based Services Medicaid Waiver as outlined in Section 701 in the Georgia Department of Community Health Manual, Part II Policies and Procedures for Service Options Using Resources in Community Environments (SOURCE).

You do not meet the eligibility requirements because (check as many as apply)

☐ a) You don’t Receive full Medicaid / or full Medicaid under SSI or Public Law categories
   Contact your local DFCS and ask if you are eligible for waiver Medicaid
   ☐ b) You did not have SSI. You must contact Social Security at 1-800-772-1213

☐ c) You are an excluded member of Medicaid because you are, at the time of application or enrollment you are:
   ☐ A Member with retroactive eligibility only or presumptive eligibility
   ☐ A Member in an institution, including skilled nursing facilities, hospital swing bed units, in patient hospice, intermediate care facilities for people with developmental disabilities, or correctional institutions in the Georgia Families program
   ☐ A Child enrolled in the Medical Services Program administered by the Georgia Division of Public Health (Children’s Medical Services) or receiving services under Title V (CMS funding)
   ☐ A Member in another waiver program (CCSP, Independent Care Waiver, the NOW and COMP Waiver Programs or the Georgia Pediatric Program (GAPP)
   ☐ A Child whose care is coordinated under the PRTF program
   ☐ A member of a federally- recognized Indian Tribe

☐ d) You did not Meet the 1915-c Waiver target population guidelines see- section 801.3 of the SOURCE manual: Your primary diagnosis or your primary needs are psychiatric or related to a developmental disability rather than medical needs

☐ e) You don’t meet criteria for Intermediate Nursing Home Level of Care (pursuant to Section 801.3 of the SOURCE manual) as detailed by the attached appendix I
   (Assessment indicates it is NOT necessary for you to reside in a Nursing Home for the elderly or physically disabled)

Last revision 7/13/2013 Continue onto next page
APPENDIX Z
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

To ______________________________

☐ f) Your cost of medically necessary services that can be provided by SOURCE is higher than
the Medicaid cost of nursing facility care
☐ g) You are not cooperative with enrollment in SOURCE (Member did not (have/do/ complete/
refuses etc.) ______________________________
☐ h) You don’t live in / or have moved from a SOURCE Enhanced Case Management’s
designated service area
☐ i) You don’t have the capability, with assistance from SOURCE and/or informal caregivers, of
safely residing in the community (with consideration for a recipient’s right to take calculated
risks in how and where he or she lives)
☐ j) You are an applicant who has all needs met by your informal support
☐ k) You failed to meet requirements at initial screening:
   ☐ Your DON-R (determination of need-revised) score was too low to meet
   admission requirements
   ☐ You don’t have unmet needs_______
☐ l) Other
____________________________________________________________________

If you disagree with this decision, you may request a fair hearing. You have thirty days
(30) from the date of this letter to request a hearing in writing.

Department of Community Health
Legal Services Section
2 Peachtree Street, NW 40th Floor
Atlanta, GA 30303-3159

4. Call your SOURCE Case Manager or Care Agency if you do not understand this letter. Call:

<table>
<thead>
<tr>
<th>Name of Case Manager /Other</th>
<th>Agency</th>
<th>Phone</th>
</tr>
</thead>
</table>

5. Appendix I in table format enclosed? Yes No
APPENDIX Z
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

Instructions for agency completion of Appendix Z
Agency Use ONLY

Appendix Z is a mandatory form that must be used as formatted by DCH.

1. Fill in member’s name, last 4 digits of Social security number, and date
2. Check this option if you are reducing services. Write in the reason for the reduction in services.
   i. Then: Skip to #4 and give the member contact information
3. Check this option if denying or terminating services. Then see pyramid to complete a-j.
4. Always complete #4.
5. Indicate whether Appendix I is enclosed (must be table format)

To fill out a-j of Appendix Z, Start with Step I and while looking at the member letter, check all that apply for this member:

I. Basic eligibility choices:
Check a-c if any of these apply for the member:
   a) You do not receive full Medicaid or Full Medicaid under SSI or Public Law categories
   b) You did not have SSI. You must contact Social Security at 1-800-772-1213
   c) You are an excluded member of Medicaid (check why the member is excluded)

II. Target population choice:
Did the member not meet criteria for SOURCE because they are not the target population for this waiver—i.e.:

Go to and check #d if the member is under age 65 years and their primary diagnoses that are causing problems is mental illness or mental retardation.
Step III Other choices:

Check if any of these applies to the member.

Note: Detail the reason for non-compliance if #g is selected.

Note: Fill in the details for I if any other reasons apply.

Step IV Intermediate Nursing Home level of care:

Check if this applies to the member

For every member denied or terminated services, decide if the member meets the definition to enter a Medicaid Nursing home facility i.e. if the member presented to a Nursing Home today, would they be accepted? (This is not a facility for the mentally retarded or with developmental disability) If the answer is no, check this box and send out a clean Appendix I in table format to send to client. Table I worksheet is recommended.

☐ e) Meet criteria for Intermediate Nursing Home Level of Care (pursuant to Section 801.3 of the SOURCE manual) as detailed by the attached appendix I

Appendix I in table format must be sent to member if completed in the course of assessment work for denial or terminations. A final “worksheet” version may be sent to member. Detail Column A with all applicable diagnoses. If Column B has any etiologies written in, indicate why the member does not meet. Column C should not appear to indicate nursing home level of care.

Appendix Z notice pages 1-2 must be sent to member as shown in this manual.
NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one in writing. Your request for a hearing, along with a copy of the adverse action letter, must be received within thirty (30) days of the date of the letter. Please mail your request for a hearing to:

Department of Community Health
Legal Services Section
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. Georgia Legal Services Program
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. Georgia Advocacy Office
   1-800-537-2329
   (Statewide advocacy for persons with disabilities or mental illness)

3. Atlanta Legal Aid
   404-377-0701 (Dekalb/Gwinnett Counties)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So. Fulton/Clayton County)
   678-376-4545 (Gwinnett County)

4. State Ombudsman Office
   1-888-454-5826
   (Nursing Home or Personal Care Home)
APPENDIX Z
SOURCE PCP Concurrence Form for Discharge Planning

This form is Only completed for Discharged Members that Did Not Meet” Level of Care”. The purpose of this form is to document PCP concurrence and Discharge Planning for members denied admission or continued enrollment and received an “Appendix Z” for not meeting Intermediate Nursing Home Level of Care. Documentation must include current services and community resources available to assist with the member’s needs. The R.N./L.P.N. must sign and confirm PCP concurrence of the current assessment.

Member: ___________________________________ Medicaid ID: _______________ DOB: ____________

Diagnoses__________________________________________

Case Management Agency: ___________________________________________________________

Document the date that the nurse reviewed the member’s functionality and health with the member’s PCP to ensure concurrence with MDS HC data.

○ PCP Name and date of contact: __________________________________________________________

○ Member’s functionality and health of member confirmed with PCP ☐ Yes and ☐ concurs with data on MDS HC ☐ No not confirmed or does not concur (include supportive documentation below)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________
___________________________________________

○ Diagnosis, Medications, Treatments confirmed? ☐ Yes ☐ No

○ Referrals in last 3 months? ☐ Yes ☐ No If yes, provide additional information?

____________________________________________________________________
____________________________________________________________________

○ R.N. /L.P.N. Name and Phone:

_______________________________________________________________

○ Additional information (if applicable):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

________________________________________
APPENDIX Z
Case Management Discharge Planning for SOURCE
Complete and provide a copy to the member no later than 15 days following a SOURCE involuntarily discharge

Section A:
Member’s Name: ____________________________ Medicaid number: ________________ Today’s Date: __________
Member’s Address: ____________________________________________________________

Discharge Planning Received by (name/relationship): __________________________ Date: ___/___/____
Mail ____ In Person ____ (check or circle)
Follow-up Date: ___/___/____ Mail ____ In Person ____ Phone ____ (check or circle)

Case Manager’s name/title (print): ________________________________________________
Case Manager’s Signature: ______________________________________________________

SOURCE Agency Name and phone number/extension: ________________________________

SECTION I Formal Info – Services Received or Recommended (Circle/Select all that apply or enter N/A)

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency/Units</th>
<th>Provider Contact Information (Name/Phone Number)</th>
<th>Availability/cost of service after discharge from SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Response System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Day Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative Living Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION II Community Resources – Plan must include additional Community Resources specific to member needs. Select all that apply, complete contact information and include any special conditions or availability. Suggestions are given in the () brackets but be creative and specific for member. “See Attachment” with a copied list of general resources can be given in addition to, but will not substitute for this form if member has needs.

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information (Name/Phone Number)</th>
<th>Special Conditions/ Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Support (DAS, Churches, Family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Delivered Meals (food banks, stamps, senior services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Response System (Cell phone, local discounted company, Walmart, Splash)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Day Health (Senior Day Activities)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative Living Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX Z
Case Management Discharge Planning for SOURCE
Complete and provide a copy to the member no later than 15 days following a SOURCE involuntarily discharge

<table>
<thead>
<tr>
<th>Skilled Nursing Service (set up with Medicaid through PCP)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation (Disabled County specific transport)</td>
<td></td>
</tr>
<tr>
<td>NOW/COMP if member has MR or Developmental Delay</td>
<td></td>
</tr>
<tr>
<td>DFCS if losing eligibility</td>
<td></td>
</tr>
<tr>
<td>GAPP/ Local Health Dept programs if child in need</td>
<td></td>
</tr>
<tr>
<td>DBHDD if mental health issues</td>
<td></td>
</tr>
<tr>
<td>APS as needed</td>
<td></td>
</tr>
<tr>
<td>Pharmacy /Medication set up needs</td>
<td></td>
</tr>
<tr>
<td>Other specify (i.e. energy assistance)</td>
<td></td>
</tr>
</tbody>
</table>

Instructions: Discharge planning is required for all members with involuntary discharge from SOURCE services. SOURCE requires appropriate and specific plan be given to member or member’s family. Source requires Case Management give assistance with applications for other services. The process is as follows:

- Notify member and ascertain what the member needs after discharge. Complete Section A of form.
- If member does not have any needs, document the information in Section I and give a general list of community resources for Section II (only appropriate if member does not have any needs).
- If member has specific needs, give formal (Section I) and community support specific information (Section II). Document on this form.
- After form is completed: Make copy for member records. Mail to member or present in person.
- Follow up in 7 to 10 work days to make sure member and or family understands information and questions are answered. Document all contacts to family on discharge planning.
- Special attention and tracking of this process is imperative when member must apply for other services; assist and document assistance to member with this process.

*Present this form and all discharge information to the Department of Community Health (DCH) with DCH request for member records or upon notification from the DCH staff or attorney.*
Checklist for SOURCE Request for Hearing

Case Management Agency: please provide the following forms to DCH upon notification of a
hearing request:

If GMCF gave LOC denial:

- Discharge Planning information:
  - Appendix Z6 SOURCE PCP Concurrence and
  - Appendix Z7 Case Management form for Discharge planning
  - Case Notes that document discharge planning support
- Recent Physician visits or ER visits
- If member has unknown cognitive deficits work with attorneys to resolve

If Agency issued Denial

- Appendix Z Reduction in service, Termination and Denial
  - Discharge Planning Information (as listed above)
- Appendix Z Administrative Hearing Information (as a cover sheet)
- Appendix I Level of Care with etiology for any items circled
- Appendix I Level of Care in table format sent to member
- Appendix C SOURCE assessment and addendum
- Appendix S Minimum Data set (MDS-HC)
- Medication List
- Annual Case management notes and 1-3 Quarterly Case management notes
- Annual physical examination (NN form) from PCP and/or appropriate “H&P” (history
  and physical) notes from 1-2 most recent visits with PCP
- Recent Physician visits or ER visits
- Document and send (if possible) any specialty physician visit information
  from the past 3 months
- If member has unknown cognitive deficits work with attorneys to resolve
**APPENDIX AA**

**DEATH, SIGNIFICANT INJURY OR CRITICAL INCIDENT REPORT**

**SOURCE SENTINEL EVENTS**

(Type if possible)

<table>
<thead>
<tr>
<th>Report Date:</th>
<th>Member Name:</th>
<th>Member Medicaid ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member's DOB/Age:</td>
<td>Significant Diagnosis:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>Address Where Member Resides:</td>
<td>City:</td>
<td>County</td>
</tr>
<tr>
<td>SOURCE CM Agency Name:</td>
<td>SOURCE Manager:</td>
<td>Office Hours</td>
</tr>
<tr>
<td>CM Address:</td>
<td>Which Agency Involved? Name &amp; Address:</td>
<td>Type of Provider:</td>
</tr>
<tr>
<td>Provider #:</td>
<td>Location Where Event Occurred:</td>
<td>Date Event Occurred:</td>
</tr>
<tr>
<td>Name of Supervisor/Manager:</td>
<td>Contact Phone:</td>
<td>Date CM Agency Notified:</td>
</tr>
</tbody>
</table>

**Type of Death, Injury or Incident: (see Table AA)**

<table>
<thead>
<tr>
<th>Place Occurred:</th>
<th>Name of Person Discovering Event:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause: (i.e. push, fall)</td>
<td>Address: (if different from residence)</td>
</tr>
<tr>
<td>Description: (i.e. fracture)</td>
<td></td>
</tr>
</tbody>
</table>

**CONTRIBUTING FACTORS:**

- Lack of Supervision:
- Paralysis:
- Balance Deficit:
- Incontinence:
- Family Involved:

- Cognitive Impairment:
- Medication:
- Illness:
- Pain:
- Hospital: ER:

- Progressive Muscular Disease:
- Poor Vision:
- Gait Deficit:
- Police: MD Visit:

- Progressive Neurological Disease:
- Failed to use assistive device:
- Mental Health Eval:

- Other:
- Family Notified:

**INITIAL RESPONSE:**

- Add New Services:
- MD/PCP Review Meds:
- Notified MD:
- Family Notified: (in notes)

- Eye Exam Referral:
- Case Conference:
- Family Involved:

- Safety Assessment:
- Request Therapy Order:
- Reassessment:
- Other:

**CARE COORDINATION INTERVENTIONS:**

*Service Options Using Resources In Community Environments April 1 2016*
OUTCOME OF EVENT: ONLY when the final outcome is known

Member Name and Medicaid ID:

Date Follow-up Requested:            Date Follow-up Received:

SOURCE Manager Notes:               Follow-up Notes:               SOURCE Manager Name:

Detailed summary including information helpful to understand event, adverse outcomes & follow-up of event:

ACTION PLAN and PROCESS IMPROVEMENT:

How to prevent in the future?

What processes were instituted to evaluate the effectiveness of the action plan?

MEDIA EVENT?

If so, name of media and contact person and phone:

OTHER PERSON OR SERVICES NOTIFIED:

<table>
<thead>
<tr>
<th>Title</th>
<th>Yes</th>
<th>No</th>
<th>Name</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX AA
DEATH, SIGNIFICANT INJURY OR CRITICAL INCIDENT REPORT
SOURCE SENTINEL EVENTS

| Primary Physician: | | | |
| Family/Guardian: | | | |
| APS/Police report number (non-mandatory to add this line to your form until 1/1/2015): | | | |
| DCH: | | | |
| Other: | | | |
| Signature of Case Manager: | Phone: | Date: |

Report Sentinel Events by:

Mailing or faxing the Sentinel Event Report upon completion and phone call if indicated to:
SOURCE Program Sentinel Event
2 Peachtree Street NW, 37th Floor
Atlanta, GA 30303
Phone: 404-463-6570
Fax: 404-656-8366

Reminder, if member has an APS referral, a sentinel event and police reporting is needed.
APPENDIX AA
DEATH, SIGNIFICANT INJURY OR CRITICAL INCIDENT REPORT
SOURCE SENTINEL EVENTS

Sentinel Event REPORT
Instructions

Revised: 04/11 Purpose: The care coordinator uses the Sentinel Report in the SOURCE program to report Significant Injury, Unexpected Death or other critical incidents involving SOURCE members.

Note: Reporting Sentinel events to DCH, Adult Protective Services, local law enforcement, and Long Term Care Ombudsman is needed within 1 business day of the notification of the event.

Table AA
Sentinel events include (see Section 1411 of SOURCE manual):

- Significant physical injuries / unexpected death
- Alleged criminal acts by staff against a member
- Alleged criminal acts which are reported to the police by a person who receives services
- Elopement or Member missing without authority or permission and without others’ knowledge of whereabouts
- Financial exploitation or mismanagement of member funds
- The intentional or willful damage to property by a member that would severely impact operational activities or the health and safety of the member or others
- Whether by a member or staff person on duty or other person, any threat of physical assaults, or behavior so bizarre or disruptive that it places others in a reasonable risk of harm or, in fact, causes harm
- Inappropriate sexual contact or attempted contact by a staff person (on or off duty), volunteer or visitor, directed at a member
- Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling
- Use of physical or chemical restraints
- Withholding food, water, or medications unless the member has requested the withholding
- Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation)
- Isolating member from member’s representative, family, friends, or activities
- Inadequate assistance with personal care, changing bed linen, laundry, etc.
- Leaving member alone for long periods of time (when inappropriate for member’s mental/physical well-being)
- Failure to provide basic care or seek medical care

Purpose: The care manager uses the Sentinel Report in the SOURCE program to report Serious Injury, Unexpected Death or other critical incidents involving SOURCE members.

Note: Unless the incident occurs in a hospital or rehab centers, all other incidents as outlined below are to be reported.

Incidents that result in serious injury or unexpected death are to be reported.

Emotional/ financial/ sexual abuse and criminal acts are to be reported.

Report these incidents in case notes:

Incidents that occur in hospitals or rehab centers are to be documented in the case notes only.
Who Completes/When completed: The SOURCE Care Management care coordinator completes the form within one business day of event notification. All reports received the previous month shall be completed with additional information and known outcomes no later than the 15th of the following month (Police/Forensic follow-up information may take longer).

Provider Incident Reports: The SOURCE Case Management Agency is responsible for obtaining these reports for all critical incidents that occur in ALS or ADH facilities or where provider staff is present at the time of the incident. The incident report identifies member appropriate interventions to decrease the risk of a recurrent incident that may result in serious injury or unexpected death.

Instructions:

- Give date report is filled out, member name, Medicaid number, Date of Birth, Age and any significant related diagnosis.
- Give Member resident address including city and state, county and phone number of member.
- Identify SOURCE Case Management (CM) agency name address and provider ID in the box. Add SOURCE Case manager name and contact information. Include location where event occurred (if different address there will be a place later for this address), date event occurred and date that the SOURCE Case Management agency was notified. If a provider service agency is involved give name and address, check type of provider, a contact phone and supervisor/manager name.
- Death, Significant Injury, Critical Incident: Type of Death, Significant Injury, Critical event: Use wording from table AA to identify the event (i.e. fall, significant physical injury, unexpected death, alleged criminal acts--police report filed by family etc). Death, injury or incident is for a short definition of the event (i.e. broken leg, minor injury, elopement, abuse, stolen jewelry, house fire etc). Cause may be accident, pushed, etc.
- Place where Death, Injury or Incident Occurred: this is the location where event occurred: Be specific where event occurred if possible, i.e. “member’s house, bedroom” “Other--see Case management notes” can also be used.
- Address: Give address if different from home address.
- Name of person discovering problem: give name of service personnel or SOURCE provider agency (and their title) that discovered, witnessed or first reported the member’s event.
- Contributing Factors: Identify all that may be applicable with regard to the incident being reported. Cognitive Impairment applies to members with dementia, traumatic brain injury, brain tumors or any other diseases/injuries that impairs cognition. Progressive Muscular Disease refers to diseases such as Multiple Sclerosis, Parkinson’s Disease, Muscular Dystrophy, Huntington’s Disease etc. Progressive Neurological Diseases include ALS, Post-
Polio Syndrome, Progressive Spinal or Muscular Atrophy etc., Other, please specify (may give details in Case management notes if needed).

- **Initial Response**: Check all that apply. *Family Involvement* means the family took responsibility for seeking medical care, staying with the member after the incident etc. Family notified, indicates family was called. Other, please specify in CM notes on 2nd page.

- **SOURCE Care Coordination Interventions**: This should relate to what the SOURCE case manager identified as contributing factors. *Family involvement* should be indicated if the support system increases its responsibility in the care of the member for ADLs and/or IADLs. In the case of safety education the notes should include what education was provided and who was educated. If other is checked documentation should specify what other intervention was initiated.

- **Outcome**: Update the incident record by identifying outcome only when the final outcome is known.

- **Date Follow Up Requested**: Enter date provider incident report or other items requested as a follow up to the incident. Document in incident report notes what was requested and from whom. **Date Follow Up Received**: Record date requested item was received.

**SOURCE Manager Notes**: List in narrative form the incident and injuries sustained by the member. Documentation should include the specific area of the body affected. Documentation of Who, What, Where, How will give the most concise accounting of the incident. Document information about events leading up to the incident.

**Update**: Document in narrative format follow up activities/findings and resolution to the critical incident. Include results of the member record review and provide information

**Witness**: Include the full name of the witness(es), relationship to member and contact information in narrative if not listed elsewhere.

**Action Plan and Process Improvement**: Define process to reduce risk here if not already documented and follow-up time frames for evaluating effectiveness of processes used to reduce risk.

**Media Event**: fill out if news services involved.

- **Other services/persons notified of Incident**: Document, here or in the SOURCE manager notes, the date SOURCE notified individuals such as physician, nurse, family or agencies/organizations including DCH. Document notification of Area Agency on Aging immediately or no later than one business day upon learning of the incident as appropriate.

**Note**: The Georgia Department of Community Health, Healthcare Facilities

Regulations services (HFR) and local Long Term Care Ombudsman (LTCO) are notified when the critical incident occurs in a PCH/ALS facility. For members not living in long term care facilities, Adult Protective Services is notified of critical incidents when the suspected cause of the incident may be the result of abuse, neglect or exploitation. As of 2013, there is a legislative change where Police must be concurrently notified. Others are contacted as appropriate.
APPENDIX BB
SOURCE Discharge Summary

(Rev. 10/15)
SOURCE Member: ______________________ Date of Discharge: __________________

Discharging Agency: _______________________

Discharge due to:

___ death     ___nursing home (facility)  

___ moved from service area        ___ lost eligibility      ___ member choice

___ involuntary/non-compliance     ___ Hospice

___ other ______________________________________

SOURCE member discharged from:

___ home  ___ hospital (____________)  ___ personal care home

Primary reason for nursing home placement (if applicable):

___ increased cognitive impairment  ___ increased physical impairment

___ increased medical acuity        ___ informal support issue

___ other __________________________________

Referrals (if applicable):

___ CCSP  ___ ICWP  ___ Hospice  ___ home health  ___ MRWP

___ other ____________________________

Brief discharge summary:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Indicate all key outcomes not met at time of discharge (refers to Carepath):

___ COMM  ___ SKIN  ___ MEDS  ___ I/ADLs  ___ TRANS/MOB

___ NUTR’N  ___ CLIN  ___ BEHAVIOR  ___ INF. SUPPORT
Discharge Planning Policy Statement

Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix Z (7-8) to be filed in the member's chart.
SOURCE Billing

SOURCE Reimbursed Services

- Adult Day Health
- Personal Support (PSS)
- Extended Personal Support
- Alternative Living Services (ALS)
- Home Delivered Meals (HDM)
- Home Delivered Services (HDS)
- Emergency Response Services (ERS)
- Nursing Visits
- Case Management

Provider Billing

The Hewlett Packard is the third-party administrator for Georgia’s Medicaid and PeachCare for Kids programs. Providers should begin submitting claims and other transactions to HP as of November 1st, 2010.

Provider claims will be entered via the web at http://mmis.georgia.gov.

Customer Interaction Center: 1-800-766-4456

Customer Service Representative Availability: 8am- 7pm Monday thru Friday

Interactive Voice Response System Availability: 24 hrs day, 7 days a week

Written Correspondence: HP, P.O. Box 105200, Tucker, GA 30085-5200
Procedures for Completing CMS 1500 (Web Portal or WINASAP)

Completion of the CMS1500 (Items not required by Georgia DMA are not included in these instructions)

This section provides specific instructions for completing the CMS Insurance Claim Form (CMSHCFA-1500) [12-90]. A sample invoice is included for your reference.

- Health Insurance Coverage
- Check Medicaid box for the patient’s coverage.
- Insured’s I.D. Number
- Enter the Recipient Client Number exactly as it appears on the recipient’s Patient’s Name exactly as it appears on the patient’s current Medical Assistance Eligibility Certification (last name first).
- Patient’s Birth Date and Sex
- Patient relationship to insured
- Patient Status
- Other Insured’s Name
- SOURCE Enhanced Case Management (authorization) provider number in the first Referring ID field.

A reasonable effort must be made to collect all benefits from other third party coverage. Federal regulations require that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all providers.)

When a liable third party carrier is identified within the computer system, the services billed to Medicaid will be denied. The information necessary to bill the third party carrier will be provided as part of the Remittance Advice on the Third Party Carrier Page.

- Other Insured’s Policy or Group~ Number
- If the recipient has other third party coverage for these services, enter the policy or group number.
- Name of Referring Physician
- Enter the name of the physician or other source that referred the patient. Leave blank if there is no referral.
- Enter the SOURCE Enhanced Case Management Authorization Number in fields Refer to Provider field and Referral ID field

Dates of Service (DOS) - CRITICAL ELEMENT FOR CORRECT PAYMENT

Enter period of time that procedure/service occurred. If billing a partial month of service, enter the first day of the service in the “FROM” space and the last day of service in the “TO” space.

If billing a full month of service, enter the first day of the month in the “FROM” space and the last day of the month in the “TO” space.
APPENDIX CC
SOURCE Billing

The date(s) in this box must contain month, day and year in MM/DD/YY format (e.g., enter February 1 to February 28, 2003, as 02/01/2003 to 02/28/2003). Claims for dates of service spanning more than one calendar month MUST be billed on separate invoices so that the Capitation (MCP) rate will be paid correctly.

NOTE: Monthly Professional Capitation Billing
If you are billing for the full capitation fee, the date of service will be the first day of the month and the last day of the month.
If the patient was not under your care for the full month, you must bill only for the portion of the month the patient was under your care.

Place of Service (P.O.S.)
Type of Service (T.O.S.)
Procedures code
Diagnosis Code
Charges
Enter the product of your “usual and customary” charge for the procedure multiplied times the units of service.
Days or Units

A “1” must always be entered when billing for Capitation (MCP) rate. For other services, enter the number of times the service was performed.

Note:
If you are billing more than one (1) unit for the same procedure code on the same date of service, please use one (1) line on the CMS 1500 and list your total units. If you use more than one line, the system will consider the subsequent lines a duplicate and will deny them.

Total Charge
Enter the total of the charges listed for each line.

Amount Paid
Enter the amount received from third party. If not applicable, leave blank.

Balance Due
Enter the submitted charge less any third party payment received.

Signature of Physician or Supplies Including Degrees or Credentials
The provider must sign or signature stamp each claim for services rendered and enter the date.

Unsigned invoice forms cannot be accepted for processing.

Name and Address of Facility Where Services Rendered

<table>
<thead>
<tr>
<th>Place of Service (P.O.S.)</th>
<th>Type of Service (T.O.S.)</th>
<th>Procedures code</th>
<th>Diagnosis Code</th>
<th>Charges</th>
<th>Days or Units</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Charge</th>
<th>Amount Paid</th>
<th>Balance Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Physician or Supplies Including Degrees or Credentials</th>
</tr>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unsigned invoice forms cannot be accepted for processing.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name and Address of Facility Where Services Rendered</th>
</tr>
</thead>
</table>
Enter the full name, location (city) and Medicaid Provider number (if Medicaid enrolled) of the facility where billed services were performed.

Physician’s Supplier’s Billing Name. Address. Zip-Code and Phone Number

a. Enter the provider’s name and address. Providers must notify the HP provider Enrollment Unit in writing of address changes.
General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers’ definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is.* The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim cannot be paid.

The following resources are available for more information:

- Access the department’s DCH-i newsletter and FAQs at http://dch.georgia.gov/publications
- Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx
  
  Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider’s last name.

  
  Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

*For COS 930 this would be the NPI of the provider who signs the Appendix F
<table>
<thead>
<tr>
<th>Old Code</th>
<th>Description</th>
<th>National Code</th>
<th>Description</th>
<th>Modifier</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y3801</td>
<td>Home Delivered Services; Nursing Visit</td>
<td>T1030</td>
<td>Nursing care, in home, by registered nurse</td>
<td>TD</td>
<td>Provider Specific (51st unit of service)</td>
</tr>
<tr>
<td>Y3802</td>
<td>Home Delivered Services; Physical Therapy</td>
<td>S9131</td>
<td>Physical therapy, in home, per diem</td>
<td></td>
<td>Provider Specific (51st unit of service)</td>
</tr>
<tr>
<td>Y3803</td>
<td>Home Delivered Services; Speech Therapy</td>
<td>S9128</td>
<td>Speech therapy, in the home, per diem</td>
<td></td>
<td>Provider Specific (51st unit of service)</td>
</tr>
<tr>
<td>Y3804</td>
<td>Home Delivered Services; Occupational Therapy</td>
<td>S9129</td>
<td>Occupational therapy, in the home, per diem</td>
<td></td>
<td>Provider Specific (51st unit of service)</td>
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<tr>
<td>Y3805</td>
<td>Home Delivered Services; Medical Social Services</td>
<td>S9127</td>
<td>Social work visit, in the home, per diem</td>
<td></td>
<td>Provider Specific (51st unit of service)</td>
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<tr>
<td>Y3806</td>
<td>Home Delivered Services; Home Health Aide</td>
<td>T1021</td>
<td>Home health aide or certified nurse assistant, per visit</td>
<td>Provider Specific (51st unit of service)</td>
<td></td>
</tr>
<tr>
<td>Y3725</td>
<td>Adult Day Health Level I Full Day</td>
<td>S5102</td>
<td>Day care services, adult, per diem</td>
<td>$50.45 per day minimum 5 hours</td>
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</tr>
<tr>
<td>Y3726</td>
<td>Adult day Health Level I Partial Day</td>
<td>S5101</td>
<td>Day care services, adult, per half day</td>
<td>$30.27 per day minimum 3 hours</td>
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</tr>
<tr>
<td>Y3740</td>
<td>Adult Day Health; Physical Therapy</td>
<td>S9131</td>
<td>Physical therapy in the home, per diem; services delivered under an outpatient physical therapy plan of care</td>
<td>GP</td>
<td>$44.15 per visit</td>
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<tr>
<td>Y3750</td>
<td>Adult Day Health; Speech Therapy</td>
<td>S9128</td>
<td>Speech therapy, in the home, per diem; services delivered under</td>
<td>GN</td>
<td>$44.15 per visit</td>
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</tbody>
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## APPENDIX DD
### SOURCE National Codes and Rates

<table>
<thead>
<tr>
<th>Old Code</th>
<th>Description</th>
<th>National Code</th>
<th>Description</th>
<th>Modifier</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y3790</td>
<td>Adult Day Health; Occupational Therapy</td>
<td>S9129</td>
<td>Occupational therapy, in the home, per diem; services delivered under an outpatient occupational therapy plan</td>
<td>GO</td>
<td>$44.15 per visit</td>
</tr>
<tr>
<td>Y3827</td>
<td>Adult Day Health Level II Full Day</td>
<td>S5102</td>
<td>Day care Services, adult, per diem: intermediate level of care</td>
<td>TF</td>
<td>$63.07 per day</td>
</tr>
<tr>
<td>Y3828</td>
<td>Adult Day Health Level II Partial Day</td>
<td>S5101</td>
<td>Day care services, adult, per half day; intermediate level of care</td>
<td>TF</td>
<td>$37.85 per day</td>
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<tr>
<td>Y3647</td>
<td>Alternative Living Services - Group Model</td>
<td>T1020</td>
<td>Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Group Setting</td>
<td>HQ</td>
<td>$37.38 per day</td>
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</table>
### APPENDIX DD
#### SOURCE: National Codes and Rates

<table>
<thead>
<tr>
<th>Old Code</th>
<th>Description</th>
<th>National Code</th>
<th>Description</th>
<th>Modifier</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y3625</td>
<td>Alternative Living Services – Family Model</td>
<td>T1020</td>
<td>Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Individualized service provided to more than patient in same setting</td>
<td>TT</td>
<td><strong>$37.38 per day</strong> (payment to the individual model home must be no less than $15.25 per day)</td>
</tr>
<tr>
<td>Y3600</td>
<td>Out of Home Respite (12 hours)</td>
<td>S5151</td>
<td>Unskilled respite care, not hospice, per diem; intermediate level of care</td>
<td>TF</td>
<td><strong>$42.57 per night</strong> minimum 12 hours</td>
</tr>
<tr>
<td>Y3715</td>
<td>Out of Home Respite (hourly)</td>
<td>S5150</td>
<td>Unskilled respite care, not hospice, per 15 minutes</td>
<td></td>
<td><strong>$3.00 per unit</strong>, 32 units (8 hours) maximum, 12 units minimum (3 hours)</td>
</tr>
<tr>
<td>Y3822</td>
<td>Personal Support Service</td>
<td>T1021</td>
<td>Personal care services, per 30 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)</td>
<td>U-1</td>
<td><strong>$10.10 per 30 minutes</strong> units. 30 minutes equal 1 unit. (not to exceed 5 units or 2.5 hours per visit)</td>
</tr>
</tbody>
</table>
### APPENDIX DD

**SOURCE National Codes and Rates**

<table>
<thead>
<tr>
<th>Old Code</th>
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<th>National Code</th>
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<th>Modifier</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Y3840</td>
<td>Extended Personal Support</td>
<td>T1021</td>
<td>Personal care services. Per 30 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) intermediate level of care</td>
<td>TF</td>
<td>$8.98 per 30 minutes equal 1 unit. (Not to exceed 48 units a day) Not to exceed 720 units/ Month (360 hours/15 days)</td>
</tr>
<tr>
<td>Y3823</td>
<td>Emergency Response Monitoring (Monthly)</td>
<td>S5161</td>
<td>Emergency response system; service fee, per month (excludes installation and testing)</td>
<td></td>
<td>$31.53 per month</td>
</tr>
<tr>
<td>Y3824</td>
<td>Emergency Response Monitoring (Weekly)</td>
<td>T2025</td>
<td>Emergency response system; waiver services; not otherwise specified (NOS)</td>
<td>U9</td>
<td>$7.88 per week</td>
</tr>
<tr>
<td>Y3825</td>
<td>Emergency Response Installment</td>
<td>S5160</td>
<td>Emergency response system; installation and testing</td>
<td></td>
<td>Up to $94.60 one installment</td>
</tr>
<tr>
<td>Y3831</td>
<td>Home Delivered Meals</td>
<td>S5170</td>
<td>Home Delivered Meals</td>
<td></td>
<td>$6.58 per meal maximum 21 per week</td>
</tr>
<tr>
<td>Y3850</td>
<td>Skilled Nursing Services RN</td>
<td>T1030</td>
<td>Nursing care, in the home by a registered nurse per diem</td>
<td></td>
<td>$65.00 per visit</td>
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<tr>
<td>Y2851</td>
<td>Skilled Nursing Services LPN</td>
<td>T1031</td>
<td>Nursing care in home, by licensed practical nurse per diem</td>
<td></td>
<td>$50.00 per visit</td>
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<tr>
<td></td>
<td>SOURCE CM fee</td>
<td>T2022</td>
<td></td>
<td>SE</td>
<td>$186.67, per month</td>
</tr>
</tbody>
</table>

Rev. 07/08
Albany ARC
Contact Person: Grace Williams, Program Director, BSW, MS or
Shon Houston, Asst. Program Director, BHS, MS
(229) 883-2334  Fax: (229) 883-2710
1105 Old Dawson Road, Albany, Georgia 31707
Counties: Baker, Calhoun, Clay, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth

Columbus Regional Healthcare System
Contact Person: Jenny Dowdy, RN (706) 571-1946
Fax: (706) 660-6279
1900 10th Avenue, Columbus GA, 31901
Counties: Chattahoochee, Harris, Marion, Muscogee, Talbot, Stewart, Meriwether, Upson, Pike, Taylor, Troup

Crisp Care Management
Contact Person: Tony Dickerson, RN Program Manager
Office: (229) 276-2126  Fax: 229-271-4669
910 North 5th Street, Cordele, GA 31015
Counties: Crisp, Dooly, Macon, Pulaski, Sumter, Wilcox

Corners of Care SOURCE
Contact Person: Juanita Benjamin, Owner/Administrator
803-226-0236 or 1-800-811-7534
Fax: 803-226-0335 or 1-888-316-9859
3050 Whiskey Road
Aiken, South Carolina 29803
P. O. Box 5569
Augusta, Georgia 30906
County: Burke, Columbia, Richmond

Crossroads Community SOURCE
Contact person: Laura Phillippi, RN, BSN, Program Manager
Office: (478)224-6677
Fax: (478)988-0093
1211-D Macon Road Perry, GA 31069
Counties: Bibb, Bleckley, Crawford, Dooly, Houston, Peach, Pulaski, Twiggs, Wilcox

Diversified Resources Inc.
Contact Person:  Owner/Administrators: Pat Albritton or Kathy Yarbrough (912) 285-3089 or 1800-283-0041
Case Manager Supervisor: Donna Robinson, RN, BSN
APPENDIX EE
Case management Provider Main Offices

Fax: (912) 285-0367
147 Knight Avenue Circle
P. O. Box 1099 (31502)
Waycross, Georgia 31503
Counties: Atkinson, Clinch, Coffee, Pierce and Ware

Nahunta Office
Contact Person: Vickie Chesser, RN, CM Supervisor (912) 462-8449 or (866) 903-7473
179-A North Main Street, Nahunta, GA 31553
Counties: Brantley, Camden, Charlton, Glynn

Tifton Office
Contact Person: Robin Harris, RN, CM Supervisor (229) 386-9296 or (800) 575-7004
1411 US Highway 41 North
P.O. Box 7614
Tifton, Georgia 31793
Counties: Ben Hill, Irwin, Tift, Turner, Wilcox

Valdosta Office
Contact Person: Donna Robinson, Acting CM Supervisor (229)253-9995 or (800) 706-9674
124 N. Patterson St.
Valdosta, Ga. 31602
Counties: Berrien, Brooks, Cook, Echols, Lanier and Lowndes

Faith Health Services of GA Inc.
Contact: Faith Vickerie- Morgan, RN (678) 624-1646
Fax: 678-624-1696
P.O. Box 2063, Alpharetta, GA 30023
Counties: Fulton, Cobb, Clayton, Dekalb, Forsyth, Gwinnett, Rockdale

Legacy Link Inc
Contact: Amy Allen (770) 538-2668
Contact: Dianne Dodgins (770) 538-2669
4080 Mundy Mill Road, Oakwood, GA 30566
Counties: Banks, Barrow, Cherokee, Clark, Dawson, Elbert, Forsyth, Franklin, Gwinnett, Habersham, Hall,
Hart, Jackson, Lumpkin, Madison, Rabun, , Stephens, Towns, Union, White

Next Step Care
Corporate Office
15 Merritt Street  P.O. Box 952 Hawkinsville, GA 31036
Christie Shaw, MHSA, Director of Operations
Ph: 478-621-2070
Referral Intake
10 South Broad Street, P.O. Box 25 Butler, GA 31006
Lou Ann Moulton, Assistant Director of Referral Intake
Ph: 478-862-5886
Alt Number: 888-762-2420
Fax: (478) 862-9111
E-mail: info@nextstepcare.org

Next Step Care Offices

Albany
Administrator: Gladys Bussey, LPN
Ph: 229-431-0523
Fax: 229-431-0525
507 N Jefferson St, Albany, GA 31701
Counties: Crisp, Dooly, Lee, Sumter, Terrell, Turner, Wilcox, Worth, Ben Hill, Irwin, Dougherty

Augusta
Administrator: Edwina Wright
Ph: 706-737-0705
Fax: 706-737-0250
2100 Central Avenue Suite #5, Augusta 30904
Counties: Burke, Columbia, Richmond

Athens
Administrator: Steven Johnston, BS
Ph: 706-543-8460
Fax: 706-543-8293
405 Gaines School Rd., Athens, GA 30605
Counties: Barrow, Clark, Elbert, Franklin, Hart, Jackson, Madison, Oconee, Oglethorpe, Banks, Stephens

Butler
Administrator: Claire Locke, MFS
Ph: 478-862-4840
Fax: 478-862-4844
12 South Broad Street, P.O.Box 89 Butler, GA 31006
Counties: Crawford, Macon, Marion, Schley, Talbot, Taylor, Upson, Spalding, Pike

Columbus
Administrator: Claire Locke, MFS
Ph: 706-562-2340
Fax: 706-257-1006
6531 Effingham Way, Suite K, Columbus, GA 31909
Counties: Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Webster
Covington
Administrator: Shanika Warren
Phone: 404-832-4225
Fax: 770-388 - 7539
2120 Lee Street SW, Covington, GA 30014
Counties: Rockdale, Walton, Newton, Henry, Dekalb

Duluth
Administrator: Steven Johnston, BS
Ph: 770-717-2690
Fax: 770-717-2692
2825 Breckenridge Blvd., Suite 130, Duluth, GA 30096
Counties: Gwinnett, Fannin, Gilmer, Pickens, Cherokee, Union, Lumpkin, Dawson, Forsyth, Towns, White, Hall, Habersham, Rabun

Eatonton
Administrator: Michael Barton (Interim)
Ph: 706-485-4128
Fax: 706-485-4159
951 Harmony Rd, Suite 104, Eatonton, GA 31024
Counties: Baldwin, Greene, Hancock, Jasper, Lincoln, McDuffie, Morgan, Putnam, Taliaferro, Warren, Wilkes

Macon
Administrator: Steven Johnston, BS (Interim)
Ph: 478-471-0782
Fax: 478-621-7538
2000 A Northside Crossing Macon, GA 31210
Counties: Bibb, Jones, Monroe, Butts, Lamar

Metter
Administrator: Melinda Howell, LPN
Ph: 478-314-1573
Fax: 912-685-7640
58 SE Broad Street, P.O. Box 631 Metter, GA 30439
Counties: Bulloch, Candler, Emanuel, Evans, Jeff Davis, Jenkins, Montgomery, Screven, Tattnall, Telfair, Toombs, Treutlen, Wheeler, Appling, Atkinson, Bacon, Brantley, Bryan, Camden, Charlton, Chatham, Clinch, Coffee, Effingham, Glynn, Liberty, Long, McIntosh, Pierce, Ware, Wayne

Perry
Administrator: Claire Locke, MFS
Phone: 478-314-1573
Fax: 478-218 - 0378
Address: 107 Woodlawn Drive, Perry, GA 31069
Counties: Peach, Bleckley, Twiggs, Houston, Dodge, Pulaski
APPENDIX EE
Case management Provider Main Offices

Rome
Administrator: Michael Barton, BS
Ph: 706-378-1270
Fax: 706-378-1330
413 Shorter Avenue, Suite 111, Rome, GA 30165
Counties: Bartow, Catoosa, Chattooga, Cobb, Dade, Floyd, Gordon, Haralson, Murray, Paulding, Polk, Walker, Whitfield

Thomasville
Administrator: Shonell Rogers
Ph: 229-227-6430
Fax: 229-227-6156
14004 Hwy. 19 S. Suite 101, Thomasville, GA 31757
Counties: Baker, Brooks, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Miller, Mitchell, Seminole, Thomas, Tift, Berrien, Cook, Lanier, Lowndes, Echols

Tyrone
Administrator: Brenda Nelson, RN, BSHA
Ph: 770-629-2197
Fax: 770-742-0913
602 Dogwood Trail, Suite A, Tyrone, GA 30290
Counties: Carroll, Coweta, Douglas, Fayette, Heard, Meriwether, Troup, Fulton, Clayton

Wrightsville
Administrator: Olivia Humphrey
Ph: 478-864-3126
Fax: 478-864-9423
8647 South Marcus Street, P.O. Box 64, Wrightsville, GA 31096
Counties: Glascock, Jefferson, Johnson, Laurens, Washington, Wilkinson

St. Joseph's/Candler Health System
Contact Person: Terri Davis or Jackie Immel (912) 819-1520 or (866) 218-2259
Fax (912) 819-1548
1900 Abercorn Street, Savannah, GA 31401
Counties: Bryan, Bulloch, Candler, Chatham, Effingham, Liberty

Baxley Office
Contact Person: Jilda Brown (866) 835-0709 or (912) 367-6108
Fax (912) 367-0392
68 North Oak St. Suite E Street, Baxley, GA 31513
Counties: Appling, Bacon, Evans, Jeff Davis, Long, McIntosh, Montgomery, Tattnall, Toombs, Wayne

SOURCE Partners Atlanta – VNHS
Fax 404-527-0606
5775 Glenridge Drive, NE Suite E375
Trinity Case Management Source
Contact Person: Administrator: Sonja Lockett, BS
(706) 507-5510 or (706) 507-5517
Fax: (706) 507-5550
5510 Veterans Parkway Suite 103
Columbus, Ga. 31904
Counties: Chattahoochee, Clay, Harris, Muscogee, Meriwether, Marion, Quitman, Randolph, Stewart, Talbot, and Webster

PruittHealth Home First (Formerly Unihealth)
Patricia Walker, Vice President (770)331-7954
1626 Jeurgens Court. Norcross, GA 30093

PruittHealth Home First -Corporate Office
Patricia Walker, Vice President (770) 331-7954
1626 Jeurgens Court. Norcross, GA 30093

Athens
Contact Person: Kristie Dorsey, Administrator (706) 549-3315
Fax: 706 543-3841
435 Hawthorne Ave., Suite 300, Athens, GA 30606
Counties: Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Stephens, Walton

Atlanta
Contact Person: Charles Teasley, Administrator (770) 925-1143
Contact Person: Terry Bates, Administrator (770) 925-1143
Fax: 678 533-6488
1626 Jeurgens Court, Norcross GA 30093
Counties: Clayton, DeKalb, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Rockdale(Coweta, Fayette, Fulton (30291 only) , Harris, Heard, Meriwether, Muscogee, Spaulding, Talbot, Troup
APPENDIX EE
Case management Provider Main Offices

Augusta
Contact Person: Brenda Braddock, Administrator (706) 651-1535
620 Ponder Place, Evans, GA 30809
Fax: 706 863-9401
Counties: Burke, Columbia, , Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes Emmanuel

North Georgia Mountain/Blueridge
Contact Person: Jane Addison, RN, Administrator (706) 258-5300
Fax (706) 632-0028
5004 Appalachian Hwy, Suite 4, Blueridge, GA 30513
Counties: Cherokee, Dawson, Fannin, Gilmer, Lumpkin, Pickens, Rabun, Towns, White, Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haraleson Murray, Polk, Walker, Whitfield

(Cobb -- CLOSED Consolidated)
Contact Person: Ann Noles, Acting Administrator (770) 916-4502
Fax: 770 916-4505
1676 Mulkey Road, Austell, GA 30106
Counties: Carroll, Cobb, Douglas, Paulding,

Cordele
Contact Person: Jennifer Harris, Administrator (229) 273-2570
Fax: 229 273-4750
208 4th Avenue East, Cordele, GA 31015
Counties: Chattahoochee, Marion, Quitman, Stewart, Webster, Ben Hill, Bleckley, Clay, Crisp, Dodge, Dooly, Dougherty, Irwin, Lee, Macon, , Pulaski, Randolph, Schley, Sumter, Telfair, Tift, Turner, Wilcox, Worth

Jesup (consolidated 7.13)

Macon
Contact Person: Mildred O'Neal, Administrator (478) 474-0979 or (800) 913-0134
Fax: (478) 474-2068
6060 Lakeside Commons Drive, Box 9, Macon, GA 31210
Counties: Baldwin, Bibb, Butts, Putnam, Taylor, Twiggs, Upson, Wilkinson, Laurens, Jasper, Jones, Monroe, Lamar, Pike, Crawford, , Peach, Houston, Johnson, Montgomery Treutlen, Wheeler

(Newnan -- CLOSED - Consolidated)
Contact Person: Diana Davis, RN, Administrator 770 254-1545
Fax: (770) 254-8605
APPENDIX EE
Case management Provider Main Offices

7345 Red Oak Road Building 26
Union City, Georgia 30291
Counties: Coweta, Fayette, Fulton (30291 only), Harris, Heard, Meriwether, Muscogee, Spalding, Talbot, Troup

(Rome -- CLOSED Consolidated)
Contact Person: Debbie Faulkner, Administrator (706) 236-4705
Fax: 706-232-5912
39 Three Rivers Drive, NE, Rome, GA 30161
Counties: Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haraleson Murray, Polk, Walker, Whitfield

Swainsboro -- CONSOLIDATED 7/15
Contact Person: Mona Williamson Rushing, RN Administrator (478) 237-7270
Fax (770) 237-7290
667 South Main Street, Swainsboro, GA 30401
Counties: Bulloch, Chandler, Emmanuel, Evans, Johnson, Montgomery, Tattnall, Tombs, Treutlen, Wheeler

Valdosta
Contact Person: Trina Still Valdosta, Administrator, (229) 241-8750
Fax: 229 241-8940
312 Canna Drive
Valdosta, Georgia 31602
Counties: Atkinson, Berrien, Brooks, Clinch, Coffee, Colquitt, Cook, Echols, Lanier, Lowndes, Thomas, Ware, Jeff Davis

Savannah
Contact Person: Mary Cuff, Administrator-912 925-9181
Fax: 912 925 9340
9100 White Bluff Road suite 303
Savannah, Georgia 31406
Counties: Appling, Bacon, Brantley, Camden, Charlton, Glynn, Pierce, Wayne, Bryan, Chatham, Effingham, Liberty, Long, McIntosh Bulloch, Chandler Evans
Application For Enhanced Primary Care Case Management Applicants

I. Applicant Basic Information

1. Name of Company:
   Street Address:

   Mailing Address:
   Telephone Number Fax Number:

2. Type of Organization (please check):

   ____Public
   ____Private Non-Profit
   ____Private for Profit
   ____Other (please specify___________________________)

3. Date the organization was established: (Only Established Companies will be considered)

4. Location of proposed SOURCE program if different than above.

   Street Address:

   Mailing Address:
   Telephone Number Fax Number:

5. Contact Person for this application.

   Name:
APPENDIX FF
Enhanced Primary Care Case Management Application

II. General Directions:

A. To ensure that applications are given appropriate consideration, responses to the SOURCE Provider Enrollment Application must be typed or computer-generated, concise and relate to the Policies and Procedures of SOURCE. Attachments should clearly identify which specific question is being addressed. Failure to submit a clear, well organized, complete application may delay enrollment and the application will be returned to the applicant.

III. Company Background Information:

Business Experience – All applicant’s companies must have experience in case management and disease management for a minimum of twenty-four months prior to making application for enrollment in SOURCE. Example ICWP Case management Agency.

All applicants must have business management experience, managing 5 or more employees, in the health care field, for a minimum of twelve (12) consecutive months prior to making application for enrollment in SOURCE.

Applicants must give assurance of conflict free case management. Details will be provided by DCH. Email to Lstewart@dch.ga.gov

In order to be a SOURCE Case Management Agency, please document the following:

1. A minimum of two years experience providing case management and disease management services and oversight
   A) Briefly summarize your company’s experience with case management, home and community based services, and disease management programs. More in-depth questions will be asked below. Include types of services provided, fund sources for the services, and the dates during which the services were provided.
Next, please give a comprehensive documentation of:

aa. **CASE MANAGEMENT EXPERIENCE:**

NOTE: Please read description of Case Management Components located in section 806 of the SOURCE manual. Applicant must have at least 2 years experience in providing case management services and oversite. Please describe your experience as it relates to the following key elements:

- Assessment and Reassessment
- Development and periodic revision of specific care plan
- Referral and related activities
- Monitoring and Follow-up activities
- Working with other service agencies
- Financial responsibilities

bb. **DISEASE MANAGEMENT EXPERIENCE:**

NOTE: Please read description of Disease Management Monitoring located in section 1310 of the SOURCE manual. Applicant must have at least 2 years experience in providing Disease Management monitoring and oversight. Applicant should describe the following:

- Disease management stratification and intervention process
- Tracking mechanism associated with the stratification process.
- How improvement or decline is tracked and followed

Provide names, addresses, and telephone numbers of three references who are familiar with your professional experience.

2) Document your company's 12 months background of business experience and oversight of 5 or more employees in the health care field.

Include what the business does, employees managed, type of services provided, financial obligations, and date the business opened.
APPENDIX FF
Enhanced Primary Care Case Management Application

3) The ability to meet the State’s electronic data reporting requirements

Document the ability to file electronically and submit data electronically.

IV. Network Development:
Proposed Service Area

List the counties you are proposing to serve in the table below. Your network coverage must be appropriate for the demographics of each county. For example, Medicaid Transit has a set one way mileage limit, so it would not be appropriate to expect a large county like Gwinnett to have only one service provider. Choice for the member must also be considered.

Primary Care Providers:

List your Primary Care Providers by Name and office. There must be at least two Primary Care Provider agreeing to work in each rural county that is proposed- situated to assure choice and access; An appropriate network (to assure choice and access for members) of Primary Care Provider is needed in urban areas, consider logistics in your choice.

List all Primary Care Providers proposed to be enrolled in the program. Indicate which counties each will serve in table below.

1. List the proposed days and counties the physicians will be responsible for covering in a table format. Include the physical address(es) the provider will use to service the clients in each county.

2. Provide written confirmation from each physician attesting that s/he will act in this capacity* and for the specified day and counties if the program is approved. *Use detailed information from sections 802, 1302, and Appendix NN so that duties and responsibilities are clearly documented. Confirm with Physician that PCP for member will meet on specified day/time with Case Manager quarterly. Detail how SOURCE Case Managers can assist in meeting health care goals.

Acute Care Provider

List all hospitals that will provide acute care services for members enrolled with the program. The must be at least one hospital that will serve each county in the proposed service area.

1. Please list the name of County matched to the Hospital(s) in a table format below.
2. You must provide written confirmation from each hospital attesting that it will act to coordinate care with your agency and members and for the counties specified if the program is approved. See Section 1403 in this manual for language to include in the attestation.
   i. From this discussion with the Acute Care provider, describe how the program will work with Acute Care Providers admission and/or discharge departments and
   ii. How will the company track emergency room visits and hospitalizations

<table>
<thead>
<tr>
<th>County</th>
<th>Physician</th>
<th>Address</th>
<th>Days for client appointments</th>
<th>Acute Care Hospital with Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

V. Program Structure

a. Attach organizational chart(s) for the organization and the program (if different). All positions related to the SOURCE program must be included (e.g., program manager, case management supervisor, case managers, registered nurse, etc.). The lines of authority must be clear.

b. Attach job descriptions for all positions related to the program and resumes, if available.

c. Document the number of people in each position you will hire per member.

d. Provide a written agreement with the person who will serve as the Medical Director of the program. Describe how the person will provide the clinical oversight required for the program. The Medical Director’s resume must be included with those attached in response to item #2 above.

VI. Hours of Operation
Provide the normal operating hours and days for the SOURCE office. Describe how a 24-hour a day/seven days per week/365 days per year on-call system will be maintained. Describe how timeliness to calls and response to problems is documented and reviewed. Assigned personnel for this task must be appropriate for the health fragile clientele population served.

VII. Service Provider Network Development

A. Home and Community Based Services (HCBS) Providers

1. As of July 1st, 2013, SOURCE opened enrollment to all current CCSP HCBS providers in good standing. Compliance with increased performance expectations is expected for all SOURCE providers to achieve optimal health states for SOURCE members.

   Document how a multitude of providers will be used in a rotation pattern for your agency.
   Document how conflict of interest could occur and will be avoided with the Service Provider Community.

VIII. Forms/Documentation

Forms that must be used are referenced in the SOURCE Manual. Attach copies of all other forms that will be used by the program for each of the functions listed below and any other forms that will be used that are not listed in the manual. Do not send copies of the SOURCE manual mandatory forms.

Screening
APPENDIX FF
Enhanced Primary Care Case Management Application

Assessment
Program Admission
Developing and Implementing EPCCM Carepaths
  Robust Disease Management tools
Referrals for all Medicaid reimbursed HCBS
PCP Contacts
Provider Contacts, monitoring
  Case Manager Hire and Training
  Case Manager Supervisor Hire and Training
RN / LPN Hire and Training
Robust Community Resources for Discharged members
Community Resource list for non-Medicaid reimbursed services

IX. Policies and Procedures

Provide copies of site-specific policies and procedures for screening, assessment, admissions, Carepath development and implementation, referral for HCBS services, member contacts (scheduled and PRN), provider contacts (scheduled and PRN), disease management, HIPAA compliance, appeals, and measures to meet unfunded member needs.

Please Note: The policies and procedures must be agency specific. Do not submit copies of the policies in the SOURCE manual.
X. Provider and Service Oversight

Describe how the program will provide oversight to assure that members are receiving the services ordered and that Carepath goals are being monitored on a regular basis.

Describe how the program will correct and monitor deficiencies in services and variances in Carepath goals.

Provide all forms that will be used to organize and complete this task.

XI. Billing

Describe who will be responsible for billing Medicaid for the case management fee and the process for oversight of billing. Give assurance that billing provider has read and will keep current with PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS.

XII. Quality Assurance

Describe in writing how quality assurance and performance will be monitored and measured. Description of QA process should include but not limited to: monitoring roles and responsibilities of case managers; HCBS providers; and Primary Care Providers. Describe how poor quality or performance will be handled and documented, including provider termination and member notification and reassignment. Describe how member satisfaction surveys will be carried out. Provide copies of tools that will be used in this process.

Signature and Title

Date Submitted

Mail completed application and a copy of the completed Provider Enrollment Application located on the Hewlett Packard website( mmis.georgia.gov ) to:
APPENDIX FF
Enhanced Primary Care Case Management Application

Department of Community Health
2 Peachtree Street NW
37th floor, c/o SOURCE Program Specialist
Atlanta, GA 30017
The name and telephone number for the contact person for the application.

- The full address of the new office and telephone number for the new office, if available.

- Days and hours of operation for the new office

- Specification of the counties to be served by the new office.

- Demographics that support unmet need for SOURCE services in the area to be served.

- Documentation that the applicant has a written agreement with a physician to be the Medical Director for the new office. Include Medical Director Resume

- Documentation that the applicant has written agreements with Primary Care Providers sufficient to cover potential member enrollment throughout the geographic area to be served by the office. Provide the names of all physicians, a copy of their written agreements, and a delineation of counties to be served by each physician.

- Documentation that the applicant has a written agreement with a physician to serve as the medical director for the new office.

- Documentation that the applicant has written agreements with HCBS providers sufficient to cover potential member enrollment throughout the geographic area to be served by the office. There must be a written agreement for at least one provider for each SOURCE service.

- Documentation that the applicant has written agreements with acute care providers sufficient to cover the entire geographic area to be served by the office. Provide the names of all acute care facilities, a copy of their written agreements, and a delineation of counties to be served by each facility.

- A staffing plan, including an organization chart for the new office that documents adequate staffing to meet the requirements for the case manager and case management functions.

- Written job descriptions for all positions in the new office.

- An organization chart delineating the relationship of the new office to the approved SOURCE site that documents adequate oversight by the SOURCE site for the new office.

- Documentation of an after-hours on-call system for contacting case managers and Primary Care Providers, including a toll-free 24-hour phone number.

- Copies of site-specific policies and procedures for screening, assessment, admissions, Carepath development and implementation, referral for HCBS services, member contacts (scheduled and PRN), provider contacts (scheduled and PRN), disease management, HIPAA compliance, appeals, and measures to meet unfunded member needs.
Please Note: The policies and procedures must be site specific. Do not submit copies of the policies in the SOURCE manual. If the site has previously submitted all of the above policies and none has changed since the last submission, the site may state that and simply refer to its initial submission.

-Documentation that the SOURCE site has resolved, or has an approved corrective action plan in place, for resolving any cited deficiencies as a result of reviews conducted by DHR or DCH or their agents.
A. When Client is able to choose

Where more than one SOURCE provider offers the same major service within a given geographic area, a choice of these providers is presented to the client. The client or client representative indicates the preferred provider.

Factors affecting the client's choice are:

3. Physician's recommendation for service

If the client's physician specifies a preference for a particular SOURCE provider to render services to the client, the client will be informed of the physician's recommendation, and whether or not the particular services needed are provided by the recommended provider. The client makes the final choice regarding the service provider.

2. Availability of services

If the client is in need of immediate (emergency) services and the SOURCE provider chosen by the client is unable to render the immediate service, an alternate provider may be utilized.

If the service dates/ times the client needs is not offered by the SOURCE agency chosen, an alternate provider may be utilized.

If the SOURCE provider chosen does not provide the comprehensive services needed (i.e., O.T.) the client may be referred to an alternate provider.

B. When Client is unable to choose

If, for any reason (unfamiliarity with service providers, confused mental state, etc.), a client is unable to choose from among multiple providers of the same service, the SOURCE agency utilizes the rotation procedure for that Planning and Service Area.
# SOURCE PROVIDER ROTATION LOG

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NAME</td>
<td>PROVIDER ID NUMBER</td>
</tr>
<tr>
<td>CLIENT NAME</td>
<td>DATE SERVICE BROKERED</td>
</tr>
<tr>
<td>REFERRAL ACCEPTED/DECLINED</td>
<td></td>
</tr>
</tbody>
</table>

## Instructions

Service Options Using Resources In Community Environments April 1 2016

HH-2
SOURCE PROVIDER ROTATION LOG INSTRUCTIONS

Purpose: This form is used when a client does not choose a provider. New providers are added to the rotation log within three business days of the notification of the provider number from the Dept of Community Health or its operating agencies.

NOTE: There is one log, per county, per service.

Who Completes/When Completed: The nurse or case manager selects a provider from the top of the rotation log when the client does not select a provider. If the provider refuses to accept a client for any reason they are placed at the bottom of the rotation list for that complete rotation.

Instructions:

Service: Enter the service provided on this rotation log (e.g., Alternative Living Services, Adult Day Health).

County: Enter the county where this service is provided.

Provider Name: Enter each provider name as they are approved to provide SOURCE services.

Provider ID Number: Enter each provider’s ID number

Client Name: Enter the name of the client assigned to a provider by the rotation system.

Date Service Brokered: Enter the date the service was brokered and accepted by the provider.

Accepted or Declined: Enter A if the provider accepted the referral and enter D if the provider declined.

NOTE: If the provider declines the referral after accepting it, enter D and the date the referral was declined.

Distribution: This is an interoffice form and not distributed for any reason.
PROVIDER CORRECTIVE ACTION

Corrective Action by Case Management (CM) Agency

A. Removal from Rotation List/Suspension of Referrals as Corrective Action

The CM agency may remove providers from the rotation list and have referrals suspended when appropriate documentation supports this action. DCH will review the notice before it is sent to the provider, however, new members can be withheld during this review period.

B. Reasons for Removing a Provider From the Rotation List/ Suspending Referrals

A provider may be removed from the rotation list and have referrals suspended for reasons including, but not limited to:

- Provider fails to accept referrals
- Provider fails to provide services as required by the comprehensive care plan
- Provider refuses to accept member because one or more of other needed services are brokered to another provider
- Provider overcharges members for services
- Provider fails to refund fees
- Provider has a documented history of confirmed complaints related to member care/issues
- Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
- Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction, or revocation of the license/permit
- Provider fails to submit requested plan of correction.
- Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit
- Provider fails to attend 2 or more meetings in a year.

C. Definition of Removal from Rotation List/Suspension of Member Referrals

When a provider agency is removed from the rotation list, Case Management agencies will not broker any SOURCE members to the provider agency and will not refer new SOURCE referrals to the provider agency for a specific period of time. The provider agency may continue providing services to SOURCE members currently brokered to the agency.

D. Procedure for Removing a Provider From the Rotation List/Suspension of referrals

The SOURCE Case Management will notify the provider in writing that the provider agency has been removed from the rotation list and that all referrals have been suspended and the reason(s) for the corrective action. The written notice will include the effective date of the removal from the rotation list/suspension of referrals, the duration of the corrective action, and the appeal process should the
provider disagree with the corrective action imposed. DCH will work with the provider on the written plan of corrective action.

The duration of the removal from the rotation list/suspension of referrals will be imposed for a specific time period. For the first offense, a minimum of three (3) months will be imposed; for subsequent offenses, a minimum of six (6) months will be imposed.

Note: DCH may request a written plan of correction from the service provider. DCH may shorten or lengthen the duration of the corrective action, depending upon the reason for the action.

E. Due Process (See also section 1409)

The provider shall have ten (10) days from the date of the written notice of removal from the rotation list/suspension of referrals to submit a written request for an Administrative Review. All requests for reviews must be submitted to

2 Peachtree Street NW
37th floor SOURCE; Aging and Special Populations Unit
Atlanta, GA 30303

this address should be specified in the corrective action notice to the provider
NOTICE OF REMOVAL FROM PROVIDER ROTATION LOG

Date of Notice: ________________

Dear Provider  

[provider name]

Provider address and phone number

[provider address and phone number]

Provider billing ID / Service type for removal:

[provider billing ID / service type for removal]

This letter is to notify you that your agency is being removed /suspended from the provider rotation list for

[case management agency name],

In these counties: ________________

You can continue to serve the members you were authorized to service prior to the date of this notification.

All new referrals have been suspended for the duration of _______months (3 months for first offense, or up to 6 months for subsequent offenses) and will end on ________________. This will be effective 10 days from the date of this written notice.____________________ Date takes effect

The reason for this corrective action is due to the following: (check as many as apply)

☐ Provider fails to accept referrals
☐ Provider fails to provide services as required by the comprehensive care plan
☐ Provider refuses to accept member because one or more of other needed services are brokered to another provider.
☐ Provider overcharges members for services
☐ Provider fails to refund fees
☐ Provider has a documented history of confirmed complaints related to member care/issues
☐ Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
☐ Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction or revocation of the license/permit.
☐ Provider fails to submit requested plan of correction

Continued to Next Page

☐ Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit.
☐ Provider fails to attend 2 or more meetings in a year.
☐ OTHER __________________________________________________________________
These are a summary of the grievances. Please see attachment for specific incidents, dates and details.

DCH Note for Provider:

If you disagree with this decision, you may request a Policy Review. You have ten days (10) from the date of this letter to request a review in writing. All requests for reviews must be submitted, with a copy of this letter, to

Department of Community Health
SOURCE Policy Services Section, 37th floor
2 Peachtree Street, NW
Atlanta, GA 30303-3159

Please contact the SOURCE Administrator for this location if you have any questions or concerns in regards to this letter. The Administrator is ____________________________

and can be reached at ____________________________ phone number.

☐ Copy to Provider
☐ Copy to DCH

CC: Copy of letter and attachments sent to DCH, ATTN: SOURCE Program, 2 Peachtree Street NW, Floor 37, Atlanta GA 30303

Rev. 10/13

Instruction for Notice of Removal from Provider Rotation Log:

Date of Notice: ________________

Service Options Using Resources In Community Environments April 1 2016
HH-7
Dear Provider _____________________________________________________ (provider name)

Provider address and phone number _____________________________________________

Provider billing ID / Service type for removal: _____________________________________

Use all of providers names that describe the company who provides the service being reviewed IE LaLa House ADH
At this address and phone number
Provider billing id xxxxA/ adult day health

(Do not include other names and services the provider may offer such as PSS or home delivered meals.)

Place your agency name i.e.

This letter is to notify you that your agency is being removed /suspended from the provider rotation list for

___SourceWaiver’s of Atlanta ________________________________ (case management agency name).
In these counties: ___Dekalb, Fulton____________________________

Fill in the number of months and date when referrals will resume.
All new referrals have been suspended for the duration of ___________ and will end on _________________. This will be effective

Don’t fill this date in in until approval from DCH
10 days from the date of this written notice.____________________ Date takes effect

Check as many reasons as apply and attach detailed supporting evidence:

☐ Provider fails to accept referrals etc etc

These are a summary of the grievances. Please see attachment for specific incidents, dates and details.

Give contact information and check appropriate boxes. Send to Dch for review/approval and comment. If approved, fill in current dates and send certified mail to the provider.

Please contact the SOURCE Administrator for this location if you have any questions or concerns in regards to this letter. The Administrator is ___________________________ and can be reached at ___________________________ phone number

Service Options Using Resources In Community Environments April 1 2016
HH-8
## APPENDIX HH-HCBS Monitor Log

### Case Management External Complaint Log For SOURCE

<table>
<thead>
<tr>
<th>Date</th>
<th>Prov. Name/#</th>
<th>Nature of Complaint</th>
<th>Cat.</th>
<th>Client</th>
<th>Caller</th>
<th>CM</th>
<th>CM Intervention/Comments</th>
<th>DCH Intervention</th>
<th>Outcome/date</th>
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### Complaint Log Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Abuse/neglect/exploitation</td>
</tr>
<tr>
<td>2.</td>
<td>Missed visit(s) (professional judgment when to start)</td>
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<tr>
<td>3.</td>
<td>Task not performed/ not adequate</td>
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<td>4.</td>
<td>Aide late</td>
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<td>5.</td>
<td>Aide not staying time ordered</td>
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<tr>
<td>6.</td>
<td>No RN supervision</td>
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<tr>
<td>7.</td>
<td>Lack of communication from provider</td>
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<tr>
<td>8.</td>
<td>Other</td>
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</tbody>
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### Category Totals

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
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<td>Total</td>
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</tbody>
</table>

### Case Management Internal Complaint/Review Log FOR SOURCE

<table>
<thead>
<tr>
<th>Date</th>
<th>Prov. Name/#</th>
<th>Nature of Complaint</th>
<th>Cat.</th>
<th>Client</th>
<th>Caller</th>
<th>CM</th>
<th>CM Intervention/Comments</th>
<th>DCH Intervention</th>
<th>Outcome/date</th>
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</table>

Service Options Using Resources In Community Environments April 1 2016
HH-9
<table>
<thead>
<tr>
<th>Nature of Complaint/ Problem</th>
<th>Date</th>
<th>CAT</th>
<th>Client</th>
<th>CM</th>
<th>CM Interventions/ Comments</th>
<th>DCH Interventions</th>
<th>Outcomes</th>
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**CM: Initials**  **Signatures**

**SCM Initials**  **Signature**  **Date of Review**

9. Provider fails to accept referrals
10. Provider fails to provide services as required by the comprehensive care plan
11. Provider refuses to accept member because one or more of other needed services are brokered to another provider
12. Provider overcharges members for services
13. Provider fails to refund fees
14. Provider has a documented history of confirmed complaints related to member care/issues
15. Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
16. Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction, or revocation of the license/permit
17. Provider fails to submit requested plan of correction,
18. Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit
19. Provider fails to attend 2 or more meetings in a year.
20. Other____

(Internal )Category Totals
9. ____  12. ____  15. ____  18. __
10. ____  13. ____  16. ____  19._____ 
11. ____  14. ____  17. ____  20. __

Total_______
# APPENDIX HH-HCBS Monitor Log

## SOURCE Case Management Internal/External Complaint Log

**HCBS Name:**

**Month/Year:**

<table>
<thead>
<tr>
<th>External Complaints</th>
<th>Internal Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Abuse/Neglect/Exploitation</strong></td>
<td><strong>9. Provider fails to accept referrals</strong></td>
</tr>
<tr>
<td><strong>2. Missed visit(s) - (professional judgment when to start)</strong></td>
<td><strong>10. Provider fails to provide services as required by the comprehensive care plan</strong></td>
</tr>
<tr>
<td><strong>3. Task not performed/not adequate</strong></td>
<td><strong>11. Provider refuses to accept member because one or more of other needed services are brokered to another provider</strong></td>
</tr>
<tr>
<td><strong>4. Aide late</strong></td>
<td><strong>12. Provider overcharges members for services</strong></td>
</tr>
<tr>
<td><strong>5. Aide not staying time ordered</strong></td>
<td><strong>13. Provider fails to refund fees</strong></td>
</tr>
<tr>
<td><strong>6. No RN supervision</strong></td>
<td><strong>14. Provider has a documented history of confirmed complaints related to member care/Issues</strong></td>
</tr>
<tr>
<td><strong>7. Lack of communication from provider</strong></td>
<td><strong>15. Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud</strong></td>
</tr>
<tr>
<td><strong>8. Other</strong></td>
<td><strong>16. Healthcare facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction or revocation of the license/permit</strong></td>
</tr>
<tr>
<td><strong>9. Medical/nursing staff/Service not as provided</strong></td>
<td><strong>17. Provider fails to submit requested plan of correction</strong></td>
</tr>
<tr>
<td><strong>10. Provider fails to provide requested services</strong></td>
<td><strong>18. Failure of the provider to comply with UR or to correct deficiencies cited in an audit</strong></td>
</tr>
<tr>
<td><strong>11. Provider fails to respond to complaints promptly</strong></td>
<td><strong>19. Provider fails to attend 2 or more meetings in a year</strong></td>
</tr>
<tr>
<td><strong>12. Provider fails to return member's phone call</strong></td>
<td><strong>20. Other</strong></td>
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### Internal Category Totals

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<tr>
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### External Category Totals

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### Date | Internal/External | Provider Name/Number | Nature of Complaint/Problem | Category | Client | Caller | CM | CM Interventions/Comments | DCH Interventions | Outcomes |
<table>
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**CM initial:**

**Signature/date:**

**CMS initial:**

**Signature/date:**

**CM initial:**

**Signature/date:**

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**Service Options Using Resources In Community Environments April 1 2016**

**HH-11**
APPENDIX HH-HCBS Monitor Log

SOURCE Program
Case manager External and Internal COMPLAINT LOG

Purpose: Case Management Agencies for SOURCE are responsible for follow up on provider complaints (External Complaint Log); and for monitoring provider performance (Internal complaint Log). The logs have been developed as an assistant quality improvement tool to assess timely follow up and resolution of complaints and problems with HCBS providers. It is not mandatory to use the Internal Log if a score Card is being kept for the HCBS provider. The external log can be redesigned to incorporate several months or several providers.

Who completes/When completed:
Case Manager enters information. The Case Manager Supervisor reviews logs monthly to assess for trends in complaints or providers.

Instructions:
1. HCBS Name: Enter the name of the Home and Community Based Services Provider Agency and Service Type.
2. Month/Year: Enter the month and year.
3. Category Totals: Enter the total for each category of complaints and the total number of all complaints.
4. Date: Enter the date the complaint was received/given.
5. Provider Name/Phone Number: Enter the name of the provider the complaint is being made against and the phone number of the person contacted regarding the complaint.
6. Nature of Complaint: State briefly the details concerning the complaint. Use professional judgment if first missed service call.
7. Category: Using the prescribed legend, enter the number that corresponds to the category of complaint.
8. Client Name: Enter client’s name.
9. Caller: Enter name of person making complaint and relationship to client.
10. CM: Enter the initials of the assigned Case Manager.
APPENDIX HH-HCBS Monitor Log

11. **CM Intervention/Comments**: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Removed from Rotation Log, or you may specify another intervention in the space. Enter information about follow up activities.

12. **DCH Interventions**: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Removed Provider from Rotation Log, Address(ed) at Network Meeting or you may specify another intervention in the space.

13. **Outcome/Date**: Enter resolution and date.

**NOTE:** Record detailed information about follow up and interventions in case notes.

*Distribution*: Maintain in central location. Indicate when there are no new for a month complaints, no complaints pending resolution, and no complaints resolved during the report period.

**NOTE:** Indicate “no complaints” in the comments section of the log. Include the name of the Provider Company, month, and year.
APPENDIX II
HCBS SERVICE PROVIDER ENROLLMENT

SOURCE
Provider Application Checklist

Provider Name _______________________________

Base Rendering Provider ID* _______________________________
Payee ID** _______________________________

NOTE: Forms listed in bold type can be accessed at www.mmis.georgia.gov by clicking on “Provider Enrollment” at the top of the page.

1. _____ DCH Facility Enrollment Application (June 2012 version or later)
2. _____ Current state license issued by GA Dept of Community Health, Healthcare Facility Regulation Division (HFRD)
3. _____ Letter from HFRD that lists the counties you are licensed to serve (private home care provider agencies only)
4. _____ Current business license issued by your city or county
5. _____ Statement of Participation
6. _____ Disclosure of Ownership Form (Make sure you complete Section III!)
7. _____ Approved CCSP Provider (6 mos or more)
8. _____ Proof of liability and worker’s comp insurance coverage
9. _____ Completed SOURCE Application Checklist (This form!)

* This is the provider ID you use to Medicaid.
** This is the number that is associated with your bank account and tax ID.

Scan and send the completed application packet to tunderwood@dch.ga.gov. Use “SOURCE application packet for (your agency name)” as the title of the e-mail when you transmit the packet.

NOTES:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Rev. July 2013

Instructions:

Service Options Using Resources In Community Environments April 1 2016

II-1
To apply for a Medicaid Provider Number under the SOURCE Contract (930), go to [www.mmis.georgia.gov](http://www.mmis.georgia.gov), and access the following forms by clicking directly on “Provider Enrollment” at the top of the page.

Complete the following forms:

- **Facility Enrollment Application** – Use the June 2012 version and complete all sections, including at least one entry in Sections K and L.
- **Statement of Participation** – Write the name of your agency as the “Printed Name of Enrolling Provider” on the last page.
- **Disclosure of Ownership Form** - Make sure you complete Section III to list all owners of your company.
- **SOURCE Provider Application Checklist**.

Enter your Medicaid **payee** number on the application form. This will be used to route automatic deposit of payment of SOURCE claims to the bank account you specified when you applied for a CCSP provider number. Use the same legal and DBA names that you used when you applied to be a CCSP provider.

Include the following attachments with the completed forms as part of the packet:

- **A copy of your current license that’s issued by the State of Georgia** (Health Facilities Regulation Division of the GA Dept of Community Health) if you are applying as a Group model Alternative Living Services (Specialty 010), Personal Support Services and/or Skilled Nursing Services Provider (Specialties 197, 243 or 249) or Home Delivered Services (Specialty 087) provider.
- **If you are a personal support services/skilled nursing provider, a copy of the letter from HFRD that lists the counties you are licensed to serve.**
- **A copy of your current local business license** if required by your city or county.
- **A copy of your insurance declarations page**, showing **proof of general liability and worker’s compensation** coverage for your agency.

Scan and send all the above in PDF or TIF format to **tunderwood@dch.ga.gov** or **lstewart@dch.ga.gov**
1. Agency Name: _______________  2. Report Month: _______________

2. Submitted by: __________________  4. Today’s Date/Year: _______________

Provide member counts for the report month as follows:

5. Previous Month Total Members: __________
6. Members Admitted during report month: ______
7. Members Discharged during report month: ______
8b Total members 2014-2015 who received “flu shot” (add 8a + any members from previous months as applicable.) _______
9. Unduplicated total _______________
10. Reason(s) Discharged (include number for each)-

Nursing Facility: __________
Deceased: _________
Moved out of Service Area: _______
Hospice: _______
Member Choice: _________
Non-Compliance: _______
Lost SSI/Related Eligibility: _______
Lost Level Of Care _______
Other (specify): _______________________

________________________________________

Wait List Data:

11. Total Number on the Wait List: __________
12. Wait List Report by DON-R Score:

<table>
<thead>
<tr>
<th>DON-R Score</th>
<th># Members on WL</th>
<th>DON-R Score</th>
<th># Members on WL</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Programmatic report is due to: Department of Community Health, Division of Medicaid, SOURCE Program Specialist no later than the 15th of the month following the report month. EPCMM agencies with multiple locations will complete one programmatic report for purpose of management of the waiting list.

Service Options Using Resources In Community Environments April 1 2016
Instructions for SOURCE monthly report:

The purpose of the report is to keep track of how many active members your SOURCE site currently serves (members locked into your site), how many unduplicated members the Site has served to date, track the reason why members discharge from the program, and track the number of members in process to receive service.

Instructions:

1. **Agency Name**
   Insert the SOURCE case agency name here.

2. **Report month.**
   The month the data gathered and submitted for the report. Member information gathered in April would equal an April Report Month.

3. **Submitted by**
   Who is responsible for this data or who compiled the report.

4. **Today's Date and Year**
   The date the report is submitted.

5. **Previous month total**
   Represents the current number of members active on the previous month report.

6. **Members Admitted during report month**
   Number of new members who became locked into your site during the month. (This includes anyone locked in during the report month who were retro locked back to a previous month.

7. **Members Discharged during report month**
   If you sent in a discharge and DCH closed the span.

8. **Current Active Members**
   Active members equal #5 + #6 - #7. (Number of members locked into your site as of the last day of the report month)

8a. Members unduplicated who received 2014-2015 influenza vaccine the month of the report

8b. All members who received influenza vaccine for this season. Season starts July of the calendar year to June 30th of next calendar year.
9. **Unduplicated total** equals #5 (previous month total) + #6 (members admitted during report month)

10. **Reason(s) Discharged (include number for each)**
    
    Self explanatory. Numbers must equal number discharged.

Wait List Data (WL)

11. **Total Number on Wait List:**
    
    Anyone screened during the report month and any members pending lock in from previous months. If score is less than 15, there is no need to put on the waiting list.

12. **Wait List Report by DON-R Score**
    
    The agency may devise a span of scores to group member data on this list or report by individual score.
### APPENDIX KK
**DETERMINATION OF NEED- REVISED (DON-R)**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Important Diagnosis:**

**Caregiver (CG) name:**

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Function</td>
<td>Level of Impairment</td>
<td>Unmet Need for Care</td>
</tr>
<tr>
<td>1. Eating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Bathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Grooming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Transferring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Continence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Column A Functional Impairment**

**Score 0** - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of function remains;
- Activity is not required by the client;
- Client may benefit from but does not require verbal or physical assistance.

**Score 1** - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- Experience minor, intermittent fatigue in performing the activity;
- Take longer than would be required for an unimpaired person;
- Require some verbal prompting to complete the task.

**Score 2** - Cannot perform most of the essential components of the activity, even with an assistive device, and/or requires a great deal of verbal or physical assistance to accomplish the activity. This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity;
- Take an excessive amount of time to perform the activity;
- Must perform the activity much more frequently than an unimpaired person;
- Require frequent verbal prompting to complete the task.

**Score 3** - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant physical assistance.

**Column B: Unmet Need for Care**

**Score 0** - The applicant’s need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

**Score 1** - The applicant’s need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

**Score 2** - The applicant’s need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

**Score 3** - The applicant’s need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.
# APPENDIX KK
## DETERMINATION OF NEED- REVISED (DON-R)

<table>
<thead>
<tr>
<th>Function</th>
<th>Column A LOI</th>
<th>Column B Unmet Need</th>
<th>Comments: If scores 1-3 give reason why client needs assistance ie bad leg, weak arm, dementia etc</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Managing Money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Telephoning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Preparing Meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Laundry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Housework</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12. Outside Home</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13. Routine Health</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14. Special Health</td>
<td></td>
<td></td>
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<tr>
<td>15. Being Alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 1-6 (ADL)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 7-15 (IADL)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 1-15 (ADL+ IADL)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Column A Functional Impairment**

**Score 0** - Performs or can perform all essential components of the activity, with or without an assistive device, such that:
- No significant impairment of function remains;
- Activity is not required by the client;
- Client may benefit from but does not require verbal or physical assistance.

**Score 1** - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:
- Experience minor, intermittent fatigue in performing the activity; or
- Take longer than would be required for an unimpaired person; or
- Require some verbal prompting to complete the task.

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- Experience frequent fatigue or minor exertion in performing the activity; or
- Take an excessive amount of time to perform the activity; or
- Must perform the activity much more frequently than an unimpaired person; or
- Require frequent verbal prompting to complete the task.

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**Score 3** - The applicant’s need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.
Tool to determine appropriateness for services based on the applicant’s medical and financial status.

When Completed: The screening and intake is completed within three business days of receiving the referral or inquiry.

Inform applicant of screening process before you begin.

Instructions for completion of the Determination Of Need-Revised (DON-R) Functional Assessment are outlined below.

DETERMINATION OF NEED - REVISED FUNCTIONAL ASSESSMENT (DON-R)

The Determination of Need (DON) defines the factors which help determine a person’s functional capacity and any unmet need for assistance in dealing with these impairments. The DON-R allows for independent assessment of both impairment in functioning on Basic Activities of Daily Living (BADL) and Instrumental Activities of Daily Living (IADL) and the need for assistance to compensate for these impairments.

Assess both Column A Level of Impairment, and Column B Unmet Need for Care on all applicants.

A minimum score of 15 is required in Column A Level of Impairment along with identified Unmet Need for Care in Column B, before a client is referred for assessment. If the Level of Impairment score is less than 15 refer client to other available services through the Area Agency on Aging or other resource.

The central question to determining the level of need for care is whether a person can perform activities of daily living (ADL). Table 1 presents the list of ADL included in the DON under two headings: BASIC AND INSTRUMENTAL.

<table>
<thead>
<tr>
<th>Table 1 - Activities of Daily Living Included in the Determination of Need (DON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASIC ACTIVITIES OF DAILY LIVING (BADL)</td>
</tr>
<tr>
<td>Eating</td>
</tr>
</tbody>
</table>

Service Options Using Resources In Community Environments April 1 2016
# APPENDIX KK

**DETERMINATION OF NEED- REVISED (DON-R)**

<table>
<thead>
<tr>
<th>Bathing</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grooming</td>
<td>Preparing Meals</td>
</tr>
<tr>
<td>Dressing</td>
<td>Laundry</td>
</tr>
<tr>
<td>Transfer (In and Out of Bed/Chair)</td>
<td>Housework</td>
</tr>
<tr>
<td>Bowel/Bladder Continence</td>
<td>Outside Home</td>
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<td></td>
<td>Routine Health</td>
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<td></td>
<td>Special Health</td>
</tr>
<tr>
<td></td>
<td>Being Alone</td>
</tr>
</tbody>
</table>

## ITEM DEFINITIONS

1. **EATING:**

   A. Is the client able to feed himself/herself?

   Assess the client’s ability to feed oneself a meal using routine or adapted table utensils and without frequent spills. Include the client’s ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages. When a special diet is needed, do not consider the preparation of the special diet when scoring this item (see “preparing meals” and “routine health” items).

   B. Is someone available to assist the client at mealtimes?

   If the client scores at least (1) in Column A, evaluate whether someone (including telephone reassurance) is available to assist or motivate the client in eating.

2. **BATHING**

   A. Is the client able to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene as needed for the client’s circumstances?

   Assess the client’s ability to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, and frequent profuse nose bleeds. Consider ability to get in and out of the tub or shower, to turn faucets, regulate water temperature, wash and dry fully. Include douches if required by impairment.

   B. Is someone available to assist or supervise the client in bathing?

   If the client scores at least (1) in Column A, evaluate the continued availability of resources to assist in bathing. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

---

Service Options Using Resources In Community Environments April 1 2016
APPENDIX KK
DETERMINATION OF NEED- REVISED (DON-R)

3. GROOMING

A. Is the client able to take care of his/her personal appearance?

Assess client’s ability to take care of personal appearance, grooming, and hygiene activities. Only consider shaving, nail care, hair care, and dental hygiene.

B. Is someone available to assist the client in personal grooming tasks?

If the client scores at least (1) in Column A, evaluate the continued personal assistance needed, including health professionals, to assist client in grooming.

4. DRESSING

A. Is the client able to dress and undress as necessary to carry out other activities of daily living?

Assess the client’s ability to dress and undress as necessary to carry out the client’s activities of daily living in terms of appropriate dress for weather and street attire as needed. Also include ability to put on prostheses or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or winter coat. Do not include style or color coordination.

B. Is someone available to assist the client in dressing and undressing?

If someone scores at least one (1) in Column A, evaluate whether someone is available to help dressing and/or undressing the client at the times needed by the client. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

5. TRANSFER

A. Is the client able to get into and out of bed or other usual sleeping place?

Assess the client’s ability to get into and out of bed or other usual sleeping place, including pallet or armchair. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Include ability to adjust the bed or place/remove handrails, if applicable and necessary. When scoring, do not consider putting on prostheses or assistive devices.

B. Is someone available to assist or motivate the client to get in and out of bed?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, (including telephone reassurance and friendly visiting) to assist or motivate the client in getting into and out of bed.

6. CONTINENCE

A. Is the client able to take care of bladder/bowel functions without difficulty?

Assess the client’s ability to take care of bladder/bowel functions by reaching the bathroom or other appropriate facility in a timely manner. Consider the need for reminders.

B. Is someone available to assist the client in performing bladder/bowel functions?

If the client scores at least (1) in Column A, evaluate whether someone is available to assist or remind the client as needed in bladder/bowel functions.
NOTE: When using the MDS-HC, the DON question regarding continence is incorporated in the MDS-HC question for toilet use.

7. MANAGING MONEY

A. Assess the client’s ability to handle money and pay bills. Include ability to plan, budget, write checks or money orders, exchange currency, and handle paper work and coins. Include the ability to read, write and count sufficiently to perform the activity. Do not increase score based on insufficient funds.

C. Is someone available to help the client with money management and money transactions? If the client scores at least (1) in Column A, evaluate whether an appropriate person is available to plan and budget or make deposits and payments on behalf of the client. Consider automatic deposits, banking by mail, etc.

8. TELEPHONING

A. Is the client able to use the telephone to communicate essential needs? Assess the client’s ability to use a telephone to communicate essential needs. The client must be able to use the phone: answer, dial, articulate and comprehend. If the client uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment. Do not consider the absence of a telephone in the client’s home. (Note: the use of an emergency response system device should not be considered.

B. Is someone available to assist the client with telephone use? If the client scores at least (1) in Column A, evaluate whether someone is available to help the client reach and use the telephone or whether someone is available to use the telephone on behalf of the client. Consider the reliability and the availability of neighbors to accept essential routine calls and to call authorities in an emergency.

9. PREPARING MEALS

A. Is the client able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the client can eat? Assess the client’s ability to plan and prepare routine hot and cold, nutritionally balanced meals. Include ability to prepare foodstuffs, to open containers, to use kitchen appliances, and to clean up after the meal, including washing, drying and storing dishes and other utensils in meal preparation. Do not consider the ability to plan therapeutic or prescribed meals.

B. Is someone available to prepare meals as needed by the client? If the client scores at least one (1) in Column A, evaluate the continued availability of resources (including restaurants and home delivered meals) to prepare meals or supervise meal preparation for the client. Consider whether the resources can be called upon to prepare meals in advance for reheating later.

LAUNDRY

A. Is the client able to do his/her laundry? Assess the client’s ability to do laundry including sorting, carrying, and loading, unloading, folding, and putting away. Include the use of coins where needed and use of machines and/or sinks. Do not consider the location of the laundry facilities.
APPENDIX KK
DETERMINATION OF NEED- REVISED (DON-R)

B. Is someone available to assist with the performing or supervising the laundry needs of the client? If the client scores at least one (1) in Column A, evaluate the continued availability of laundry assistance, including washing and/or dry cleaning. If public laundries are used, consider the reliability of others to insert coins, transfer loads, etc.

11. HOUSEWORK

A. Is the client able to do routine housework? Assess the client’s ability to do routine housework. Include sweeping, scrubbing, and vacuuming floors. Include dusting, cleaning up spills, and cleaning sinks, toilets, bathtubs. Minimum hygienic conditions for client’s health and safety are required. Do not include laundry, washing and drying dishes or the refusal to do tasks if refusal is unrelated to the impairment.

B. Is someone available to supervise, assist with, or perform routine household tasks for the client as needed to meet minimum health and hygiene standards? If the client scores at least one (1) in Column A, evaluate the continued availability of resources, including private pay household assistance and family available to maintain the client’s living space. When the client lives with others, do not assume the others will clean up for the client. This item measures only those needs related to maintaining the client’s living space and is not to measure the maintenance needs of living space occupied by others in the same residence.

12. OUTSIDE HOME

A. Is the client able to get out of his/her home and to essential places outside the home? Assess the client’s ability to get to and from essential places outside the home. Essential places may include the bank, post office, mail box, medical offices, stores, and laundry if nearest available facilities are outside the home. Consider ability to negotiate stairs, streets, porches, sidewalks, entrance and exits of residence, vehicle, and destination in all types of weather. Consider the ability to secure appropriate and available transportation as needed, will increase the score. However, in scoring, do not consider the inability to afford public transportation.

B. Is someone available to assist the client in reaching needed destinations? If the client scores at least one (1) in Column A, evaluate the continued availability of escort and transportation, or someone to go out on behalf of the client. Consider banking by mail, delivery services, changing laundromats, etc., to make destinations more accessible.

NOTE: When using the MDS-HC, the DON question regarding outside home is incorporated in the MDS-HC question for transportation.

13. ROUTINE HEALTH CARE

A. Is the client able to follow the directions of physicians, nurses, or therapists, as needed for routine health care? Assess the client’s ability to follow directions from a physician, nurse, or therapist, and to manipulate equipment in the performance of routine health care. Include simple dressings, special diet planning,
monitoring of symptoms and vital signs (e.g., blood pressure, pulse, temperature and weight), routine medications, routine posturing and exercise not requiring services or supervision of a physical therapist.

**B. Is someone available to carry out or supervise routine medical directions of the client’s physician or other health care professionals?**

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to remind, supervise or assist the client in complying with routine medical directions. If the assistance needed involves intimate care, and the care giver is inappropriate and/or opposed by the client, consider the assistance unavailable.

**14. SPECIAL HEALTH CARE**

**A. Is the client able to follow directions of physicians, nurses or therapists as needed for specialized health care?**

Assess the client’s ability to perform or assist in the performance of specialized health care tasks which are prescribed and generally performed by licensed personnel including physicians, nurses, and therapists. Include blood chemistry and urinalysis; complex catheter and ostomy care; complex or non-routine posturing/suctioning; tub feeding; complex dressings and decubitus care; physical, occupational and speech therapy; intravenous care; respiratory therapy; or other prescribed health care provided by a licensed professional. Score “0” for clients who have no specialized health care needs.

**B. Is someone available to assist with or provide specialized health care for the client?**

If the client scores at least one (1) in Column A, evaluate the continued availability of specially trained resources as necessary to assist with or perform the specialized health care task required by the client.

**15. BEING ALONE**

**A. Can the client be left alone?**

Assess the client’s ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the client’s ability to evacuate the premises or alert others to the client’s need for assistance, if applicable, and to use appropriate judgment regarding personal health and safety.

**B. Is someone available to assist or supervise the client when the client cannot be left alone?**

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to assist or supervise the client as needed to avoid danger and respond to emergencies. Consider friendly visiting, telephone reassurance, and neighborhood watch programs.

BADL’s refer to those activities and behaviors that are the most fundamental self-care activities to perform and are an indication of whether the person can care for his or her own physical needs.

IADL’s are the more complex activities associated with daily life. (They are applications of the BADL’s.) Information regarding both BADL and IADL are essential to evaluating whether a person can live independently in the community.

The DON-R Functional Assessment is a unique measure of functional assessment in that it differentiates between impairment in functional capacity and the need for care around a particular functional capacity. Furthermore, it is an ordinal scale with clearly defined meanings for each level of unmet need for care and each functional activity. Because of its ordinal nature, it permits quantification of scores so that changes in
scores in subscales for BADL’s and IADL’s and for Total Impairment represent actual changes in impairment, and changes in scores for unmet need for care in BADL’s, IADL’s and Total Unmet Need for Care represent actual changes in unmet need for care.

Ask if client has a medical/health problem/diagnosis with functional impairment. Take the following action as appropriate:

1. If answer is “no”, inform applicant of CCSP/SOURCE ineligibility and right to appeal. If applicant agrees, refer client to other resources as appropriate. (If client appeals, please complete the case management form under Appendix Z6) Attempt to give member/ family county specific resources as well as state offerings. Gather resources through contacts, from internet, the local health department https://dhs.georgia.gov/ and others as appropriate. Focus resources on what the member identifies as the reason for the application to the program i.e. if needs monitoring refer to ADH or churches/ similar programs; if member needs food, refer to food banks, food stamps, meals on wheels etc; if family needs respite, search for respite offerings in community. https://dhs.georgia.gov/

2. If applicant’s answer is yes, continue screening process answering each area with appropriate number (0-3).

Some general comments about the DON-R are provided to assist in the completion of the instrument.

The “Case Comments” space to the right of Column B in the functional status section is used to:

● Note special reasons for impairment or unmet need.

● Describe the type of service, caregiver support or assistive devices that decreases the client’s unmet need.

● Record the primary care giver’s name or other pertinent information.

Column Rules:

Use the following criteria to decide when to stop asking questions for a particular Functional Status item or when to skip Column B:

1. Ask each Functional Status item, starting with Column A, Level of Impairment.

2. If Column A, “level of impairment” is scored “0”, score Column B “0”.

3. If Column A is scored greater than “0”, ask Column B, Unmet Need for Care.

**Column A: Level of Impairment**
Each one of the BADLs and IADLs needs to be discussed in terms of level of impairment. How the assessor mentions functional impairment is not as important as encouraging the client to report difficulties with the activity. Sample questions could include:

- Are you able to do...?
- How much difficulty do you have in doing...?

**NOTE:** If an applicant is living in a personal care home or nursing home, determine Impairment Level using Column A of the DON-R. The objective is to gather sufficient information to determine the most appropriate score.

Answers to these questions should address the degree of unmet need for care if discharge occurs.

**Score 0** - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of function remains; or
- Activity is not required by the client (IADLs: medication management, routine and special health only); or
- Client may benefit from but does not require verbal or physical assistance.

**Score 1** - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- Experience minor, intermittent fatigue in performing the activity; or
- Take longer than would be required for an unimpaired person; or
- Require some verbal prompting to complete the task

**Score 2** - Cannot perform most of the essential components of the activity, even with an assistive device, and /or requires a great deal of verbal or physical assistance to accomplish the activity.

This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; or
- Take an excessive amount of time to perform the activity; or
- Must perform the activity much more frequently than an unimpaired person; or
• Require frequent verbal prompting to complete the task.

Score 3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant verbal or physical assistance.

Column B: Unmet Need for Care
In scoring this column, the idea is both to obtain information from the applicant about his or her perceptions regarding need for care and to use observational skills to determine the impact on the applicant should care or assistance not be provided, or a caregiver is unable to continue providing care at the current level. The availability of an appropriate caregiver also needs to be assessed.
Assess the degree to which the caregiver feels overwhelmed or burdened by the caregiving situation. The Zarit burden scale or the Caregiver Hassels Scale are formal assessments that may be used to assess caregiver burden.
Questions that might be asked of applicants and caregivers are:
• Do you feel burdened by providing care to your family member or friend?
• How often do you feel this way: frequently (daily), occasionally (weekly), sometimes (monthly), rarely (less than monthly)?
• How long will you be willing/able to provide care at the current level?

Questions that might be asked of applicants and caregivers are:
• Can you tell me if you are getting enough help in meeting your needs with...?
• Do you think you need more help with...?

If the applicant is living in a personal care home or nursing home, score the applicant according to the care he would receive if discharged. To determine the future need for care, include the following questions:

a. Who will/would provide care in the home if the person was discharged?
b. How much care will the person need?
c. How much can the person do for him/herself?
d. How often will assistance be provided/available?
e. How long would this plan last?

NOTE: Answers to these questions should address the degree of unmet need for care if discharge occurs. Observe the applicant’s mobility, level of clutter, personal appearance, unpaid bills, forgetfulness, etc., to assess the level of risk to health or safety if current levels of assistance are not maintained, or if additional assistance is not added.

Score 0 - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.
Score 1 - The applicant’s need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant’s need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant’s need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

Comments - Ask applicant “If you are not able to get these services, what will happen” and record the answer in applicant’s own words.
FAQs

SOURCE program admission now includes GMCF review for initial admission assessment, 6 month reassessment, and a designated number of annual reviews.

Information on their services and how to access their services is now available to Providers via the Provider Workspace/Education and Training link.

To access the training resources referenced in the SOURCE Webinar, please follow these instructions:

Open the web portal at www.mmis.georgia.gov
Log in using your assigned credentials to open the Secure Home Page
Click the Prior Authorization link
Click Provider Workspace from the drop list
Go to the bottom of the workspace page, and under the Help & Contact Us section, click Education and Training Material and Links

Help & Contact Us

Education & Training Material and Links - Use this link to access workshops, webinars, user manuals, and other resources.
Contact Us or Search My Correspondence - Use this link to contact review nurse staff behind the scenes of MMIS portal.

If GMCF gives a final denial to the member it is the responsibility of the SOURCE Case Management Agency to follow up with the member per section 901 under Procedures/ Medicaid Eligibility: Screening staff will access the GAMMIS website to confirm a potential member’s eligibility status. For persons not eligible for SOURCE or not interested in joining the program, appropriate referrals to other services or organizations will be made (including referral to the Social Security Administration if the person screened may be eligible for SSI). See also Policy No. 1405, Right to Appeal.

2nd level Reviews:

The 2nd level review option is only for members who have an evaluation denial from GMCF
- The member receives this information in their denial letter and will have 10 business days to provide new information to GMCF through their Case Management agency.
- Please do not use the contact us system. Use the Reconsideration Link only (page 39 of the Provider Workspace User Manual).
- If the member provides new information in the 10 days, they will either be accepted by GMCF for LOC, or they will receive a 2nd and final denial letter. (see attached SOURCE Second Denial Notification)
- If the member does not give new information, no new denial letter will be issued from GMCF. The member continues to have the right to ask for an appeal 30 days from issuance of the original denial letter.
The Affordable Care Act (ACA)
The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers’ definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim cannot be paid.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider’s name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the “ordering” provider field for claims that require a prescribing physician.

For claims transmitted via EDI:
The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.
# NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions

The NEW CMS 1500 Claim Form (version 02/12) is used for submitting claims to health insurance companies. It is designed to replace the UB-04 form. The form is approved by the National Uniform Claim Committee (NUCC) and is used for claims submission.

### HEALTH INSURANCE CLAIM FORM

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L. MEDICARE</td>
<td>Medicare Number (Medical ID)</td>
</tr>
<tr>
<td>M. MEDICAID</td>
<td>Medicaid Number (Medical ID)</td>
</tr>
<tr>
<td>T. TRicare</td>
<td>Tricare Number (Medical ID)</td>
</tr>
<tr>
<td>C. CHAMPVA</td>
<td>CHAMPVA Number (Medical ID)</td>
</tr>
<tr>
<td>A. GROUP PLAN</td>
<td>Group Plan Number (Medical ID)</td>
</tr>
<tr>
<td>B. HMO</td>
<td>HMO Number (Medical ID)</td>
</tr>
<tr>
<td>D. OTHER</td>
<td>Other Number (Medical ID)</td>
</tr>
<tr>
<td>4. INSURED'S SSN</td>
<td>Insured's Social Security Number (SSN)</td>
</tr>
<tr>
<td>5. PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>6. PATIENT'S DATE OF BIRTH</td>
<td>Patient's Date of Birth</td>
</tr>
<tr>
<td>7. PATIENT'S RELATIONSHIP TO INSURED</td>
<td>Patient's Relationship to Insured</td>
</tr>
<tr>
<td>8. INSURED'S ADDRESS (No., Street)</td>
<td>Insured's Address (No., Street)</td>
</tr>
<tr>
<td>9. CITY</td>
<td>City</td>
</tr>
<tr>
<td>10. STATE</td>
<td>State</td>
</tr>
<tr>
<td>11. ZIP Code</td>
<td>Zip Code</td>
</tr>
<tr>
<td>12. TELEPHONE</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>13. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Other Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>14. OTHER INSURED'S DATE OF BIRTH</td>
<td>Other Insured's Date of Birth</td>
</tr>
<tr>
<td>15. OTHER INSURED'S ADDRESS (No., Street)</td>
<td>Other Insured's Address (No., Street)</td>
</tr>
<tr>
<td>16. INSURANCE PLAN NAME</td>
<td>Insurance Plan Name</td>
</tr>
<tr>
<td>17. INSURANCE PLAN SERVICES</td>
<td>Insurance Plan Services</td>
</tr>
<tr>
<td>18. INSURANCE PLAN ID</td>
<td>Insurance Plan ID</td>
</tr>
<tr>
<td>20. OUT-OF-POCKET LIMITS</td>
<td>Out-of-Pocket Amount</td>
</tr>
<tr>
<td>21. PATIENT'S SOCIAL SECURITY NUMBER</td>
<td>Patient's Social Security Number</td>
</tr>
<tr>
<td>22. PATIENT'S EMPLOYER</td>
<td>Patient's Employer</td>
</tr>
<tr>
<td>23. PATIENT'S DEPENDENTS</td>
<td>Patient's Dependents</td>
</tr>
<tr>
<td>24. PATIENT'S OCCUPATION</td>
<td>Patient's Occupation</td>
</tr>
</tbody>
</table>

### ADDITIONAL CLAIM FORM INFORMATION (Designated by NUCC)

- **Addenda**: Additional information required by some insurance companies.
- **Diagnosis**: The diagnosis code for the service provided.
- **Procedure**: The procedure code for the service provided.
- **Referral**: Referral information for the service provided.
- **Coverage**: Coverage information for the service provided.

### PPINS (Provisional Provider Number)

- **PPINS**: Provisional Provider Number (used when a provider has not yet been assigned a PPINS).
- **NPI**: National Provider Identifier (used for identifying providers).

### BILLING INFORMATION

- **Provider Information**: Information about the provider billing the claim.
- **Date of Service**: The date the service was provided.
- **diagnosisCode**: The diagnosis code for the service provided.
- **procedureCode**: The procedure code for the service provided.
- **referral**: Referral information for the service provided.
- **coverage**: Coverage information for the service provided.

### ZFLD Locator Instructions

- **ZFLD**: Zone Forecasting Location System.
- **Instructions**: Instructions for locating and submitting claims through the ZFLD system.
The following table outlines the revised changes on the above CMS 1500 claim form version 02/12:

<table>
<thead>
<tr>
<th>FLD Location</th>
<th>NEW Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Header</td>
<td>Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)</td>
</tr>
<tr>
<td>Header</td>
<td>Added &quot;(NUCC)&quot; after &quot;APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE.&quot;</td>
</tr>
<tr>
<td>Header</td>
<td>Replaced &quot;08/05&quot; with &quot;02/12&quot;</td>
</tr>
<tr>
<td>Item Number 1</td>
<td>Changed &quot;TRICARE CHAMPUS&quot; to &quot;TRICARE&quot; and changed (Sponsor’s SSN)” to &quot;(ID#/DoD#).&quot;</td>
</tr>
<tr>
<td>Item Number 1</td>
<td>Changed &quot;(SSN or ID)&quot; to &quot;(ID#)&quot; under “GROUP HEALTH PLAN”</td>
</tr>
<tr>
<td>Item Number 1</td>
<td>Changed &quot;(SSN)&quot; to &quot;(ID#)&quot; under &quot;FECA BLK LUNG.&quot;</td>
</tr>
<tr>
<td>Item Number 1</td>
<td>Changed &quot;(ID)&quot; to &quot;(ID#)&quot; under “OTHER.”</td>
</tr>
<tr>
<td>Item Number 8</td>
<td>Deleted “PATIENT STATUS” and content of field. Changed title to “RESERVED FOR NUCC USE.”</td>
</tr>
<tr>
<td>Item Number 9b</td>
<td>Deleted “OTHER INSURED’s DATE OF BIRTH, SEX.” Changed title to “RESERVED FOR NUCC USE.”</td>
</tr>
<tr>
<td>Item Number 9c</td>
<td>Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “RESERVED FOR NUCC USE.”</td>
</tr>
<tr>
<td>Item Number 10d</td>
<td>Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).” Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC. <strong>FOR DCH/HP:</strong> FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.</td>
</tr>
<tr>
<td>Item Number 11b</td>
<td>Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “OTHER CLAIM ID (Designated by NUCC).” Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier</td>
</tr>
<tr>
<td>Item Number 11d</td>
<td>Changed “If yes, return to and complete Item 9 a-d” to “If yes, complete items 9, 9a, and 9d.” (Is there another Health Benefit Plan?)</td>
</tr>
<tr>
<td>Item Number 14</td>
<td>Changed title to “DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP).” Removed the arrow and text in the right-hand side of the field. Added “QUAL.” with a dotted line to accommodate a 3-byte qualifier. <strong>FOR DCH/HP:</strong> Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).</td>
</tr>
</tbody>
</table>
| Item Number 15 | Changed title from ‘IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE” to “OTHER DATE.” Added “QUALIFIER.” with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or
### APPENDIX MM

**Claims, Billing** *(See Part I for ICD 9, and 10 information)*

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – <strong>Used by Medicare</strong> for identifiers for provider roles: Ordering, Referring and Supervising. <strong>FOR DCH/HP:</strong> Use the following Ordering Provider, Referring, Supervising Qualifiers <em>(effective 4/01/2014)</em>: Ordering = DK; Referring = DN or Supervising = DQ.</td>
</tr>
<tr>
<td>19</td>
<td>Changed title from “<strong>RESERVED FOR LOCAL USE</strong>” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).” <strong>FOR DCH/HP:</strong> Remove the Health Check logic from field 19 and add it in <strong>field 24H.</strong></td>
</tr>
<tr>
<td>21</td>
<td>Changed instruction after title (Diagnosis or Nature of Illness or Injury) from “(Relate Items 1, 2, 3 or 4 to Item 24E by Line)” to “Relate A-L to service line below (24E).” <strong>FOR DCH/HP:</strong> Removed arrow pointing to 24E (Diagnosis Pointer). Added “ICD Indicator.” and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. <strong>Diagnosis Code ICD Indicator</strong> - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. <em>(Do not bill ICD 10 code sets before October 1, 2015.)</em> Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field. Changed labels of the diagnosis code lines to alpha characters (A-L). Removed the period within the diagnosis code lines. Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.” The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim) The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. <strong>FOR DCH/HP:</strong> Item numbers 24A &amp; 24G are used to capture Hemophilia drug units. <strong>24H</strong> (EPSDT/Family Planning). Deleted “BALANCED DUE.” Changed title to “<strong>RESERVED FOR NUCC USE.</strong>” Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”</td>
</tr>
</tbody>
</table>
APPENDIX NN
Non-mandatory Forms for October 2014 Quarter

ANNUAL MEDICAL EXAM & REPORT FOR SOURCE WAIVER APPLICANT
DETERMINATION OF FUNCTIONAL/COGNITIVE IMPAIRMENTS Version 9/2014 do not alter

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

<table>
<thead>
<tr>
<th>AGENCY’S NAME &amp; ADDRESS</th>
<th>MEMBER’S NAME</th>
<th>MCD #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone and Fax</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEMBER’S ADDRESS</th>
<th>SEX</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ MALE</td>
<td>□ FEMALE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY, STATE, ZIP</th>
</tr>
</thead>
</table>

SECTION II – MEDICAL REPORT

NOTICE TO PHYSICIAN: This member has made application or reapplication for Service Options Using Resources in Community Environments (SOURCE) which requires nursing home level of care. Your cooperation in completing this form to show the patient’s current condition, focusing on both limitations and remaining capabilities, is requested. Your promptness will insure a timely decision on the patient’s application. Please return completed form to the agency in Section I above.

<table>
<thead>
<tr>
<th>DATE OF EXAMINATION:</th>
<th>ACTIVE/IMPORTANT DIAGNOSIS(ES):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT MEDICATIONS AND USES:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

3. GENERAL FINDINGS:

<table>
<thead>
<tr>
<th>HEIGHT:</th>
<th>WEIGHT:</th>
<th>BP:</th>
<th>HGB</th>
<th>A1C:</th>
<th>Other pertinent labs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Ft. _____ In.</td>
<td>_____ Lbs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PATIENT COMPLIANCE – Has patient demonstrated compliance with medical treatment? □ YES □ NO
If “No”, please state reason:
________________________________________________________________________________________________________________________________________________________

BODY SYSTEMS – Please indicate if the systems listed below are “normal”/“abnormal” or “present”/“absent.” (“Abnormal” or “present” means applicant’s complaint, objective physical finding or atypical diagnostic test.) Where “abnormal”/“present” body systems are indicated, please complete the appropriate body system section in detail or submit a summary of your records which contain the required information. Please include operative notes if surgical procedures have been performed.

<table>
<thead>
<tr>
<th>BODY SYSTEM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>IMPAIRMENT</th>
<th>PRESENT</th>
<th>ABSENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td>Mental Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing, Vision or Speech</td>
<td></td>
<td></td>
<td>Developmental Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>Moderate to Severe Cognitive Disorder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX NN  
Non-mandatory Forms for October 2014 Quarter

(BODY SYSTEM | NORMAL | ABNORMAL | IMPAIRMENT | PRESENT | ABSENT)
--- | --- | --- | --- | --- | ---
Cardiovascular |  | Requires mobility aides |  |  |  
Digestive |  | Enteral feedings |  |  |  
Genito-Urinary |  | Stage III or IV ESRD |  |  |  
Blood & Lymphatic |  | Stage III or IV Decubiti |  |  |  
Skin |  | Driving Restrictions |  |  |  
Endocrine |  | Uncontrolled Seizures |  |  |  
Neurological |  | Severe SOB with exertion requiring continuous 02 |  |  |  
Gait & Balance Disorder |  | Frequent Falls |  |  |  

DURATION – Has the impairment(s) described above lasted, or can it/they be expected to last for 1 year, or more? □ YES □ NO If “No”, how long?____________

□ Summary of “abnormal/present” related to member’s complaint, objective physical finding or atypical diagnostic test (ie. neuro exam) which supports nursing home level of care criteria:

______________________________________________________________________________________________________________________________

General Questions (only describe if you check the box and functional status is affected):

□ Does the SOURCE member have any IADL/ADL functional impairments/limitations which require(s) nursing home level of care? If so, please describe:

______________________________________________________________________________________________________________________________

□ Does the SOURCE member have any comorbid medical conditions(s) that contribute to the patient’s functional impairments?

______________________________________________________________________________________________________________________________

□ Has the SOURCE member experienced or will have in the near future any medical or surgical procedures that have contributed to the need for nursing home level of care? If so, please document the date (actual/expected) of the procedure, procedure type and expected recovery time.

______________________________________________________________________________________________________________________________

Give graded strength on a scale of 1-5/5:

<table>
<thead>
<tr>
<th>UPPER EXTREMITIES</th>
<th>LOWER EXTREMITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIGHT</td>
<td>LEFT</td>
</tr>
<tr>
<td>1. Flaccid, Paralysis</td>
<td></td>
</tr>
<tr>
<td>2. Severe Weakness (no movement against gravity)</td>
<td>A. Proximal</td>
</tr>
<tr>
<td>3. Moderate Weakness (movement against gravity but not resistance)</td>
<td>B. Distal</td>
</tr>
<tr>
<td>4. Mild Weakness (move against resistance)</td>
<td></td>
</tr>
<tr>
<td>5. Normal Strength</td>
<td></td>
</tr>
</tbody>
</table>

I attest that this SOURCE applicant meets the requirements for admission into a nursing home if SOURCE was not available. □ Yes □ No

_________________________  __________________________  __________________________
Physician Name/Title  Phone Number  Date

This form is in concurrence with DCH SOURCE Policy 1303. Scheduled Contacts with Primary Care Provider:

If the member has an Annual reevaluation scheduled in the next 3 months, concurrence with diagnosis, medications, and functionality should be discussed and documented with the PCP (by the Case Manager). (May also be requested by DCH)
VAMC SLUMS Examination

Questions about this assessment tool? E-mail awinz@slu.edu

Name ____________________________ Age ____________
Is patient alert? ______________ Level of education ____________

1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
   Apple      Pen      Tie      House     Car
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
   How much did you spend?
   How much do you have left?
6. Please name as many animals as you can in one minute.
   0-4 animals  5-9 animals  10-14 animals  15+ animals
7. What were the five objects I asked you to remember? 1 point for each one correct.
8. I am going to give you a series of numbers and I would like you to give them to me backwards.
   For example, if I say 42, you would say 24.
   87  649  8537
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
   Hour markers okay
   Time correct
10. Please place an X in the triangle.
    Which of the above figures is largest?

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
    Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met
    Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago.
    She then stopped work and stayed at home to bring up her children. When they were teenagers, she
    went back to work. She and Jack lived happily ever after.
    What was the female's name?
    When did she go back to work?
    What work did she do?
    What state did she live in?

TOTAL SCORE

<table>
<thead>
<tr>
<th>HIGH SCHOOL EDUCATION</th>
<th>LESS THAN HIGH SCHOOL EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>27-30</td>
<td>Normal</td>
</tr>
<tr>
<td>21-26</td>
<td>MNCID</td>
</tr>
<tr>
<td>1-20</td>
<td>Dementia</td>
</tr>
</tbody>
</table>

* Mild Neurocognitive Disorder


Service Options Using Resources In Community Environments April 1 2016
APPENDIX O0 SLUMS Examination

Purpose of the Form: To screen individuals to look for the presence of cognitive deficits, and to identify changes in cognition over time. This is a non proprietary exam instead of the MMSE. Use this link for training.

VAMC Saint Louis University Mental Status Examination
Form Details

Who Can Complete the Form: Social Services, Reflections/Passages Program Coordinators, Licensed Nurses, MDs, NPs, OTs, PTs, Residence Supervisors and Other Qualified Healthcare Professional who have been trained (and retrained annually) by viewing the VA-produced DVD (available upon request to turnosan@slu.edu).

Purpose of the Form: To screen individuals to look for the presence of cognitive deficits, and to identify changes in cognition over time.

Instructions for Use:
1. Complete resident demographics at the top of the page.
2. We recommend that you put the date and the name of the evaluator on the bottom of the page as well (see #19).
3. Administration should be conducted privately and in the examinee's primary language. Be prepared with the items you need to complete the exam. You will need a watch with a second hand on it.
4. Record the number of years the patient attended school. If the patient obtained an Associates, Bachelor's, Master's or Doctorate degree, note the degree achieved instead of actual years of school attended.
5. Determine if the patient is alert. Do not answer "yes" or "no", but indicate level of alertness. Alert indicates that the individual is fully awake and able to focus. Other descriptors include: drowsy, confused, distractible, inattentive, preoccupied.
6. Begin by asking the patient the following: "Do you have any trouble with your memory?" "May I ask you some questions about your memory?" Then proceed with the exam questions.
7. Read the questions aloud clearly and slowly to the examinee. It is not usually necessary to speak loudly but it is necessary to speak slowly.
8. Begin by asking the patient something similar to the following: "Do you have any trouble with your memory?" "May I ask you some questions about your memory?" "I'd like to see how good your memory is by asking you some questions." You may need to reassure patients by telling them that this is not a test that they can fail but merely a tool much like a thermometer that takes temperature is a tool. What this does is checks for the amount of memory they have. Then begin to administer the exam questions.
9. Score the questions as indicated on the examination.
10. On question #4, read the statement as listed on the exam. Ask the patient to repeat each of the five objects (Apple, Pen, Tie, House, Car) that you recite to make sure that the patient heard and understood what you said. Repeat them as many times as it takes for the patient to repeat them back to you correctly.
LEGAL MEDICAL RECORD STANDARDS FOR SOURCE

PURPOSE

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet basic legal standards. To give guidance on electronic/paper documentation with more hybrid medical records evolving.

All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient’s full name, and another unique identifier. Each page of a double-sided or multi-page forms must be marked with member identification, since single pages may be photocopied, faxed or imaged and separated from the whole.

Documentation requires the signature and professional title of staff, and the date of documentation.

Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, unless that recording was incorrectly assigned to the wrong member.

Handwritten entries should be made with permanent black or blue ink. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The contents of Medical Records must not otherwise be edited, altered, or removed.

Copy and Paste Guidelines

Copying for re-use of data: A clinician may copy and paste entries as long as care is taken to ensure that the information actually applies to the current patient condition and visit, that applicable changes are made to variable data, and that any new information is recorded.
Appendix QQ:
Modified Re Evaluation Contact Sheet for Members with Active Prior Authorizations/Approvals

### Section A. Identification
Case Management Agency:  [Redacted]
Date of Visit:  [Redacted]
Member’s Name:  [Redacted]
DOB:  [Redacted]
Place of Assessment:  Home  Nursing Home  Other

### Section B. Reason for Re Evaluation:
Significant change:  (circle)  Mobility  ADL’s  IADL’s  Other
Explain:  [Redacted]
Nursing Home Return:  Yes  No
Hospitalization:  Yes  No
List equipment, supplies, home modifications needed at this time:

### Section C. Communication
Speech clear:  Yes  No  or  No Speech
Hearing problem:  Yes  No
Vision problem:  Yes  No
Able to make needs known:  Yes  No

### Section D. Behaviors/ Cognition
Memory Loss:  Yes  No
Confusion:  Yes  No
Wandering:  Yes  No
Resists Care:  Yes  No
Inappropriate/other behaviors:  Yes  No
Specify:  [Redacted]
Dementia:  Yes  No

### Section E. Continence
Bowel Continent:  Yes  No  At times
Bladder Continent:  Yes  No  At times
Colostomy  Catheter
Other Device:  [Redacted]

### Section F. Other
Pain:  Yes  No  Location:  [Redacted]
Swelling:  Yes  No  Location:  [Redacted]
Fatigue:  Yes  No
Short of breath:  Yes  No
Dizziness:  Yes  No
Infection in last 90 days:  Yes  No
Other:  [Redacted]

### Section G. Current Diagnoses
Diagnoses/Conditions leading to Nursing Home Stay:

<table>
<thead>
<tr>
<th>Other diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. [Redacted]</td>
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<tr>
<td>b. [Redacted]</td>
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<tr>
<td>c. [Redacted]</td>
</tr>
<tr>
<td>d. [Redacted]</td>
</tr>
<tr>
<td>e. [Redacted]</td>
</tr>
</tbody>
</table>

### Section H. Hospitalizations/ER Visits/PCP appointments
Nursing Home Admission Date:  [Redacted]
Nursing Home Discharge Date:  [Redacted]
Hospitalizations last 90 days:  Yes  No
Admit/Discharge Dates:  [Redacted]
Diagnoses:  [Redacted]
ER visits last 90 days:  Yes  No
ER Diagnoses:  [Redacted]
PCP name:  [Redacted]
Specialist:  [Redacted]
Next office Visit (dates):  [Redacted]
New Referrals:  [Redacted]

### Section I. Assistance Needed with ADLs/IADLs

<table>
<thead>
<tr>
<th>Task</th>
<th>Help Needed (Yes) – who provides assist.</th>
<th>Help Needed (No)</th>
<th>Decline in member’s Performance Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meal Prep</td>
<td></td>
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<td>Housework</td>
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<td>Managing</td>
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<td>Managing Money</td>
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<td>Phone Use</td>
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<td>Stairs</td>
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<td>Shopping</td>
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<td>Transportation</td>
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<td>Bathing</td>
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<td>Hygiene</td>
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<td>Dressing</td>
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<td>Walking</td>
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<td>Locomotion</td>
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<td></td>
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<tr>
<td>Toilet Use</td>
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<td></td>
<td></td>
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<tr>
<td>Bed Mobility</td>
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<tr>
<td>Eating</td>
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</table>

### Section J. Other

| Fall in last 90 days                      | Yes  No |
| Uses assistive device for ambulation/locomotion | Yes  No |
| Unsteady Gait                             | Yes  No |
Appendix QQ:
Modified Re Evaluation Contact Sheet for Members with Active Prior Authorizations/Approvals

<table>
<thead>
<tr>
<th>Member’s Name:</th>
<th>D.O.B.</th>
<th>Date of Contact:</th>
</tr>
</thead>
</table>

**Section J. Equipment and Devices (CIRCLE)**
- Cane
- Walker
- Wheelchair
- Scooter
- Hospital bed
- Bedside Commode
- Oxygen
- Grab Bars
- Adaptive eating equipment
- Prosthetics
- Lift (manual/electric)
- Braces
- Bathing equipment
- Other ______________________

**Section K. Diet and Weight**
- Specify Diet Ordered ______________________
- Is this a new diet? □ Yes □ No
- Height ________Weight________
- □ Weight Loss □ Weight Gain □ No Change
- Feeding Tube □ Yes □ No □ G-tube? □ Yes □ No
- Other:____________________

**Section L. Treatments (Yes / No)**
- Chemotherapy □ Scheduled
- Radiation
- Dialysis
- Suctioning
- IV medication
- Home Monitoring □ Blood Sugar □ BP
- □ Weight □ Other ______________________

**Section M. Skin**
- Condition
- Location
- Other Information
- Pressure Ulcer Stage -
- Other Ulcer Type -
- Skin Tear
- Rash
- Surgical Site
- Infusion, feeding, or Dialysis access Specify -
- Wound care/dressing change □ Yes □ No
- Provider ______________________

**Section N. Formal and Informal Support**
- Who does member live with? Name/relationship ______________________
- If member lives alone, list name of primary support person: _____________________________________________
- Legal Guardian □ Yes □ No Name/contact information: _________________________________________________
- Support Services Needed: Indicate increase/decrease or new
- Service | New Service Y/N | Provider Assigned | MC, PCP, RL | Frequency
- PSS | | | |
- HDM | | | |
- ERS | | | |
- SNS | | | |
- PT | | | |
- OT | | | |
- ST | | | |
- ALS | | | |
- ADH | | | |

**Section Q. Medications**
- See Medication List for more medications
- Pharmacy name/number:
- Medication | Dose | Route | Frequency | Diagnosis | New Med Y/N
- ______________________
- ______________________
- ______________________
- ______________________
Appendix QQ:
Modified Re Evaluation Contact Sheet for Members with Active Prior Authorizations/Approvals

<table>
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<tr>
<th>Member’s Name:</th>
<th>D.O.B.</th>
<th>Date of Contact:</th>
</tr>
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Present During or Contributing to Member’s Assessment | Agency | How related to Member | Date |
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Additional Notes: Teaching/ training needed for new diagnosis, diet, equipment, labs, treatments, medications etc.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
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_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Interviewer Print Name _______________________________ Title ______

Interviewer Signature/date _________________________ Date: _______

Case Manager Supervisor Printed Name_____________________________ Sign _______________________ Date: __________

R.N. Print Name _______________________________ Sign ________________________ Date: __________

R.N. Assessment: Disease Management Needed? □ Yes □ No

Service Options Using Resources In Community Environments April 1 2016