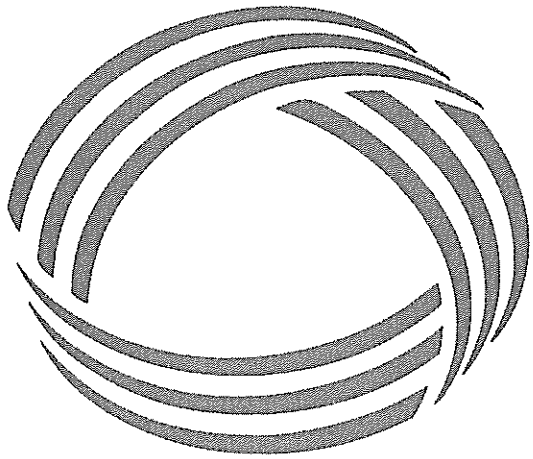
Services Options Using Resources in Community Environments DOCUMENTS



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

April 1, 2019

Appendix A SOURCE Screening Form

SCREENER_____REFERRAL DATE_____

SCREENING DATE_____

NAME_____DOB_____/_____/_____

SEX M_____ F_____ SSN_____-_____-_____

MEDICAID YES/ NO MEDICAID NUMBER_____

SSI: YES_____ NO_____

IF NO, IS MONTHLY INCOME SSI LEVEL OR BELOW? _____

MEDICARE NUMBER _____

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 ( ) _____-_____
STREET ADDRESS _____
City _____ State_____ Zip_____
WILLING TO USE SOURCE PCP _____ YES _____ NO
REFERRED FOR SOURCE ASSESSMENT _____ YES _____ NO
NOT ELIGIBLE REASON _____

REFERRED FOR OTHER SERVICES _____

OTHER_____

APPENDIX B

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.

1._____
Provider Agency

_____
Contact Person

_____
Telephone #

2._____
Provider Agency

_____
Contact Person

_____
Telephone #

3._____
Provider Agency

_____
Contact Person

_____
Telephone #

4._____
Provider Agency

_____
Contact Person

_____
Telephone #

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_____

APPENDIX C
SOURCE ASSESSMENT ADDENDUM

Member:_____ Date: _____

1. Home Assessment:

List people who live in the home:

Name/Relationship	Age	Work: FT, PT, Night	Status: Permanent, Temporary, Intermittent	School: Yes or No

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:

Features:	Yes	No	Features:	Yes	No
Electrical hazards			Space heater(s)		
Stove/refrigerator on premises			Telephone		
Signs of careless smoking			Smoke detectors		
Washer/dryer on premises			Running water		
Other fire hazards			Indoor toilets		
Pets (specify)			Adequate ventilation		
Satisfied with living situation			Planning to move		

Comments: _____

_____

_____

3. Medications:

Pharmacy name and telephone number: _____

How do you get your medications? _____

APPENDIX C
SOURCE ASSESSMENT ADDENDUM

Member:_____ Date: _____

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

	Yes	No		Yes	No
Illness/injury			Change in marital status		
Change in job, residence			Victim of crime or Exploitation		
Losses or deaths			Other (specify)		

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?____others assisting _____

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

Category:	WHO helps and WHEN? (include ALL assistance – family/friends AND formal services)
Telephone	
Shopping	
Food preparation	Breakfast/Lunch/Supper
Housekeeping	
Laundry	
Mode of Transportation	
Medications	
Finances	

APPENDIX C
SOURCE ASSESSMENT ADDENDUM

Member:_____ Date: _____

Basic Activities of Daily Living – If assistance is required:

Category	WHO helps and WHEN? (ALL informal AND paid support)
Bed mobility:	
Transfer:	
Locomotion:	
Dressing:	
Eating:	
Toilet use:	
Personal hygiene:	
Bathing:	
Continence:	

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 _____

APPENDIX C
SOURCE ASSESSMENT ADDENDUM

Member:_____ Date: _____

13. Medical Treatment

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

Treatments:	Provider/Telephone Number:
Pressure sore treatment	
Wound or other skin care treatment	
Skilled therapy (PO/OT/speech)	
Colostomy/ostomy care	
Oxygen	
Other	

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 _____

APPENDIX C-1
SOURCE MEMBER CHOICE OF PROVIDER FORM

Member:_____ Date: _____

Issues Noted	Services Recommended	Provider Assigned	Member Choice of Provide PCP	Frequency	Participant Feedback
			MC PC		
			MC PC		
			MC PC		
			MC PC		
			MC PC		

_____ _____

Member Signature Date

_____ _____

Case Manager Signature Date

APPENDIX D
Consent for Enrollment & Member Rights and Responsibilities

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

APPENDIX E

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

Admit Discharge Transfer Other

LOC PA Number: Effective/End Dates_____/_____

Georgia Department of Community Health
SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT

1. SOURCE TEAM NAME & ADDRESS Telephone: Provider ID#	2. Patient's Name (Last, First, Middle Initial): 3. Home Address: 4. Telephone Number; 5. County:

6. Medicaid Number	7. Social Security Number	8. Mother's Maiden Name:

9. Sex	10. Age	11 Birthday	12. Race	13. Marital Status	14. Type of Recommendation 1. ☐ Initial 2. ☐ Reassessment	15. Referral Source

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*		1. ICD 10	2. ICD10	3. ICD10
18. Diagnosis on Admission to SOURCE 1. Primary _____ 2. Secondary _____ 3. Other _____	19. Is Patient free of communicable disease? 1. ☐ Yes 2 ☐ No			

Medications (including OTC)				Diagnostic and Treatment
20. Name	Dosage	Route	Frequency	21 Type Frequency

22. SOURCE SERVICES ORDERED: ECMS _____ _____ _____ _____ _____

23. Diet	24. Hours Out of Bed Per Day	25. Overall Condition	26 Restorative	27. Mental and Behavioral Status		
☐ Regular	☐ Intake ☐ IV	☐ Improving	☐ Good	☐ Agitated	☐ Noisy	☐ Dependent
☐ Diabetic	☐ Output ☐ Bedfast	☐ Stable	☐ Fair	☐ Confused	☐ Nonresponsive	☐ Independent
☐ Formula	☐ Catheter Care	☐ Fluctuating	☐ Poor	☐ Cooperative	☐ Vacillating	☐ Anxious
☐ Low Sodium	☐ Colostomy Care	☐ Deteriorating	☐	☐ Depressed	☐ Violent	☐ Well Adjusted
☐ Tube Feeding	☐ Sterile Dressings	☐ Critical	☐ None	☐ Forgetful	☐ Wanders	☐ Disoriented
☐ Other	☐ Suctioning	☐ Terminal		☐ Alert	☐ Withdrawn	☐ Inappropriate Reaction

28. Decubiti	29, Bowel	30. Bladder	31. Indicate Frequency Per Week of the following services:						
			Physical Therapy	Occupational Therapy	Restorative Therapy	Reality Orientation	Speech Therapy	Bowel Bladder Retrain	Activities Program
☐ Yes ☐ No ☐ Infected ☐ On Admission Surgery Date_____	☐ Continent ☐ Occas Incontinent ☐ Incontinent ☐ Colostomy	☐ Continent ☐ Occas Incontinent ☐ Incontinent ☐ Catheter							

32. Record Appropriate Legend	IMPAIRMENT				
1. Severe 2. Moderate 3. Mild 4. None	Sight	Hearing	Speech	Ltd Motion	Paralysis
	☐____	☐	☐	☐	☐____

Record Appropriate Legend	Activities of Daily Living					
1. Dependent 2. Needs Asst 3 Independent 4. Not App	Eats	Wheel-Chair	Transfers	Bathing	Ambulation	Dressing
	☐	☐	☐	☐	☐	☐____

33.. This patient's condition ☐ could ☐ could not be managed by provision of ☐ SOURCE or ☐ Home Health Services.:

37. Physician's Name (Print)

38. Address:

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

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

36. Physician's Signature:

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

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.

09, 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

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 toSOURCE 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 AHS 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.**

NOTE: Physician or nurse practitioner signs within 60* days of completion of form*. Physician or nurse practitioner's signature must be original. Signature stamps are not acceptable. UR will recoup payments made to the provider if there is no physician's signature. "Faxed" copies of LOC page are acceptable.

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

For SOURCE : LOS Certified Through Date = Expiration on PA * For SOURCE "Date of Signature" for the Physician and RN is extended to 90 days

Distribution: The original is filed in the case record. Include a copy with the provider assessment/ reassessment packet

SOURCE Care Path Level (OPTIONAL)

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 Level I	CRITERIA: Based on GA Nursing Home ICF and SNF Levels

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.

APPENDIX H
Standards of Promptness

Case Managers complete SOURCE activities within the standards of promptness guidelines

Standard of Promptness for Care Coordination	
IF ACTIVITY IS	**THEN STANDARD OF PROMPTNESS IS WITHIN**
Responding to telephone inquiry regarding SOURCE admission	3 business days after telephone inquiry
SCREENING	
Screening a referral	3 business days after telephone inquiry
Notifying client referral source of client denial/ineligibility determination at screening	Within 3 business days after decision of non-eligibility
INITIAL ASSESSMENT	
Nurse completion of face to face assessment for new admissions	within 15 business days of notification of slot availability
RN review of the assessment	10 business days following the assessment visit
Sending assessment /reassessment package to AHS for LOC review	
REASSESSMENT	
Send Reassessment package to AHS for LOC review	At least 45 days before expiration of the current Level of Care and no sooner than 89 days before LOC expiration
RN review of the assessment	10 business days following the assessment visit
Medical Director/PCP signature confirming LOC	Within 90 days of member signature on LOC* See Section 1406
Completing reassessments when requested by: • SOURCE service provider • Utilization Review analyst • Legal Services Office • Administrative Law Judge • Member	10 business days after reassessment request
Brokering services for new client	Within 5 business days of SOURCE admission or confirmation of lock in
Telephone follow-up with a client after service brokered to assess service compliance, client satisfaction	10 business days after service initiation
Sending member a Participation Form and Member Care Path	5 business days after service initiation

APPENDIX H
Standards of Promptness

IF ACTIVITY IS (cont'd.)	THEN STANDARD OF PROMPTNESS IS WITHIN (cont'd.)
Sending referral packet to provider	Before service provider begins services
Completing and returning Member Information Form (MIF) to provider	3 business days after receipt from provider 2 business days if involving a sentinel event
Telephone contact with member	Monthly
Face to Face Care Path review	Quarterly
Provider meeting for the coordination of care (Applies to all ALS, ADH, and PSS providers)	Monthly Note: may be conducted face to face, telephone or electronically
Reporting Sentinel events to DCH, Adult Protective Services, local law enforcement, and LongTerm Care Ombudsman	Email within 1 business day of the notification or discovery of the event. Completed Sentinel event must be sent within 5 business days
Transfer of client record when client moves to another SOURCE site with the same provider (copy of records is acceptable)	5 business days after notification of transfer
Submitting Monthly Statistical Reports to DCH	By the 15th of the month following the month subject to report
Involuntary 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 AHS 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
Level of Care

INSTRUCTIONS/GUIDE for Determination of ILOC

Intermediate Level of Care Criteria: SOURCE Applications

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

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Has at least one chronic condition . . . "	Examples: HTN, diabetes, heart disease, pulmonary disease, Alzheimer's, spinal cord injury, CVA, arthritis, etc.
2. Nutritional management . . . "	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.
3. "Maintenance and preventive skin care . . . "	Diabetics; SRC members spending significant time in wheelchair or bed; existing wound care/skin issues or history of; members with incontinence
4. "Catheter care . . . "	Self-explanatory
5. "Therapy services . . . "	Self-explanatory
6. "Restorative nursing services . . . "	Self-explanatory
7. "Monitoring of key clinical indicators, laboratory studies or weights . . . "	Diagnosis requiring ongoing monitoring of clinical indicators: hypertension, pulmonary disease, diabetes, cardiovascular disease, etc. (key clinical indicators

	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.
8. "Management and administration of medications . . . "	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)

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Documented short or long-term memory deficits . . . "	Linked to a diagnosis (CVA, TBI, dementia, Alzheimer's, etc.) documented in medical record; review MMSE score.
2. "Documented moderately or severely impaired cognitive skills . . . "	Same as above. Allow for eccentricities.
3. "Problem behavior . . . "	Self-explanatory. Allow for eccentricities.
4. "Undetermined cognitive patterns which cannot be assessed by a mental status exam . . ."	Rarely used. Aphasia listed as example.

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	PRIMARY LOC APPLICATIONS
1. "Transfer and locomotion performance requires limited/extensive assistance . . . "	"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.
2. "Assistance with feeding."	May be due to significant physical or cognitive impairment. Cueing and set-up help required together (i.e., not just an IADL issue).
3. "Direct assistance . . . to maintain continence."	"Assistance of another person" is key indicator (i.e., not just using incontinence products). May be due to physical (transfers, etc.) or cognitive impairments.
4. "Documented communication deficits . . . "	Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement.
5. "Assistance . . . dressing/personal hygiene"	Self-explanatory. See "another deficit" requirement described.

RN will complete this form and attach to packet uploaded to AHS. Each section will be completed by the RN by circling the section of the MDS beside each item in each Column. For instance, if the MDS indicates that the member requires moderate assistance with ambulation, then circle the 3 or 4 by G2g under Column C number 1. On the blank line indicate the diagnosis that causes the level of impairment. Each item that is circled should match the scoring on the MDS.

Column A Medical Status	Column B Mental Status	Column C Functional Status
1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. I1a-u, I2a-f, N2a-k=1,2,or 3 In addition to the criteria listed immediately above, the patient's specific medical condition must require any of the following plus one item in Column B or Column C. 2. Nutritional management; which may include therapeutic diets or maintenance or hydration status. K2a-d=1 or an issue K3(1-9)=5,6,7,or 8 is selected N2d=2 or 3 3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti. L1=2,3,4,5 L3:L4:L5=1/yes L7=2 or 3 N2=k (wound care/present) 4. Catheter care such as catheter change and irrigation. H1=1 H2= 2 or 3 5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (3 times per week or less). N3b, 3e, 3f, 3g =Present N2a-k=Present/1,2,3 6. Restorative nursing services such as range of motion exercises and bowel and bladder training. N3e and N2l= Present 7. Monitoring of vital signs and laboratory studies or weights. N1a=1 N2a,b,d, and i = Present N3b= Present K2a=Present 8. Management and administration of medications including injections. G1d 1-6 (performance) N2a, N2d, N2i = Present M1d=IM(intramuscular), IV (intravenous), Sub-Q (Subcutaneous or ET (Enteral Tube) M3=1 or 2 is selected	The mental status must be such that the cognitive loss is more than occasional forgetfulness. 1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/ care plan for continued placement. C2a, b, or c = 1 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. C1= 3, 4 5 C5=2 3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention. E3a-f =1, 2 or 3 4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia. J3j=2,3, or 4 ---I1j; I1c; I1d=1,2,3---I2a-f* Possible Diagnoses: severe seizure do, TBI, ABI, Anoxic brain injury Client Name_____ Completed by_____ Date of Visit___ RN Approving LOC Date of LOC_____	One of the following conditions must exist (with the exception of #5 that can not stand alone). 1. Transfer and locomotion performance of the resident requires limited/extensive assistance by staff through help of one person physical assist. G2g, G2f=3,4,5,or 6 G3c, G3d = 0 J3a; J3b = 1,2,3, 4 2. Assistance with feeding. Continuous stand-by supervision, encouragement, or cueing required and set up of meals. G2j= 3,4,5,or 6 3. Requires direct assistance of another person to maintain continence. G2g; G2h=3,4,5 or 6 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. D1; D2= 3 or 4 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.) G2a;G2b,G2c ;G2d= 3,4,5 or 6 **If J3a-b is circled (C1), is this compensated by walker, cane, slower movements, or use of furniture? Y/N If so, this is NOT enough for NH level.

APPENDIX J
Carepath Rev. 10/18

Member_____Medicaid #_____Date:_____

Service Options Using Resources In Community Environments

CAREPATH

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 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.

APPENDIX J
Carepath Rev. 10/2018

Member_____Medicaid #_____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
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. GOALS: 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.	**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. 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:*	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

Member_____Medicaid #_____Date:_____

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: _____ _____ _____	B. __met __not met C. __met __not met Sentinel events? _____

(Providers and units/schedules listed on Member Version)

APPENDIX J
Carepath Rev. 10/2018

Member_____Medicaid #_____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
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):	GOALS: 1st review period (/ /): A. __met __not met B. __met __not met 2nd review period (/ /): A. __met __not met B. __met __not met 3rd review period (__/__/__): A. __met __not met B. __met __not met 4th review period (/ /): A. __met

Member_____Medicaid #_____Date:_____

	Mon_____B_____L_____S Thurs___B_____L_____S Tues_____B_____L_____S Fri_____B_____L_____S Wed_____B_____L_____S Sat_____B_____L_____S Sun_____B_____L_____S NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	__not met B. __met __not met

APPENDIX J
Carepath Rev. 10/2018

Member_____Medicaid #_____Date:_____
Rev 7/1/03

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
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:	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:_____

	Assistance required: ___turning/repositioning (see page_____) ___continence (see page_____) ___nutrition (see page____) NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	

APPENDIX J
Carepath Rev. 10/2018

Member_____Medicaid #_____Date:_____

Rev. 07/12

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
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	MEMBER/CAREGIVER EDUCATION: ___SOURCE PCP/PCP staff ____SOURCE educational material ___other_____ MONITOR CLINICAL INDICATORS: ____SOURCE PCP (OV) ADDITIONAL MONITORING REQUIRED: ___Self-care ___ASSISTANCE REQUIRED ___informal caregiver_____ ___ADH ___PSS aide ___ALS ___RN provider: _____	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:_____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	

07/12

Member_____Medicaid #_____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
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.**	**MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP/PCP staff ___SOURCE educational material ___other_____ **MEDICATION ADMINISTRATION/MANAGEMENT:** ___Self-care ___informal caregiver _____ ___ADH/DHC ___ALS ___PSS aides (cueing) ___RN provider_____ Dates of Service: **OBTAINING MEDICATIONS:** ___Self-care ___informal caregiver ___pharmacy delivery _____ ___other_____ **PHARMACY:**_____ NOTES: _____	**GOALS:** 1st review period (___/___/___): _ met _ not met Sentinel events? _____ 2nd review period (___/___/___): _ met _ not met Sentinel events? _____ 3rd review period (___/___/___): _ met _ not met Sentinel events? _____

Member_____Medicaid #_____Date:_____

	_____ _____ _____ (Providers and units/schedules listed on Member Version)	4th review period (___/___/___): _ met _ not met Sentinel events? _____

APPENDIX J
Carepath Rev. 10/2018

Member_____Medicaid #_____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Regular performance of ADLs and IADLs is not interrupted due to cognitive or functional impairments. GOALS: No observations by Case Managers or reports from mbr. /caregiver/other providers (including SOURCE PCP) identifying problems with ADLs, IADLs and/or patient safety. Sentinel events are discussed with appropriate parties (exclude falls).	___**ASSISTANCE REQUIRED:** (S=SELF; INF=informal support; PSS=PSS aide; HDM=home delivered meals; ALS=alternative living service): _____bathing _____dressing _____eating _____transferring _____toileting/continence _____turning/repositioning _____errands _____chores_____financial mgt._____meal prep. __**informal caregiver(s)** providing assistance: _____ _____ ___**home delivered meals** ___**ADH** ___**ALS** ___**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

Member_____Medicaid #_____Date:_____

	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)	

APPENDIX J
Carepath Rev. 10/2018

Member_____Medicaid #_____Date:_____

Rev 7/1/03

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Problem behavior will not place the Member at risk of social isolation, neglect or physical injury to themselves or others. Diagnosis: _depression _substance abuse ___bi-polar disorder ___schizophrenia ___Alzheimer's other dementia ___other _____ **GOALS:** **A. Residential arrangements remain stable.** **B. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers. Indicators of inadequately managed behavior include:** • **hospitalization for condition** • **discussion of potential institutionalization** • **increased level of caregiver stress** • **physical danger to self or others posed by behavior** • **discharge from a program or service due to behavior** **Examples of problem or symptomatic behavior:**	**ROUTINE AND PRN MONITORING AND EVALUATION** by SOURCE PCP for signs of changes in mental status **MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP ___other_____ __**ongoing management of condition** by mental health professional provider:_____schedule_____ ___**supervision** by informal caregiver(s): _____ ___**ALS** for supervision and monitoring ___**PSS** aides for supervision and monitoring ___**day program** for supervision and monitoring of mental status when or if informal support is unavailable	**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

Member_____Medicaid #_____Date:_____

wandering impaired memory substance abuse profoundly impaired judgment physical aggression suicide attempts or threats 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? _____

Member_____Medicaid #_____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
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.**	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): _____	**GOALS:** 1st review period (___/___/___): _ met _ not met Sentinel events? _____ 2nd review period (___/___/___): _ met _ not met Sentinel events? _____ 3rd review period (___/___/___): _ met _ not met Sentinel events?

Member_____Medicaid #_____Date:_____

	_____ NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	_____ 4th review period (__/__/__): _ met _ not met Sentinel events? _____

Member_____Medicaid #_____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
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.).**	___**Ongoing SOURCE case management/support service plan** ___**Referral to support group** _____ ___**In-home respite** Extended Personal Support (EPS) schedule: _____ ___**Out-of-home respite** provider: _____ schedule: _____ ___**ADH** for respite purposes for informal caregiver 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

APPENDIX J
Carepath Rev. 10/2018

Member_____Medicaid #_____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
GOALS: GOALS:		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:_____

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: _____ 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_____

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

MEMBER_____DATE _____

APPENDIX L

APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_____DATE _____

SOURCE
HOUSING, INCONTINENCE CAREPATHS

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in housing that is safe, affordable and accessible. Issues identified: ___substandard physical structure ___unaffordable not accessible ___geographic isolation ___family/household dynamics other _____ **GOALS:**	___Member preference is to explore relocating to a new home. ___Member preference is to remain in existing home and explore repair options as feasible. ___**SOURCE RELOCATION ASSISTANCE:** ___Assess Member's own circumstances, preferences and financial resources for housing. ___Identify a contact person – if available – to explore housing options on behalf of the Member, if applicable. ___Offer list of housing resources maintained by ___For Members with inadequate informal support, review available options. ___Complete application process (gathering necessary documentation).		**MEASURES:** _____ 1st review period (/ /): _ met _ not met _____ 2nd review period (/ / _): _ met _ not met 3rd review period (___/ / ___): _ met _ not met

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 ___new service (deposit) ___change of address with Social Security, DFCS, etc. ___notification of providers		

MEMBER_____DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	
Member will reside in housing that is safe, affordable and accessible. (CONT'D, Page 2)	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_____		MEA 1st re _ m _ no 2nd re _ m _ no 3rd re _ m _ no

MEMBER_____DATE _____

	___Identify informal support to provide assistance, if available. _____ ___Provide SOURCE resources to informal support. ___Obtain permission to contact landlord if applicable, if no informal support available for this assistance.		

MEMBER_____DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in safe, affordable and accessible housing. (CONT'D, page 3)	___Identify and contact landlord, describing nature of need repairs. ___One-month follow-up ___repairs acceptable____/____/____ ___repairs in progress____/____/____ ___no repairs initiated____/____/____ ___Notify appropriate authority: ___City Inspection Department___/___/___ (structural, plumbing, wiring) ___Health Department___/_ /___ (infestation, sewage) ___Fire Department___/___/___ (electrical, wiring, smoke alarms) ___One month follow-up with Member ___repairs in progress/completed ___repairs not initiated ___Re-contact appropriate authority		MEASURES: 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

MEMBER_____DATE _____

	Final disposition: ___repairs made ___repairs not made ___Member preference is to relocate (see relocate plan)__ ___Member preference is to remain in home under present conditions		

MEMBER_____DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in safe, affordable and accessible housing. (CONT'D, page 4)	___HOME REPAIRS, owner: ___Review Member/family personal resources for home repair ___If unavailable, identify a family member capable of pursuing other options for Member ___Provide SOURCE collection of local resource information. ___Broadly describe nature of repair work needed ___structural ___electrical ___plumbing ___infestation ___heating/cooling ___major accessibility modifications ___other_____		MEASURES: 1st review period (___/___/___): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

MEMBER_____DATE _____

	___Explore available funding from other sources: _____		

APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_____DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	Quarterly Reviews
Member will reside in safe, affordable and accessible housing. (CONTD, page 5)	__One month follow-up ___repairs acceptable / /__ ___repairs in progress / /___ ___no repairs initiated / /__ ___Re-contact appropriate funding source __Final disposition: __repairs made __ repairs not made ___Member preference is to relocate (see "Relocation" section) ___Member preference is to remain in home under present conditions		MEASURES: 1st review period (_/_/_) : __met __not met 2nd review period (_/_/_): __met __not met 3rd review period (_/_/_) : __met __not met

MEMBER_____DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE	FUNDING	QUARTERLY REVIEWS
Member's incontinence will be managed to promote skin integrity and adequate personal hygiene. GOALS: **A. Member has no skin breakdowns or decubiti requiring clinical intervention/wound care** **B. Member maintains acceptable personal hygiene (no perceptible odor, etc., and no reports by Member or caregiver/provider/PCP).** **C. Member has no infections/complications OR frequency of infections decreased for persons with catheter.**	___**paper continence products** supplier:____Member/informal caregiver ___Community Benefits ___assistance by informal caregiver ___assistance by PSS aide provider: schedule: ___**catheterization** ___in-and-out ___assistance by informal caregiver ___assistance by LPN/RN provider: schedule: ___in-dwelling ___assistance by informal caregiver ___assistance by RN/LPN provider: schedule: ___external ___assistance by informal caregiver		MEASURES: 1st review period (___/___/___):_ A. A. __met _ not met B. __met _ not met C _ met _ not met 2nd review period (___/___/___):_ A. __met _ not met B. _ met _ not met C. _ met _ not met 3rd review period (___/___/___): A.

MEMBER_____DATE _____

	___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:		__ met _ not met B. __ met _ not met C. __ met _ not met 4th review period (___/___/___): A. __ met _ not met B. __ met _ not met C. __ met _ not met

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:

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:

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) and 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

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[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. NAME
   a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2. GENDER
   1. Male 2. Female
3. BIRTHDATE
   Year — Month — Day
4. MARITAL STATUS
   1. Never married
   2. Married
   3. Partner / Significant other
   4. Widowed
   5. Separated
   6. Divorced
5. NATIONAL NUMERIC IDENTIFIER [EXAMPLE - USA]
   a. Social Security number
   b. Medicare number (or comparable railroad insurance number)
   c. Medicaid number
   [Note: "+" if pending, "N" if not a Medicaid recipient]
6. FACILITY / AGENCY PROVIDER NUMBER
7. CURRENT PAYMENT SOURCES [EXAMPLE - USA]
   [Note: Billing Office to indicate]
   0. No 1. Yes
   a. Medicaid
   b. Medicare
   c. Self or family pays for full cost
   d. Medicare with Medicaid co-payment
   e. Private insurance
   f. Other per diem
8. REASON FOR ASSESSMENT
   1. First assessment
   2. Routine reassessment
   3. Return assessment
   4. Significant change in status reassessment
   5. Discharge assessment, covers last 3 days of service
   6. Discharge tracking only
   7. Other—e.g., research
9. ASSESSMENT REFERENCE DATE
   2 0 — Year — Month — Day
10. PERSON'S EXPRESSED GOALS OF CARE
    Enter primary goal in boxes at bottom
11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE - USA]
12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT
    1. Private home / apartment / rented room
    2. Board and care
    3. Assisted living or semi-independent living
    4. Mental health residence—e.g., psychiatric group home
    5. Group home for persons with physical disability
    6. Setting for persons with intellectual disability
    7. Psychiatric hospital or unit
    8. Homeless (with or without shelter)
    9. Long-term care facility (nursing home)
    10. Rehabilitation hospital / unit
    11. Hospice facility / palliative care unit
    12. Acute care hospital
    13. Correctional facility
    14. Other
13. LIVING ARRANGEMENT
    a. Lives
    1. Alone
    2. With spouse / partner only
    3. With spouse / partner and other(s)
    4. With child (not spouse / partner)
    5. With parent(s) or guardian(s)
    6. With sibling(s)
    7. With other relatives
    8. With non-relative(s)
    b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new—e.g., moved in with another person, other moved in
    0. No 1. Yes
    c. Person or relative feels that the person would be better off living elsewhere
    0. No
    1. Yes, other community residence
    2. Yes, institution
14. TIME SINCE LAST HOSPITAL STAY
    Code for most recent instance in LAST 90 DAYS
    0. No hospitalization within 90 days
    1. 31 to 90 days ago
    2. 15 to 30 days ago
    3. 8 to 14 days ago
    4. In the last 7 days
    5. Now in hospital

SECTION B. INTAKE AND INITIAL HISTORY

[Note: Complete at Admission/First Assessment only]

1. DATE CASE OPENED (this agency)
   2 0 — Year — Month — Day
2. ETHNICITY AND RACE [EXAMPLE - USA]
   0. No 1. Yes
   ETHNICITY
   a. Hispanic or Latino
   RACE
   b. American Indian or Alaska Native
   c. Asian
   d. Black or African American
   e. Native Hawaiian or other Pacific Islander
   f. White
3. PRIMARY LANGUAGE [EXAMPLE - USA]
   1. English
   2. Spanish
   3. French
   4. Other
4. RESIDENTIAL HISTORY OVER LAST 5 YEARS
   Code for all settings person lived in during 5 YEARS prior to date case opened [Item B1]
   0. No 1. Yes
   a. Long-term care facility—e.g., nursing home
   b. Board and care home, assisted living
   c. Mental health residence—e.g., psychiatric group home
   d. Psychiatric hospital or unit
   e. Setting for persons with intellectual disability

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SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING
Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do
0. *Independent*—Decisions consistent, reasonable, and safe
1. *Modified independence*—Some difficulty in new situations only
2. *Minimally impaired*—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
3. *Moderately impaired*—Decisions consistently poor or unsafe; cues / supervision required at all times
4. *Severely impaired*—Never or rarely makes decisions
5. *No discernable consciousness, coma [Skip to Section G]*

2. MEMORY / RECALL ABILITY
Code for recall of what was learned or known
0. Yes, memory OK 1. Memory problem
a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
c. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS
[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]
0. Behavior not present
1. Behavior present, consistent with usual functioning
2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—*e.g., restlessness, lethargy, difficult to arouse, altered environmental perception*
0. No 1. Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)
0. Improved 2. Declined
1. No change 8. Uncertain

SECTION D. COMMUNICATION AND VISION

1. MAKING SELF UNDERSTOOD (Expression)
Expressing information content—both verbal and non-verbal
0. *Understood*—Expresses ideas without difficulty
1. *Usually understood*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
2. *Often understood*—Difficulty finding words or finishing thoughts AND prompting usually required
3. *Sometimes understood*—Ability is limited to making concrete requests
4. *Rarely or never understood*

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)
Understanding verbal information content (however able, with hearing appliance normally used)
0. ***Understands***—Clear comprehension
1. ***Usually understands***—Misses some part / intent of message BUT comprehends most conversation
2. ***Often understands***—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
3. ***Sometimes understands***—Responds adequately to simple, direct communication only
4. ***Rarely or never understands***

3. HEARING
Ability to hear (with hearing appliance normally used)
0. ***Adequate***—No difficulty in normal conversation, social interaction, listening to TV
1. ***Minimal difficulty***—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)
2. ***Moderate difficulty***—Problem hearing normal conversation, requires quiet setting to hear well
3. ***Severe difficulty***—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
4. ***No hearing***

4. VISION
Ability to see in adequate light (with glasses or with other visual appliance normally used)
0. ***Adequate***—Sees fine detail, including regular print in newspapers / books
1. ***Minimal difficulty***—Sees large print, but not regular print in newspapers / books
2. ***Moderate difficulty***—Limited vision; not able to see newspaper headlines, but can identify objects
3. ***Severe difficulty***—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
4. ***No vision***

SECTION E. MOOD AND BEHAVIOR

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD
Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]
0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days
a. **Made negative statements**—e.g., "*Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die*"
b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being let alone, being with others; intense fear of specific objects or situations
d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
e. **Repetitive anxious complaints / concerns (non-health related)**—e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
g. **Crying, tearfulness**
h. **Recurrent statements that something terrible is about to happen**–e.g., believes he or she is about to die, have a heart attack
i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
j. **Reduced social interactions**
k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)**—e.g., "*I don't enjoy anything anymore*"

2. SELF-REPORTED MOOD
0. Not in last 3 days
1. Not in last 3 days, but often feels that way
2. In 1-2 of last 3 days
3. Daily in the last 3 days
8. Person could not (would not) respond
Ask: "In the last 3 days, how often have you felt..."
a. ***Little interest or pleasure in things you normally enjoy?***
b. ***Anxious, restless, or uneasy?***
c. ***Sad, depressed, or hopeless?***

3. BEHAVIOR SYMPTOMS
Code for indicators observed, irrespective of the assumed cause
0. Not Present
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days
a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings
e. **Inappropriate public sexual behavior or public disrobing**
f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance

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SECTION F. PSYCHOSOCIAL WELL-BEING

1. SOCIAL RELATIONSHIPS
[Note: Whenever possible, ask person]
0. Never
1. More than 30 days ago
2. 8 to 30 days ago
3. 4 to 7 days ago
4. In last 3 days
8. Unable to determine

a. **Participation in social activities of long-standing interest**
b. **Visit with a long-standing social relation or family member**
c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail
d. **Conflict or anger with family or friends**
e. **Fearful of a family member or close acquaintance**
f. **Neglected, abused, or mistreated**

2. LONELY
Says or indicates that he / she feels lonely
0. No 1. Yes

3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)
Decline in level of participation in social, religious, occupational or other preferred activities
IF THERE WAS A DECLINE, person distressed by this fact
0. No decline
1. Decline, not distressed
2. Decline, distressed

4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)
0. Less than 1 hour
1. 1-2 hours
2. More than 2 hours but less than 8 hours
3. 8 hours or more

5. MAJOR LIFE STRESSORS IN LAST 90 DAYS—*e.g., episode of severe personal illness; death or severe illness of close family member/friend; loss of home; major loss of income/assets; victim of a crime such as robbery or assault; loss of driving license/car*
0. No 1. Yes

SECTION G. FUNCTIONAL STATUS

1. IADL SELF PERFORMANCE AND CAPACITY
Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0. *Independent*—No help, setup, or supervision
1. *Setup help only*
2. *Supervision*—Oversight /cuing
3. *Limited assistance*—Help on some occasions
4. *Extensive assistance*—Help throughout task, but performs 50% or more of task on own
5. *Maximal assistance*—Help throughout task, but performs less than 50% of task on own
6. *Total dependence*—Full performance by others during entire period
8. *Activity did not occur*—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

	PERFORMANCE	CAPACITY
a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)		
b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. **Managing finances**—How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored		
d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. **Stairs**—How full flight of stairs is managed (12-14 stairs)		
g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION		

h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)

2. ADL SELF-PERFORMANCE
Consider all episodes over 3-day period.

If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and others less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes for all episodes if performed fewer than 3 times). If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

0. *Independent*—No physical assistance, setup, or supervision in any episode
1. *Independent, setup help only*—Article or device provided or placed within reach, no physical assistance or supervision in any episode
2. *Supervision*—Oversight /cuing
3. *Limited assistance*—Guided maneuvering of limbs, physical guidance without taking weight
4. *Extensive assistance*—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5. *Maximal assistance*—Weight-bearing support (including lifting limbs) by 2+ helpers—OR—Weight-bearing support for more than 50% of subtasks
6. *Total dependence*—Full performance by others during all episodes
8. *Activity did not occur during entire period*

a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR
b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
e. **Walking**—How walks between locations on same floor indoors
f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
g. **Transfer toilet**—How moves on and off toilet or commode
h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET
i. **Bed mobility**—How moves to and from lying position, turns from side to side, and positions body while in bed
j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

3. LOCOMOTION / WALKING
a. **Primary mode of locomotion**
0. Walking, no assistive device
1. Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
2. Wheelchair, scooter
3. Bedbound

b. **Timed 4-meter (13 foot) walk**
[Lay out a straight unobstructed course. Have person stand in still position, feet just touching start line]
Then say: ***"When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?"*** Assessor may demonstrate test.
Then say: ***"Begin to walk now"*** Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-meter mark.
Then say: ***"You may stop now"***
Enter time in seconds, up to 30 seconds.
30. 30 or more seconds to walk 4-meters
77. Stopped before test complete
88. Refused to do the test
99. Not tested—e.g., does not walk on own

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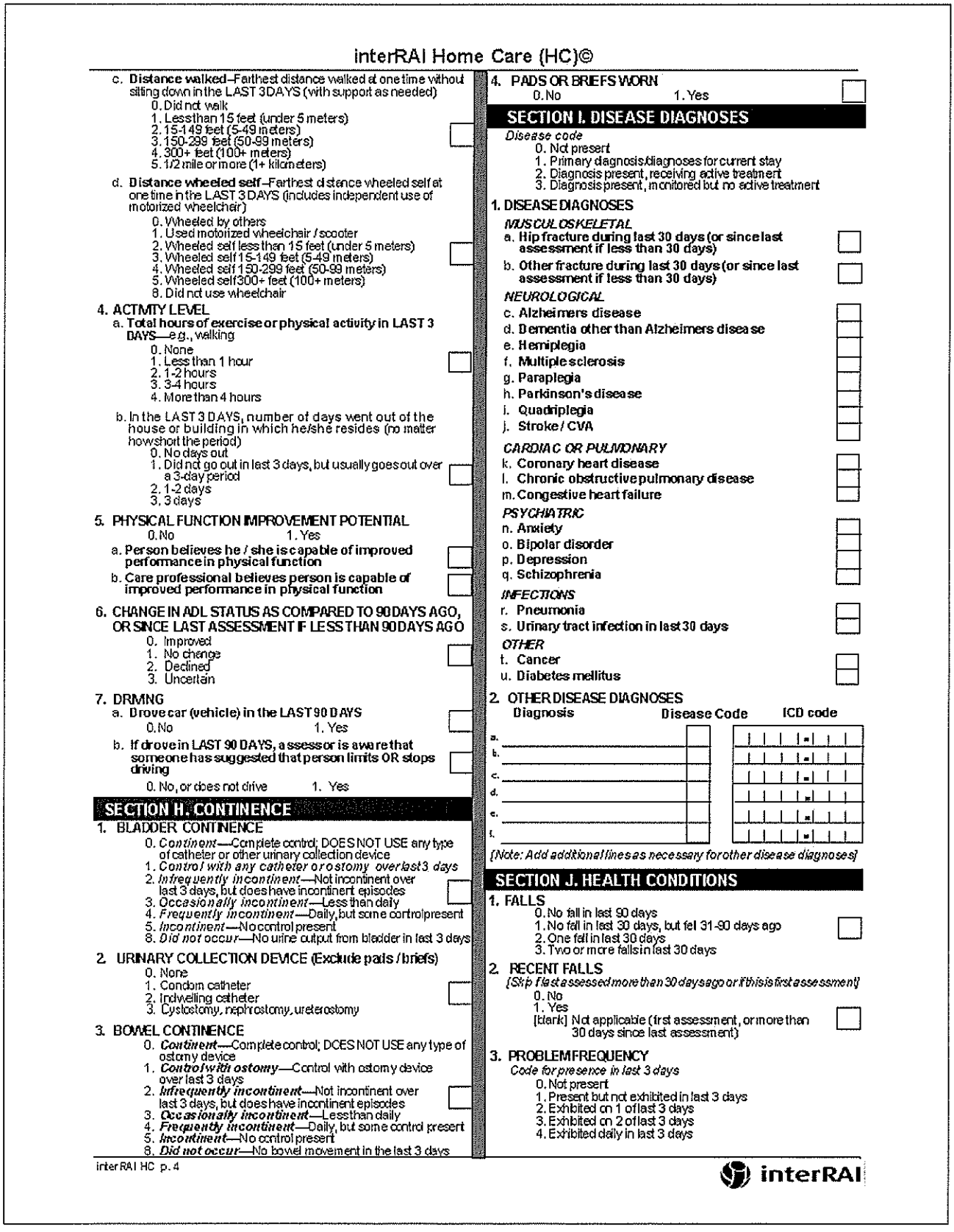

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c. **Distance walked**–Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)
0. Did not walk
1. Less than 15 feet (under 5 meters)
2. 15-149 feet (5-49 meters)
3. 150-299 feet (50-99 meters)
4. 300+ feet (100+ meters)
5. 1/2 mile or more (1+ kilometers)

d. **Distance wheeled self**–Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)
0. Wheeled by others
1. Used motorized wheelchair / scooter
2. Wheeled self less than 15 feet (under 5 meters)
3. Wheeled self 15-149 feet (5-49 meters)
4. Wheeled self 150-299 feet (50-99 meters)
5. Wheeled self 300+ feet (100+ meters)
8. Did not use wheelchair

4. ACTIVITY LEVEL
a. **Total hours of exercise or physical activity in LAST 3 DAYS**—*e.g.*, walking
0. None
1. Less than 1 hour
2. 1-2 hours
3. 3-4 hours
4. More than 4 hours

b. In the LAST 3 DAYS, number of days went out of the house or building in which he/she resides (no matter how short the period)
0. No days out
1. Did not go out in last 3 days, but usually goes out over a 3-day period
2. 1-2 days
3. 3 days

5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL
0. No 1. Yes
a. **Person believes he / she is capable of improved performance in physical function**
b. **Care professional believes person is capable of improved performance in physical function**

6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO
0. Improved
1. No change
2. Declined
3. Uncertain

7. DRIVING
a. **Drove car (vehicle) in the LAST 90 DAYS**
0. No 1. Yes
b. **If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving**
0. No, or does not drive 1. Yes

SECTION H. CONTINENCE

1. BLADDER CONTINENCE
0. *Continent*—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. *Control with any catheter or ostomy over last 3 days*
2. *Infrequently incontinent*—Not incontinent over last 3 days, but does have incontinent episodes
3. *Occasionally incontinent*—Less than daily
4. *Frequently incontinent*—Daily, but some control present
5. *Incontinent*—No control present
8. *Did not occur*—No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE (Exclude pads / briefs)
0. None
1. Condom catheter
2. Indwelling catheter
3. Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE
0. ***Continent***—Complete control; DOES NOT USE any type of ostomy device
1. ***Control with ostomy***—Control with ostomy device over last 3 days
2. ***Infrequently incontinent***—Not incontinent over last 3 days, but does have incontinent episodes
3. ***Occasionally incontinent***—Less than daily
4. ***Frequently incontinent***—Daily, but some control present
5. ***Incontinent***—No control present
8. ***Did not occur***—No bowel movement in the last 3 days

4. PADS OR BRIEFS WORN
0. No 1. Yes

SECTION I. DISEASE DIAGNOSES

Disease code
0. Not present
1. Primary diagnosis/diagnoses for current stay
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES

MUSCULOSKELETAL
a. **Hip fracture during last 30 days (or since last assessment if less than 30 days)**
b. **Other fracture during last 30 days (or since last assessment if less than 30 days)**

NEUROLOGICAL
c. **Alzheimers disease**
d. **Dementia other than Alzheimers disease**
e. **Hemiplegia**
f. **Multiple sclerosis**
g. **Paraplegia**
h. **Parkinson's disease**
i. **Quadriplegia**
j. **Stroke / CVA**

CARDIAC OR PULMONARY
k. **Coronary heart disease**
l. **Chronic obstructive pulmonary disease**
m. **Congestive heart failure**

PSYCHIATRIC
n. **Anxiety**
o. **Bipolar disorder**
p. **Depression**
q. **Schizophrenia**

INFECTIONS
r. **Pneumonia**
s. **Urinary tract infection in last 30 days**

OTHER
t. **Cancer**
u. **Diabetes mellitus**

2. OTHER DISEASE DIAGNOSES

	Diagnosis	Disease Code	ICD code
a.			.
b.			.
c.			.
d.			.
e.			.
f.			.

[Note: Add additional lines as necessary for other disease diagnoses]

SECTION J. HEALTH CONDITIONS

1. FALLS
0. No fall in last 90 days
1. No fall in last 30 days, but fell 31-90 days ago
2. One fall in last 30 days
3. Two or more falls in last 30 days

2. RECENT FALLS
[Skip if last assessed more than 30 days ago or if this is first assessment]
0. No
1. Yes
[blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY
Code for presence in last 3 days
0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1 of last 3 days
3. Exhibited on 2 of last 3 days
4. Exhibited daily in last 3 days

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BALANCE

a. **Difficult or unable to move self to standing position unassisted**

b. **Difficult or unable to turn self around and face the opposite direction when standing**

c. **Dizziness**

d. **Unsteady gait**

CARDIAC OR PULMONARY

e. **Chest pain**

f. **Difficulty clearing airway secretions**

PSYCHIATRIC

g. **Abnormal thought process**—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality

h. **Delusions**—Fixed false beliefs

i. **Hallucinations**—False sensory perceptions

NEUROLOGICAL

j. **Aphasia**

GI STATUS

k. **Acid reflux**—Regurgitation of acid from stomach to throat

l. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool

m. **Diarrhea**

n. **Vomiting**

SLEEP PROBLEMS

o. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep**

p. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning

OTHER

q. **Aspiration**

r. **Fever**

s. **GI or GU bleeding**

t. **Hygiene**—Unusually poor hygiene, unkempt, disheveled

u. **Peripheral edema**

4. DYSPNEA (Shortness of breath)
0. Absence of symptom
1. Absent at rest, but present when performed moderate activities
2. Absent at rest, but present when performed normal day-to-day activities
3. Present at rest

5. FATIGUE
Inability to complete normal daily activities—e.g., ADLs, IADLs
0. ***None***
1. ***Minimal***—Diminished energy but completes normal day-to-day activities
2. ***Moderate***—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
3. ***Severe***—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4. ***Unable to commence any normal day-to-day activities***—Due to diminished energy

6. PAIN SYMPTOMS
[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

a. **Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)**
0. No pain
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days

b. **Intensity of highest level of pain present**
0. No pain
1. Mild
2. Moderate
3. Severe
4. Times when pain is horrible or excruciating

c. **Consistency of pain**
0. No pain
1. Single episode during last 3 days
2. Intermittent
3. Constant

d. **Breakthrough pain**—Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain
0. No 1. Yes

e. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)
0. No issue of pain
1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
2. Controlled adequately by therapeutic regimen
3. Controlled when therapeutic regimen followed, but not always followed as ordered
4. Therapeutic regimen followed, but pain control not adequate
5. No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS
0. No 1. Yes

a. **Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable** (fluctuating, precarious, or deteriorating)

b. **Experiencing an acute episode, or a flare-up of a recurrent or chronic problem**

c. **End-stage disease, 6 or fewer months to live**

8. SELF-REPORTED HEALTH
Ask: "In general, how would you rate your health?"
0. Excellent
1. Good
2. Fair
3. Poor
8. Could not (would not) respond

9. TOBACCO AND ALCOHOL

a. **Smokes tobacco daily**
0. No
1. Not in last 3 days, but is usually a daily smoker
2. Yes

b. **Alcohol**—Highest number of drinks in any "single sitting" in LAST 14 DAYS
0. None
1. 1
2. 2-4
3. 5 or more

SECTION K. ORAL AND NUTRITIONAL STATUS

1. HEIGHT AND WEIGHT [INCHES AND POUNDS– COUNTRY SPECIFIC]
Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.

a. **HT (in.)** ☐☐ b. **WT (lb.)** ☐☐☐

2. NUTRITIONAL ISSUES
0. No 1. Yes

a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS**

b. **Dehydrated or BUN / Cre ratio>25** [Ratio, country specific]

c. **Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)**

d. **Fluid output exceeds input**

3. MODE OF NUTRITIONAL INTAKE
0. ***Normal***—Swallows all types of foods
1. ***Modified independent***—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
2. ***Requires diet modification to swallow solid food***—e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
3. ***Requires modification to swallow liquids***—e.g., thickened liquids
4. ***Can swallow only pureed solids —AND— thickened liquids***
5. ***Combined oral and parenteral or tube feeding***
6. ***Nasogastric tube feeding only***
7. ***Abdominal feeding tube***—e.g., PEG tube
8. ***Parenteral feeding only***—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
9. **Activity did not occur**—During entire period

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4. DENTAL OR ORAL
0. No 1. Yes
a. Wears a denture (removable prosthesis)
b. Has broken, fragmented, loose, or otherwise non-intact natural teeth
c. Reports having dry mouth
d. Reports difficulty chewing

SECTION L. SKIN CONDITION

1. MOST SEVERE PRESSURE ULCER
0. No pressure ulcer
1. Any area of persistent skin redness
2. Partial loss of skin layers
3. Deep craters in the skin
4. Breaks in skin exposing muscle or bone
5. Not codeable, e.g., necrotic eschar predominant

2. PRIOR PRESSURE ULCER
0. No 1. Yes

3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER—*e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer*
0. No 1. Yes

4. MAJOR SKIN PROBLEMS—*e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds*
0. No 1. Yes

5. SKIN TEARS OR CUTS—*Other than surgery*
0. No 1. Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION—*e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema*
0. No 1. Yes

7. FOOT PROBLEMS—*e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers*
0. No foot problems
1. Foot problems, no limitation in walking
2. Foot problems limit walking
3. Foot problems prevent walking
4. Foot problems, does not walk for other reasons

SECTION M. MEDICATIONS

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS

[Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug record:
a. **Name**

b. **Dose**—A positive number such as 0.5, 5, 150, 300. [Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]

c. **Unit**—Code using the following list
gtts (Drops) meq (Milli-equivalent) Puffs
gm (Gram) mg (Milligram) % (Percent)
L (Liters) ml (Milliliter) Units
mcg (Microgram) oz (Ounce) OTH (Other)

d. **Route of administration**—Code using the following list
PO (By mouth/oral) REC (Rectal) ET (Enteral Tube)
SL (Sublingual) TOP (Topical) TD (Transdermal)
IM (Intramuscular) IH (Inhalation) EYE (Eye)
IV (Intravenous) NAS (Nasal) OTH (Other)
Sub-Q (Subcutaneous)

e. **Freq**—Code the number of times per day, week, or month the medication is administered using the following list
Q1H (Every hour) 5D (5 times daily)
Q2H (Every 2 hours) Q2D (Every other day)
Q3H (Every 3 hours) Q3D (Every 3 days)
Q4H (Every 4 hours) Weekly
Q6H (Every 6 hours) 2W (2 times weekly)
Q8H (Every 8 hours) 3W (3 times weekly)
Daily 4W (4 times weekly)
BED (At bedtime) 5W (5 times weekly)
BID (2 times daily) 6W (6 times weekly)
(includes every 12 hrs) 1M (Monthly)
TID (3 times daily) 2M (Twice every month)
QID (4 times daily) OTH (Other)

f. PRN
0. No 1. Yes

g. **Computer-entered drug code**

	a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. ATC or NDC code
1.							
2.							
3.							
4.							
5.							

[NOTE: Add additional lines, as necessary, for other drugs taken]
[Abbreviations are Country Specific for Unit, Route, Frequency]

2. ALLERGY TO ANY DRUG
0. No known drug allergies 1. Yes

3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN
0. Always adherent
1. Adherent 80% of time or more
2. Adherent less than 80% of time, including failure to purchase prescribed medications
8. No medications prescribed

SECTION N. TREATMENT AND PROCEDURES

1. PREVENTION
0. No 1. Yes
a. Blood pressure measured in LAST YEAR
b. Colonoscopy test in LAST 5 YEARS
c. Dental exam in LAST YEAR
d. Eye exam in LAST YEAR
e. Hearing exam in LAST 2 YEARS
f. Influenza vaccine in LAST YEAR
g. Mammogram or breast exam in LAST 2 YEARS (for women)
h. Pneumovax vaccine in LAST 5 YEARS or after age 65

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)
0. Not ordered AND did not occur
1. Ordered, not implemented
2. 1-2 of last 3 days
3. Daily in last 3 days

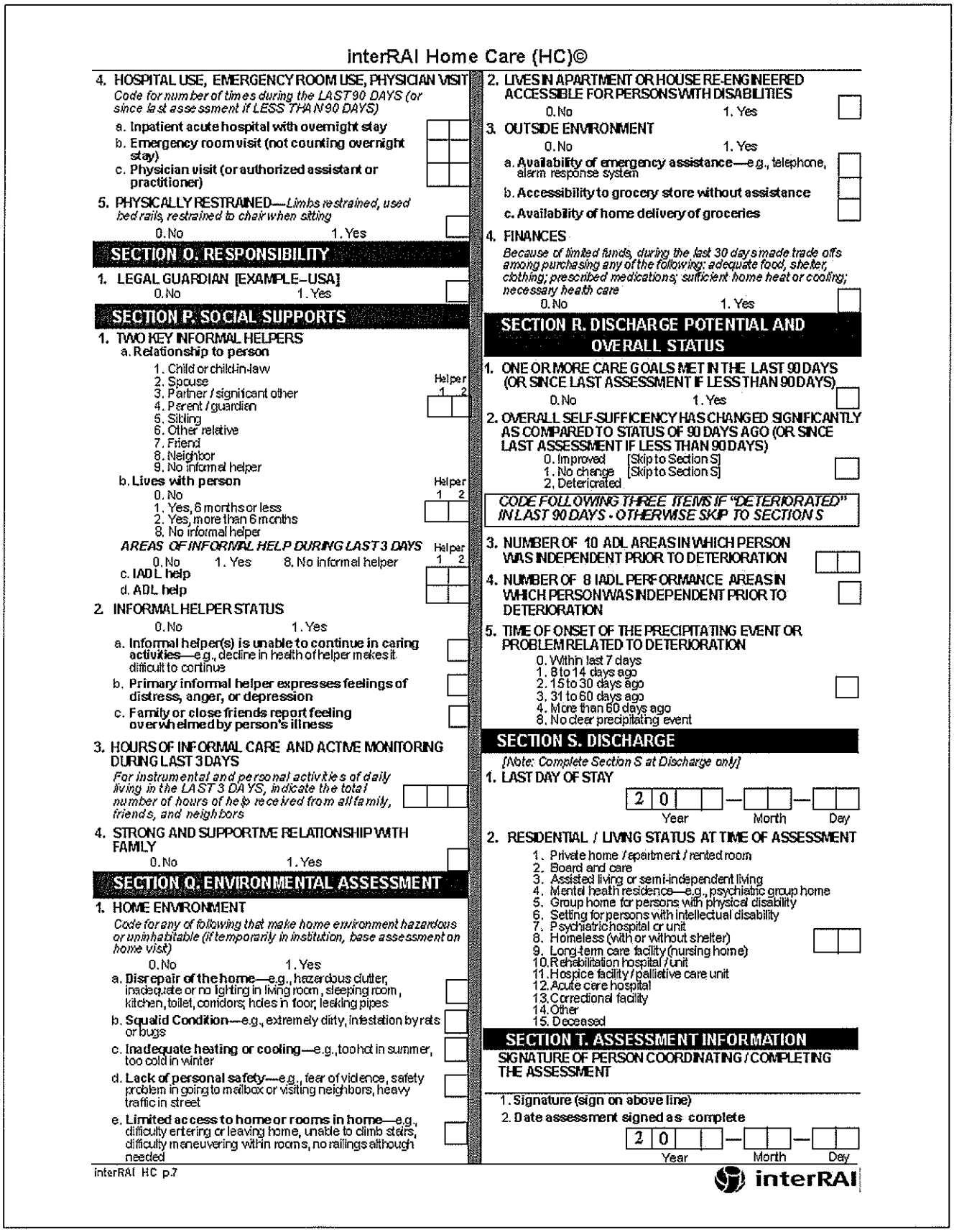
TREATMENTS
a. Chemotherapy
b. Dialysis
c. Infection control—e.g., isolation, quarantine
d. IV medication
e. Oxygen therapy
f. Radiation
g. Suctioning
h. Tracheostomy care
i. Transfusion
j. Ventilator or respirator
k. Wound care

PROGRAMS
l. Scheduled toileting program
m. Palliative care program
n. Turning / repositioning program

3. FORMAL CARE
Days (A) and Total minutes (B) of care in last 7 days
Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

	(A) # of Days	(B) Total Minutes in last week
a. Home health aides		
b. Home nurse		
c. Homemaking services		
d. Meals		
e. Physical therapy		
f. Occupational therapy		
g. Speech-language pathology and audiology services		
h. Psychological therapy (by any licensed mental health professional)		

Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance



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4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT
Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)
a. Inpatient acute hospital with overnight stay
b. Emergency room visit (not counting overnight stay)
c. Physician visit (or authorized assistant or practitioner)

5. PHYSICALLY RESTRAINED—*Limbs restrained, used bed rails, restrained to chair when sitting*
0. No 1. Yes

SECTION O. RESPONSIBILITY

1. LEGAL GUARDIAN [EXAMPLE–USA]
0. No 1. Yes

SECTION P. SOCIAL SUPPORTS

1. TWO KEY INFORMAL HELPERS
a. Relationship to person
1. Child or child-in-law
2. Spouse
3. Partner / significant other
4. Parent / guardian
5. Sibling
6. Other relative
7. Friend
8. Neighbor
9. No informal helper
Helper 1 2
b. Lives with person
0. No
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal helper
Helper 1 2
AREAS OF INFORMAL HELP DURING LAST 3 DAYS
0. No 1. Yes 8. No informal helper
Helper 1 2
c. IADL help
d. ADL help

2. INFORMAL HELPER STATUS
0. No 1. Yes
a. Informal helper(s) is unable to continue in caring activities—e.g., decline in health of helper makes it difficult to continue
b. Primary informal helper expresses feelings of distress, anger, or depression
c. Family or close friends report feeling overwhelmed by person's illness

3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS
For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors

4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY
0. No 1. Yes

SECTION Q. ENVIRONMENTAL ASSESSMENT

1. HOME ENVIRONMENT
Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)
0. No 1. Yes
a. Disrepair of the home—e.g., hazardous clutter, inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes
b. Squalid Condition—e.g., extremely dirty, infestation by rats or bugs
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, safety problem in going to mailbox or visiting neighbors, heavy traffic in street
e. Limited access to home or rooms in home—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed

2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES
0. No 1. Yes

3. OUTSIDE ENVIRONMENT
0. No 1. Yes
a. Availability of emergency assistance—e.g., telephone, alarm response system
b. Accessibility to grocery store without assistance
c. Availability of home delivery of groceries

4. FINANCES
Because of limited funds, during the last 30 days made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care
0. No 1. Yes

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)
0. No 1. Yes

2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
0. Improved [Skip to Section S]
1. No change [Skip to Section S]
2. Deteriorated

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

4. NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION

5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION
0. Within last 7 days
1. 8 to 14 days ago
2. 15 to 30 days ago
3. 31 to 60 days ago
4. More than 60 days ago
8. No clear precipitating event

SECTION S. DISCHARGE

[Note: Complete Section S at Discharge only]

1. LAST DAY OF STAY
2 0 — — — — — —
Year Month Day

2. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT
1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other
15. Deceased

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

1. Signature (sign on above line)
2. Date assessment signed as complete
2 0 — — — — — —
Year Month Day

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APPENDIX T

MDS-HC Participants
SOURCE Program

Participant	Agency	Relationship to Applicant	Date

RN Who Reviewed MDS HC for Consistency & 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 and uploaded with packet to AHS.

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APPENDIX U1

SOURCE MONTHLY CONTACT SHEET

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.**

APPENDIX U1
SOURCE MONTHLY CONTACT SHEET

CM Supervisor Signature and Date (quarterly)	

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.**

Δ Annual visits:

See guidelines above for quarterly visits and also complete the areas marked with triangle symbol.

APPENDIX U3
SOURCE BI-ANNUAL PCP CONTACT SHEET

PCP CONFERENCE

Member's Name:_____ Date of last PCP Contact_____ 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.
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 _____

SENTINEL Events? Y N _____
Is Medical Appt. or referral needed to address Sentinel/Variances?

Review Carepath, record for any changes made. _____

Attach, Confirm/ List medications with PCP office. * = new medications:

PCP Notes, Comments/Goals for member:

Member Health complaints/ risks that may be due to Medication actions, list here so PCP may assess. Such as Fall/ER/ weakness/Dizziness, other._____

CM received H&P, notes, labs needed ____

PCP signed Contact Sheet ____

Other: ____

✓ Major Changes/Concerns in Functional Status: Yes No
✓ *Physical or cognitive?*

_____ _____ _____
PCP Signature MD/PA/NP Date

_____
CM Signature Date Case Management Supervisor Signature Date

Tips for Appendix U3 PCP Contact Form

Use this form to prepare and summarize case management areas of interest to medical providers bi-annually. Look back at six months and one year and include items such as:

1. Indicate if the visit is the 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 most of appointments with the PCP kept? Were most 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 (resolved, in progress, etc) under the correct areas.

   Were diet goals met? Was 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? (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 or attach medication list.
   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. Please encourage PCP 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

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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 V

SOURCE Referral Form

Appendix F is good through date:_____

Member is under administrative review. Please continue services until: _____

APPENDIX V

SOURCE Referral Form

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_____

APPENDIX W
MIF

SOURCE Member Information Form

_Provider to Case Manager _Case Manager to Provider

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_Initial _Change _Discharge _FYI Response required? _YES _NO

Provider Name _____

Member Name_____Medicaid No. _____

Service type: _ADH _ALS _ERS _HDM _HDS _PSS _EPS

Initial

Service offered? ____ No – Reason _____

YES, Date services initiated _____
Frequency/Units _____

Change/FYI

_Recommendation for change in service
_Change in mbr's. Health/functional status
_Hospitalization
_Service not delivered
_Change in frequency/units by case manager
_Change of physician/CM
_Other
_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_____

APPENDIX W
MIF

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.

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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's
UNIVERSAL Member WAIVER TRANSFER FORM (Non-Electronic)

SOURCE Program Member's:

1. LOC Authorization Number:_____Expiration Date: _____

2. Member Name

_____DOB:_____
(Last, First, M.I.)

Soc. Sec. No._____Medicaid# _____

3. Other Contact Information: _____

4. **Member transfer from (Agency A) Information:**

Agency Name: _____ Provider ID# _____

County _____

Care coordinator/ CM / Contact person _____

Email_____Telephone ( ) _____

Current Waiver type (CCSP/SOURCE/NOW-COMP/ICWP/GAPP) Last service date _____

Member's address _____

County_____ State _____ Zip _____

5. **Member transfer to (Agency B) Information**

Agency Name: _____ Provider ID# _____

County _____

Care coordinator/ CM / Contact person _____

Email_____Telephone ( ) _____

Waiver type (CCSP/SOURCE/NOW-COMP/ICWP/GAPP) (circle) _____

Member's address _____

County_____ State _____ Zip _____

Telephone (_____)

APPENDIX X
SOURCE MEMBER TRANSFERS

Instructions:

Purpose: The member transfer form is used to transfer case records and to notify AHS of transfer.

Who Completes/When Completed

Transferring Agency A:

The current case manager/care coordinator 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 (Agency B).

Receiving Agency B: This 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. An RN review and case note 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.

Sending to AHS:

Transfer from Agency A:

The AHS review nurse will receive the transfer form via Contact Us message – use Current Agency's (Agency A) Level of Care Prior Authorization request number to pull up the Contact Us note. As long as the transfer form is filled out in its entirety (with the addition of the receiving agency's email address), only the current Agency A needs to perform this task. Agency A should include documentation of the transfer such as a CCNF in CCSP or a MIF / Z discharge letter from SOURCE.

Transfer to Agency B:

IF there are transfer issues that still need to be addressed, it may make sense for the "transferred to" agency B to attach the transfer form again with clarifying information to AHS via contact us as outlined above.

Instructions:

APPENDIX X
SOURCE MEMBER TRANSFERS

1. Enter the current LOC Prior Authorization Number and Expiration Date of the LOC PA issued by AHS

2. Enter member's name (last name, first, and middle initial) and Date of Birth.
   Enter member's social security number.

   Enter member's Medicaid number.

3. Other contact information that may be helpful can be entered here such as a note or a family contact.

4. **Member transfer from Agency A Information:**
   (Current member's (Agency A) information)

   Enter name of current agency and provider ID

   Enter name of care coordinator, Case Manager or Contact person's email address, name, and phone.

   Enter the Last Day Agency A will give service to the client. AHS will end the LOC PA for agency A on this date. The service PA should end on this date.

   Enter or circle the Member's current Waiver type for Agency A

   Enter member's Contact information when with Agency A. Include: Address, City, County, State, Zip code

   Enter Member's Phone number when with Agency A

5. **Member transfer to Agency B Information**
   (Receiving Agency (Agency B) Information)

   Enter agency name and provider ID of agency B, the agency the member is transferring to.

   Enter Agency B contact information: email address, name, and direct phone number of the contact person who is responsible for coordinating the transfer to the new agency or new site.

   Circle or write in the new Agency B's Waiver Type (CCSP/SOURCE/NOW/COMP/ICWP)

   If the member has a new address or new phone number, enter here.

   A copy is maintained in the transferring WAIVER agency file.

APPENDIX X
SOURCE MEMBER TRANSFERS

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 (this excludes SLMB, QMB, or QI 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

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Last revision 9/10/18 Continue onto next page

APPENDIX Z (continued)

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:

_____

Name of Case Manager/Other Agency Phone

5. Appendix I in table format enclosed? Yes No

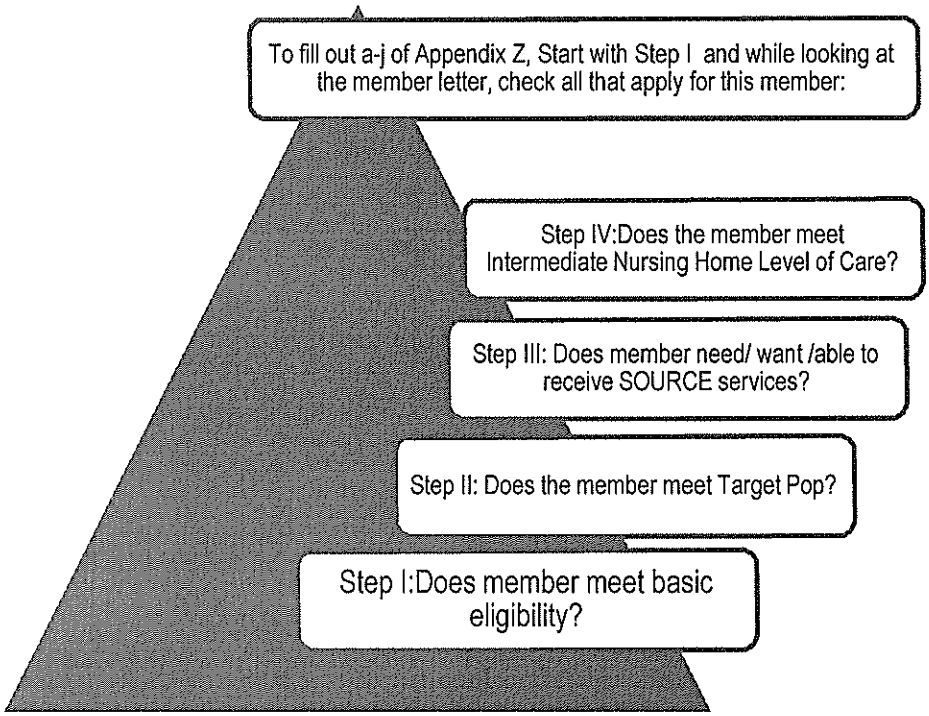
APPENDIX Z
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

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)



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 f-l if any of these applies to the member.

Note: Detail the reason for non-compliance if #g is selected, be specific.

Note: Fill in the details for l if any other reasons apply.

Step IV Intermediate Nursing Home level of care:

All denials for not meeting Intermediate Nursing Home Level of care, come from the decision made by Alliant Health Solutions. That information is mailed to the member directly from Alliant Health Solutions. Follow up with the member regarding their decision to appeal the decision or not. Assist as needed with the denial.

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

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

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)

Service	Frequency/Units	Provider Contact Information (Name/Phone Number)	Availability/cost of service after discharge from SOURCE
Personal Support			
Home Delivered Meals			
Emergency Response System			
Adult Day Health			
Alternative Living Services			
Skilled Nursing Services			

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.

Service	Contact Information (Name/Phone Number)	Special Conditions/ Comments
⌋ Personal Support (DAS, Churches, Family) ⌋ Home Delivered Meals (food banks, stamps, senior services) ⌋ Emergency Response System (Cell phone, local discounted company, Walmart, Splash) ⌋ Adult Day Health (Senior		

Day Activities) J Alternative Living Services		

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

⌋ Skilled Nursing Service (set up with Medicaid through PCP) ⌋ Transportation (Disabled County specific transport) ⌋ NOW/COMP if member has MR or Developmental Delay ⌋ DFCS if losing eligibility ⌋ GAPP/ Local Health Dept programs if child in need		
⌋ DBHDD if mental health issues ⌋ APS as needed ⌋ Pharmacy /Medication set up needs ⌋ Other specify (i.e. energy assistance)		

Instructions: Discharge planning is required for all members with involuntary discharge from SOURCE services (except for Nursing Home) . 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.

APPENDIX AA

DEATH, SIGNIFICANT INJURY OR CRITICAL INCIDENT REPORT
SOURCE SENTINEL EVENTS

~~() Death () Head Injury () Hip~~
Fracture () Suicide () APS
Referred () Fall () Accident

(TYPE IF POSSIBLE)

Report Date:	Member Name:	
Member's DOB/Age:	Significant Diagnosis:	Phone Number:
Address Where Member Resides:	City:	County
SOURCE CM Agency Name:	SOURCE Manager:	Office Hours Contact Phone:
CM Address:	Which Agency Involved? Name & Address:	Type of Provider:
Provider #:	Location Where Event Occurred:	Date Event Occurred:
Name of Supervisor/Manager:	Contact Phone:	Date CM Agency Notified:

Type of Death, Injury or Incident: (see Table AA)	Place Occurred:	Name of Person Discovering Event:
Cause: (i.e. push, fall)	Address: (if different from residence)	
Description: (i.e. fracture)		

CONTRIBUTING FACTORS: **INITIAL RESPONSE:**

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:	

CARE COORDINATION INTERVENTIONS:

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:

Order/Repair Assistive Device:	Temp Services Increase:	Safety Ed:	

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:

Title	Yes	No	Name	Date	Time
Supervisor:					

Primary Physician:					
Family/or 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: 404-463-1104

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

APPENDIX AA
DEATH, SIGNIFICANT INJURY OR CRITICAL INCIDENT REPORT
SOURCE SENTINEL EVENTS

Who Completes/When completed: The SOURCE Care Management care coordinator completes the form within **five** 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 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 Manger 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 evaluati***ng eff***ectiveness 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 SOUR***CE manage***r 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 <u>not met</u> at time of discharge (refers to Carepath):

___COMM ___SKIN ___MEDS ___I/ADLs ___TRANS/MOB

___NUTR'N ___CLIN ___BEHAVIOR ___INF. SUPPORT

APPENDIX BB

SOURCE Discharge Summary

*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 DXC is the third-party administrator for Georgia's Medicaid and PeachCare for Kids programs.

Providers will enter claims 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.

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 infield G 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

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.

- Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

  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

APPENDIX DD
SOURCE National Codes and Rates

Effective 10/1/2005 Rev. Effective 10/2014

Old Code	Description	National Code	Description	Modifier	Rate
Y3801	Home Delivered Services; Nursing Visit	T1030	Nursing care, in home, by registered nurse	TD	Provider Specific (51st unit of service)
Y3802	Home Delivered Services; Physical Therapy	S9131	Physical therapy, in home, per diem		Provider Specific (51st unit of service)
~~Y3803~~	Home Delivered Services; Speech Therapy	S9128	Speech therapy, in the home, per diem		Provider Specific (51st unit of service)
~~Y3804~~	Home Delivered Services; Occupational Therapy	S9129	Occupational therapy, in the home, per diem		Provider Specific (51st unit of service)
~~Y3805~~	Home Delivered Services; Medical Social Services	S9127	Social work visit, in the home, per diem		Provider Specific (51st unit of service)
~~Y3806~~	Home Delivered Services; Home Health Aide	T1021	Home health aide or certified nurse assistant, per visit		Provider Specific (51st unit of service)
Y3725	Adult Day Health Level I Full Day	S5102	Day care services, adult, per diem		$55.62 per day minimum 5 hours
Y3726	Adult day Health Level I Partial Day	S5101	Day care services, adult, per half day		$33.37 per day minimum 3 hours
Y3740	Adult Day Health; Physical Therapy	S9131	Physical therapy in the home, per diem; services delivered under an outpatient physical therapy plan of care	GP	$44.15 per visit
Y3750	Adult Day Health; Speech Therapy	S9128	Speech therapy, in the home, per diem; services delivered under	GN	$44.15 per visit

			an outpatient speech therapy plan of care		
~~Y3790~~	Adult Day Health; Occupational Therapy	S9129	Occupational therapy, in the home, per diem; services delivered under an outpatient occupational therapy plan	GO	$44.15 per visit
~~Y3827~~	Adult Day Health Level II Full Day	S5102	Day care Services, adult, per diem: intermediate level of care	TF	$69.53 per day
~~Y3828~~	Adult Day Health Level II Partial Day	S5101	Day care services, adult, per half day; intermediate level of care	TF	$41.73 per day
~~Y3617~~	Alternative Living Services - Group Model	T1020	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	HQ	$50.00 per day
Y3625	Alternative Living Services – Family Model	T1020	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	TT	$50.00 per day (payment to the individual model home must be no less than $15.25 per day)

			provided to more than patient in same setting		
Y3600	Out of Home Respite (12 hours)	S5151	Unskilled respite care, not hospice, per diem; intermediate level of care	TF	$42.57 per night minimum 12 hours
Y3715	Out of Home Respite (hourly)	S5150	Unskilled respite care, not hospice, per 15 minutes		$3.00 per unit, 32 units (8 hours) maximum, 12 units minimum (3 hours)
~~Y3832~~	Personal Support Service	T1021	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)	U-1	$10.14 per 30 minutes units. 30 minutes equal 1 unit. (not to exceed 5 units or 2.5 hours per visit)
Y3840	Extended Personal Support	T1021	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	TF	$9.02 per 30 minutes equal 1 unit. (Not to exceed 48units a day) Not to exceed 720 units/ Month (360 hours/15 days)

			nurse assistant) intermediate level of care		
Y3823	Emergency Response Monitoring (Monthly)	S5161	Emergency response system; service fee, per month (excludes installation and testing)		$36.69 per month
Y3824	Emergency Response Monitoring (Weekly)	T2025	Emergency response system; waiver services; not otherwise specified (NOS)	U9	$9.17 per week
Y3825	Emergency Response Installment	S5160	Emergency response system; installation and testing		Up to $110.10 one installment
~~Y3831~~	Home Delivered Meals	S5170	Home Delivered Meals		$6.74 per meal maximum 21 per week
Y3850	Skilled Nursing Services RN	T1030	Nursing care, in the home by a registered nurse per diem		$65.00 per visit/ only one visit per day maximum
~~Y2851~~	Skilled Nursing Services LPN	T1031	Nursing care in home, by licensed practical nurse per diem		$50.00 per visit
	SOURCE CM fee	T2022		SE	$192.27 per month

Case management Provider Main Offices

Ace Care Management

Contact Person: Ruchelle Thomas, ruchelle.thomas@acecaremgmt.com
Ph: 844-937-4223, Fax: 844-937-4223 ((follow prompts)
50 Hurt Plaza SE
Atlanta, Georgia 30303
Counties: Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Rockdale, Spalding, and Walton

Albany ARC

Contact Person: Shon Houston, Asst. Program Director, BHS, MS
(229) 883-2334; Fax: (229) 883-2710
2200 Stuart Ave., 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: Jimmie Smith, Program Manager
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
37 Varden Dr., Suite F
Aiken, South Carolina
29803
P. O. Box 5569
Augusta, Georgia 30906
County: Burke, Columbia, Richmond

Case management Provider Main Offices

Crossroads Community SOURCE

Contact person: Todd Sichelstiel (tsichelstiel@cc-source.net)
Office: 478-224-6677

Fax: 478-988-0093
1203 Ball Street, Perry, Georgia 32069
Counties: Bibb, Bleckley, Crawford, Crisp, Dodge, Dooly, Houston, Jones, Laurens, Macon, Monroe, Peach, Pulaski, Sumter, Taylor, Telfair, Twiggs, Wilcox, Wilkinson

Diversified Resources Inc.

Contact Person: Owner/Administrators: Pat Albritton or Kathy Yarbrough 912- 285-3089 or 1-800-283-0041
Case Manager Supervisor: Donna Robinson, RN, BSN

Fax: 912 285-0367
147 Knight Avenue Circle
P. O. Box 1099 (31502)
Waycross, Georgia 31503
Counties: Atkinson, Brantley, Camden, Charlton, Clinch, Coffee, Glynn, Liberty, Long, McIntosh, Pierce and Ware

Tifton Office

Contact Person: Cindy Foreman, 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, Colquitt, Irwin, Tift, Turner, Wilcox and Worth

Valdosta Office

Contact Person: Caroline McGovern, RN CM Supervisor
229-253-9995 or 800-706-9674
2700C N. Oak Street
Valdosta, Ga. 31602
Counties: Berrien, Brooks, Cook, Echols, Lanier, Lowndes and Thomas

Camilla Office

Contract Person: Caroline McGovern, RN CM Supervisor
229-522-3161 or 888-597-3511
Fax: 229-522-3161

Counties: Baker, Calhoun, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, and Thomas

Faith Health Services of GA Inc.
Contact: Yelena LaPlace
770-416-1910

Fax: 770-925-1448
5325 Oakbrook Pkwy, Norcross, GA, 30093
Counties: Fulton, Cobb, Clayton, Dekalb, Forsyth, Gwinnett, Rockdale

Legacy Link Inc

Contact: Amy Allen
Contact: Dianne Dodgins
770-538-2668; 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

Rome Office

Contact:
678-252-3000; Link Fax: 706-622.2399
901 N. Broad Street, suite 200
Rome, Georgia 30161

Counties: Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, and Whitfield

Next Step Care

Corporate Office
Christie Shaw, MHSA, Director of Operations
15 Merritt Street
P.O. Box 952
Hawkinsville, GA 31036
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: 888-762-2420
Fax: 229-431-0525
507 N Jefferson St, Albany, GA 31701
Counties: Ben Hill, Crisp, Dooly, Dougherty, Irwin, Lee, Sumter, Terrell, Turner, Wilcox, Worth Irwin

Augusta
Administrator: Edwina
Wright
Ph: 888-762-2420
Fax: 706-737-0250
2100 Central Avenue Suite #5, Augusta 30904
Counties: Burke, Columbia, Richmond

Athens
Administrator: Steven Johnston,
BS Ph: 888-762-2420
Fax: 706-543-8293
405 Gaines School Rd., Athens, GA 30605
Counties: Banks, Barrow, Clark, Elbert, Franklin, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Rabun, Stephens, Towns, White

Butler
Administrator: Claire Locke, MFS
Ph: 888-762-2420
Fax: 478-862-4844
12 South Broad Street, P.O. Box 89 Butler, GA 31006
Counties: Crawford, Macon, Marion, Peach, Pike, Schley, Spaulding, Talbot, Taylor, Upson

Columbus
Administrator: Ronda Phillips
Ph: 888-762-2420
Fax: 706-257-1006
6531 Effingham Way, Suite K, Columbus, GA 31909
Counties: Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Webster

Conyers
Administrator: Shanika Warren
Ph: 888-762-2420
Fax: 770- 388 - 7539
1506 Klondike Road, Conyers, Ga. 30094
Counties: Rockdale, Walton, Newton, Henry, Dekalb

Duluth
Administrator: Steven Johnston, BS
Ph: 888-762-2420
Fax: 770-717-2692
2825 Breckenridge Blvd., Suite 130, Duluth, GA 30096
Counties: Gwinnett, Fannin, Gilmer, Pickens, Cherokee, Union, Lumpkin, Dawson, Forsyth, Hall

Eatonton
Administrator: Edwina Wright
Ph: 888-762-2420
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: Claire Locke, MFS
Ph: 888-762-2420
Fax: 478-621-7538
2000 A Northside Crossing Macon, GA 31210
Counties: Bleckley, Bibb, Jones, Monroe,
Dodge, Butts, Lamar, Pulaski, Houston,
Twiggs, Butts, Lamar

Metter
Administrator: Melinda Howell, LPN
Ph: 888-762-2420
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

Rome
Administrator: Michael Barton, BS
Ph: 888-762-2420
Fax: 706-378-1330
413 Shorter Ave., Suite 111, Rome, GA 30165
Counties: Bartow, Catoosa, Chattooga, Cobb, Dade, Floyd, Gordon, Haralson, Murray, Paulding, Polk, Walker, Whitfield

Thomasville
Administrator: Shonnell Rogers
Ph: 888-762-2420
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: 888-762-2420
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: 888-762-2420
Fax: 478- 864-9423
8647 Marcus Street, Wrightsville, GA 31096
Counties: Glascock, Jefferson, Johnson, Laurens, Washington, Wilkinson

St. Joseph's/Candler Health System
Savannah Office
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, McIntosh

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, Montgomery, Tattnall, Toombs, Wayne

Visiting Nurse Source

Contact: Edie Kilpatrick
5775 Glenridge Drive, NE Suite E375 Atlanta,
GA 30328
Ph: 404-581-4782; Fax: 404-527-0606
Counties: Barrow, Bartow, Butts, Chattooga, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Floyd, Forsyth, Fulton, Gordon, Gwinnett, Hall,, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Polk, Rockdale, Spalding, Walton

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

Regional Directors

Jane Addison – North Peach
800-632-2101
6050 Appalachian Highway
Blue Ridge, Georgia 30513

jgaddison@pruitthealth.com

Charles Teasley – South Peach
770- 925-1143
1626 Jergens Court.
Norcross, GA 30093
chteasley@pruitthealth.com

Albany Home First

Contact Person: Alicia Cheatham, Acheatham@pruitthealth.com
Ph: 229-878-0128, Fax: 229-878-1093
202 North Westover Blvd.
Albany, Georgia 31707
Ben Hill, Bleckley, Chattahoochee, Clay, Crips, Dodge, Dooly, Daugherty, Irwin, Lee, Macon, Marion, Muscogee, Pulaski, Quitman, Randolph, Schley, Stewart, Sumter, Telfair, Tift, Turner, Webster, Wilcox, Worth

Athens Home First

Contact Person: Teresa Lucas. tlucas@pruitthealth.com
706-549-3315, Fax: 706-543-3841
1751 Meriweather Drive
Watkinsville, Georgia 30677
Counties: Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Morgan, Oconee, Oglethorpe, Stephens, Walton

Atlanta Home First

Contact Person: Charles Teasley, chteasley@pruitthealth.com
770-925-1143 Fax: 678 533-6488
1626 Jeurgens Court
Norcross GA 30093
Counties: Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Newton, Paulding, Polk, Rockdale, Troup

Augusta Home First

Contact Person: Brenda Braddock, bbraddock@pruihealth.com
706-651-1535, Fax: 706 863-9401
1220 Augusta West Parkway
Augusta, Georgia 30909
Counties: Burke, Columbia, Emanual, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Blue Ridge Home First

Contact Person: Jane Addison, RN jgaddison@pruitthealth.com
706-258-5300, Fax 706-632-0028
6050 Appalachian Hwy
Blue Ridge, GA 30513
Counties: Bartow, Catoosa, Cherokee, Chattooga, Dade, Dawson, Fannin, Floyd, Gilmer, Gordon,

Case management Provider Main Offices
Lumpkin, Murray, Pickens, Rabun,Towns, Union, Walker, White, Whitfield

Macon Home First

Contact Person: Mildred O'Neal moneal@pruitthealth.com
478-474-0979 Fax: 478-474-2068
6060 Lakeside Commons Drive
Macon, GA 31210
Counties: Baldwin, Bibb, Butts, Crawford, Harris, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriweather, Monroe, Montgomery, Peach, Pike, Putnam, Spaulding, Talbot, Taylor, Treutlen, Twiggs, Upson, Wheeler, Wilkinson

Savannah Home First

Contact Person: Mary Cuff, mcuff@pruitthealth.com
Ph: 912-925-9181, Fax: 912-925-934
9100 White Bluff Road, Ste. 303
Savannah, Georgia 31406
Counties: Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charleton, Chatham, Effingham, Evans, Glynn, Liberty, Long, McIntosh, Pierce, Tattnall, Toombs Wayne

Valdosta Home First

Contact Person: Trina Still tstill@pruitthealth.com
229-241-8750 Fax: 229-241-8940
312 Canna Drive
Valdosta, Georgia 31602
Counties: Atkinson, Berrien, Brooks, Clinch, Coffee, Colquitt, Cook, Echols, Jeff Davis, Lanier, Lowndes, Thomas, Ware

On My Watch

Contact Person: Lisa Peden
800-689-5123, Fax: 7063540837
1711 Prince Ave
Athens, Georgia 30606

Counties: Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton

APPENDIX FF

Enhanced Primary Care Case Management Application

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

Title

Telephone Number: Fax Number:

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 of 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 of 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 of 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.

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 and 1302 so that duties and responsibilities are clearly documented. Confirm with Physician that PCP for member will meet on specified day/ time with Case Manager bi-annually. 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.
   ii. From this discussion with the Acute Care provider, describe how the program will work with Acute Care Providers admission and/or discharge departments and
   iii. How will the company track emergency room visits and hospitalizations

County	Physician	Address	Days for client appointments	Acute Care Hospital with Contract

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
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:

Department of Community Health

2 Peachtree Street NW

37th floor, c/o SOURCE Program Specialist

Atlanta, GA 30017

APPENDIX GG
EPCCM Expansion Application

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.

NOTE: There will be an audit requirement for any Case Management agency that requests an expansion of their service area. A negative audit can result in a denial of the expansion and a ban on new admissions applied as corrective action until the agency regains compliance. 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

PROVIDER COMPLAINT LOG

Suspension of Referrals as Corrective Action

The CM agency may ask for referrals to be suspended when appropriate documentation supports this action. DCH will review the documentation sent and send the suspension letter to the provider.

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A. Reasons for Suspending Referrals

A provider may 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 numerous complaints related to member care/issues
- Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
- Provider fails to attend 2 or more meetings in a year.

B. Definition of Suspension of Member Referrals

When a provider agency is suspended by DCH from referrals, 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.

C. Procedure for Suspension of referrals

The Department of Community Health will notify the provider in writing that the provider agency has been suspended from the active provider 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 suspension of referrals will be imposed for a specific period of time. 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.

D. Due Process (See also section 1409)

The provider shall have ten (10) days from the date of the written notice of removal from 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;
Atlanta, GA 30303
this address should be specified in the corrective action notice to the provider

SOURCE Case Management Agencies will utilize the Complaint Log in this section to document all complaints from members/representatives.

1. Fill out the form for each provider for which a complaint is received. This form is not time limited and should remain going. Do not fill out a complaint form until a complaint is received.
2. Review the complaint log with the providers at each Provider Conference to ensure conversation around problems reported.
3. Notify DCH immediately of any complaints of abuse, neglect, or exploitation. Notify DCH of numerous complaints that have not been corrected by the provider. DCH will review and take action needed for providers needing corrective action.

APPENDIX HH

Case Management Complaint Log For SOURCE

Complaint Log Categories:

Abuse, Neglect, Exploration
Missed visits
Task not performed/not adequate
Aide Late
Aide not staying time ordered
No RN Supervision
Lack of Communication from Provider
Provider fails to provide services as ordered on Care PLan
Provider overcharges for services
Provider fails to refund fees
Other: Specify

HCBS Provider: _____

Date	Nature of Complaint	Client	Caller	CM	CM Intervention/Comments	DCH Intervention	Outcome/date	Supervisor Signature

APPENDIX JJ

Case Management Agency Monthly Report

1.Agency Name: _____ 2.Report Month: _____

3.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:_____
8. Current Active Members: _____

8a. Unduplicated Members with yearly "Flu Shot" _____

8b Total members 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:

DON-R Score	# Members on WL	DON-R Score	# Members on WL

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.

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)

Date:		Member Name Important Diagnosis: Caregiver (CG) name:	
	Column A	Column B	Comments:
Function	Level of Impairment	Unmet Need for Care	If scores 1-3 explain why client needs assistance ie bad leg, weak arm, dementia etc
1. Eating			
2. Bathing			
3. Grooming			
4. Dressing			
5. Transferring			
6. Continence			

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; • 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.

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

APPENDIX KK
DETERMINATION OF NEED- REVISED (DON-R)

			Member's Name:
Function	Column A LOI	Column B Unmet Need	Comments: If scores 1-3 give reason why client needs assistance ie bad leg, weak arm, dementia etc
7. Managing Money			
8. Telephoning			
9. Preparing Meals			
10. Laundry			
11. Housework			
12. Outside Home			
13. Routine Health			
14. Special Health			
15. Being Alo ne			
Total 1-6 (ADL)			
Total 7-15 (IADL)			
Total 1-15 (ADL+ IADL)			

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; • 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.

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)

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 1 - Activities of Daily Living Included in the Determination of Need (DON)

BASIC ACTIVITIES OF DAILY LIVING (BADL)	INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
Eating	Managing Money

Bathing	Telephone
Grooming	Preparing Meals
Dressing	Laundry
Transfer (In and Out of Bed/Chair)	Housework
Bowel/Bladder Continence	Outside Home
	Routine Health
	Special Health
	Being Alone

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.

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 some 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.

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 laundramats, 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 AHS 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:

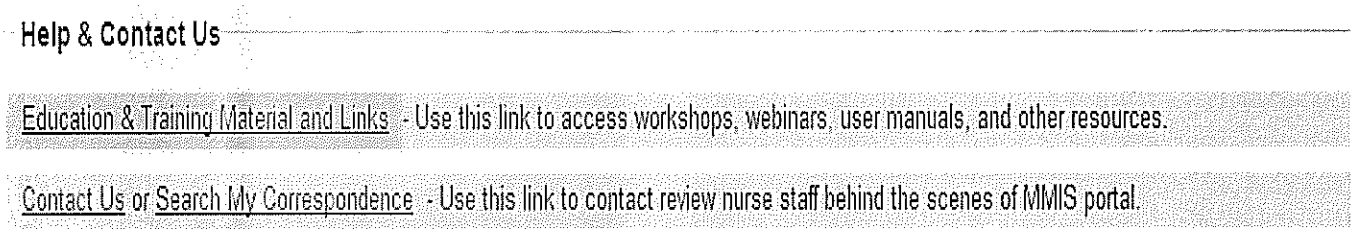
Open the web portal at www.mmis.georgia.gov

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***



If AHS 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 AHS

- The member receives this information in their denial letter and will have 30 business days to provide new information to AHS 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 30 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.
- If the member does not give new information, no new denial letter will be issued from AHS. The member continues to have the right to ask for an appeal within 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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

- The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE.**"
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE.**"
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE.**"
Item Number 10d	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.** **FOR DCH/HP:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	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
Item Number 11d	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?)
Item Number 14	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." **FOR DCH/HP: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).**
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 Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).

Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/HP:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/HP:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	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)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	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. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F **FOR DCH/HP**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE.**"
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu.

Name _____ Age _____

Is patient alert? _____ Level of education _____

__/1 (0) (1) 1. What day of the week is it?

__/1 (0) (1) 2. What is the year?

__/1 (0) (1) 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

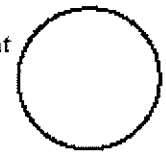
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
(0) (1) How much did you spend?
__/3 (0) (1) (2) How much do you have left?

6. Please name as many animals as you can in one minute.
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 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.
__/2 (0) 87 (1) 649 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(0) (1) (2) Hour markers okay
__/4 (0) (1) (2) Time correct

__/2 (0) (1) 10. Please place an X in the triangle.

(0) (1) 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.

__/8 (0) (1) (2) What was the female's name?
(0) (1) (2) When did she go back to work?
(0) (1) (2) What work did she do?
(0) (1) (2) What state did she live in?

_____ TOTAL SCORE

Department of Veterans Affairs

SAINT LOUIS UNIVERSITY

SCORING		
HIGH SCHOOL EDUCATION		LESS THAN HIGH SCHOOL EDUCATION
27-30	Normal	25-30
21-26	MNCD*	20-24
1-20	Dementia	1-19

* Mild Neurocognitive Disorder

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. J am Geriatri Psych (in press).

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.

http://aging.slu.edu/index.php?page=assessment_videos
http://www.elderguru.com/slums-dementia-test-available-in-various-languages/

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 tumosan@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:

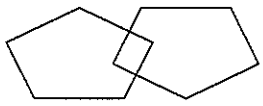
1. Complete resident demographics at the top of the page.
2. We recommend that you put the date and the name of the evaluator on the bottom of the page as well (see #19).
3. Administration should be conducted privately and in the examinee's primary language. Be prepared with the items you need to complete 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.

09/03/09

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: ***Ask the questions in the order listed. Score one point for each correct response within each question or activity.***

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

Instructions for administration and scoring of the MMSE

Orientation (10 points):

- Ask for the date. Then specifically ask for parts omitted (e.g., "Can you also tell me what season it is?"). One point for each correct answer.
- Ask in turn, "Can you tell me the name of this hospital (town, county, etc.)?" One point for each correct answer.

Registration (3 points):

- Say the names of three unrelated objects clearly and slowly, allowing approximately one second for each. After you have said all three, ask the patient to repeat them. The number of objects the patient names correctly upon the first repetition determines the score (0-3). If the patient does not repeat all three objects the first time, continue saying the names until the patient is able to repeat all three items, up to six trials. Record the number of trials it takes for the patient to learn the words. If the patient does not eventually learn all three, recall cannot be meaningfully tested.
- After completing this task, tell the patient, "Try to remember the words, as I will ask for them in a little while."

Attention and Calculation (5 points):

- Ask the patient to begin with 100 and count backward by sevens. Stop after five subtractions (93, 86, 79, 72, 65). Score the total number of correct answers.
- If the patient cannot or will not perform the subtraction task, ask the patient to spell the word "world" backwards. The score is the number of letters in correct order (e.g., dlrow=5, dlorw=3).

Recall (3 points):

- Ask the patient if he or she can recall the three words you previously asked him or her to remember. Score the total number of correct answers (0-3).

Language and Praxis (9 points):

- Naming: Show the patient a wrist watch and ask the patient what it is. Repeat with a pencil. Score one point for each correct naming (0-2).
- Repetition: Ask the patient to repeat the sentence after you ("No ifs, ands, or buts."). Allow only one trial. Score 0 or 1.
- 3-Stage Command: Give the patient a piece of blank paper and say, "Take this paper in your right hand, fold it in half, and put it on the floor." Score one point for each part of the command correctly executed.
- Reading: On a blank piece of paper print the sentence, "Close your eyes," in letters large enough for the patient to see clearly. Ask the patient to read the sentence and do what it says. Score one point only if the patient actually closes his or her eyes. This is not a test of memory, so you may prompt the patient to "do what it says" after the patient reads the sentence.
- Writing: Give the patient a blank piece of paper and ask him or her to write a sentence for you. Do not dictate a sentence; it should be written spontaneously. The sentence must contain a subject and a verb and make sense. Correct grammar and punctuation are not necessary.
- Copying: Show the patient the picture of two intersecting pentagons and ask the patient to copy the figure exactly as it is. All ten angles must be present and two must intersect to score one point. Ignore tremor and rotation.

(Folstein, Folstein & McHugh, 1975)

Interpretation of the MMSE

Method	Score	Interpretation
Single Cutoff	<24	Abnormal
Range	<21	Increased odds of dementia
	>25	Decreased odds of dementia
Education	21	Abnormal for 8th grade education
	<23	Abnormal for high school education
	<24	Abnormal for college education
Severity	24-30	No cognitive impairment
	18-23	Mild cognitive impairment
	0-17	Severe cognitive impairment

Sources:

- Crum RM, Anthony JC, Bassett SS, Folstein MF. Population-based norms for the mini-mental state examination by age and educational level. *JAMA*. 1993;269(18):2386-2391.
- Folstein MF, Folstein SE, McHugh PR. "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12:189-198.
- Rovner BW, Folstein MF. Mini-mental state exam in clinical practice. *Hosp Pract*. 1987;22(1A):99, 103, 106, 110.
- Tombaugh TN, McIntyre NJ. The mini-mental state examination: a comprehensive review. *J Am Geriatr Soc*. 1992;40(9):922-935.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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:

Section A. Identification Date of Visit_____

Member Name: _____ DOB _____ Medicaid number _____

Place of Assessment: ☐ Home ☐ Hospital ☐ Nursing Home ☐ ALS/PCH ☐ other _____

Section B. Reason for evaluation

☐ Discharged from Nursing Facility ☐ Discharge from institutional stay (mental health) ☐ Internal Transfer

☐ External Transfer ☐ Change in function (cognitive or physical) ☐ Other _____

Section C. Diagnoses (if applicable, include diagnosis relevant to nursing facility or institutional stay and/or change in function)

1. _____ 2. _____ 3. _____

Section C. Carepath Goals

Community	Service Recommended	Provider	Frequency/Units
Nutrition/Weight	Ordered diet: _____ ☐ Weight gain (90 days) ☐ Weight Loss (90 days)		
Skin Care	☐ No skin breakdown ☐ Decubitus ulcer/stage and location _____ ☐ Other wound/ulcer (specify) and location _____ ☐ Wound care provider and frequency _____		
Clinical Indicators	☐ Self-monitoring ☐ BP ☐ Blood sugar ☐ Weight ☐ Other _____ ☐ Assisted monitoring ☐ Dialysis ☐ Chemotherapy/radiation ☐ Oxygen Nursing Facility admit date_____ discharge date _____		
Medication	☐ Self-monitoring ☐ Compliant ☐ Noncompliant ☐ Needs assistance ☐ Medication list updated		
ADL/IADL Performance (S-Self; INF-informal support; PSS)	____ bathing __dressing ____ eating ____ transferring _____ toileting ____ walking _____ managing finances _____ errands ____ meal prep _____ laundry _____ shopping _____ transportation		
Transfers	☐ cane ☐ walker ☐ wheelchair ☐ bedbound ☐ other _____ ☐ fall in 30 days ☐ fall in 90 days ☐ fall with injury in 90 days _____		
Problem Behavior	☐ Alzheimer's ☐ Dementia ☐ mental health ☐ substance abuse ☐ depression ☐ Other _____		
Informal Support/Caregiver	☐ indicators present for caregiver burnout ☐ adequate caregiver support/name _____		
Other – Continence, Housing, Hospice, other	☐ UTI/other urinary related infection ☐ Urinary Incontinence ☐ Bowel Incontinence ☐ Request to move ☐ Dual enrollment hospice/provider _____		

Additional information (i.e. home health, PT, OT, ST, etc.)

_____

_____

_____

Member signature _____ **Date** _____

LPN/RN Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____

Appendix SS

Client Name:				Date:	
Med Name	Dosage	Route	Frequency	Indication	Physician

- Problems identified that need reported to the MD?

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

The Division of Aging Services (DAS) of the Georgia Department of Human Services (DHS) provides Adult Protective Services (APS) for the prevention of abuse, neglect and exploitation of older individuals (65+) or adults (18+) with a disability who do not reside in long-term care facilities. 1.866.552.4464 option 3 http://aging.dhs.georgia.gov

Healthcare Facility Regulation 1.800.878.6442 (Mandated reporters must report abuse in licensed facilities) www.dch.georgia.gov

State Long-Term Care Ombudsman- 1.866.552-4464 (Advocates for resident in long-term care facilities). www.georgiaombudsman.org

Aging and Disability Resource Connection- www.georgiaadrc.com (Web-based resource guide of partnering organizations) 1.866.552.4464 option 2.

- **Abuse** – is defined as any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a client, including but not limited to assault or battery, failure to provide treatment or care, or sexual harassment of the client. Abuse may be mental, verbal, sexual, or physical.
- **Neglect** – is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
- **Exploitation** – is defined as an unjust or improper use of another person or the person's property through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one's own profit or advantage.
- **Mistreatment** – is defined as any behavior or practice that has the potential to or results in any type of individual exploitation.
- **Unexpected Death** – is defined as death that occurs suddenly when the individual is in apparent good health or as the result of homicide, suicide, or accident.
- **Serious Injury** – is defined as bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, sexual assault, violence, protracted and obvious disfigurement or impairment.
- **Elopement** – is defined as a cognitively impaired person successfully leaving a facility unsupervised and undetected.

Office of Inspector General- (OIG/HHS) Medicare /Medicaid Fraud Control Unit-1.800.447.8477 option 5 http://oig.hhs.gov/fraud/hotline

Food Stamp Fraud (OIG/USDA)- 1.800.447.8477 option 1

Social Security Fraud (OIG/SSA) 1.800.447.8477 option 2

Governor's Office of Consumer Protection- 1.800.869.1123 http://consumer.georgia.gov

Elderly and Disabled Waiver Program (EDWP)

Physicians Evaluation

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

Agency's Name , Address, Phone & Fax	Member's Name	Medicaid Number	
	Member's Address	Sex:	DOB
	City, State, Zip	Male Female	

SECTION II – MEDICAL REPORT

NOTICE TO PHYSICIAN: This member has requested services from the EDWP. Members must meet a nursing home level of care. Please complete the information below to document the patient's current condition, physical and cognitive limitations, and capabilities. Timely completion will support a prompt decision on the patient's application. Please return completed form to the agency listed in Section I.

Date of Last Exam:		Active Diagnosis(es) that limit ability to perform ADLs		
Current Medications and Uses:				
General Findings Height: _____ft. _____in.	Weight: _____lbs.	BP:	HGB AIC:	Other labs:

Physical Functional Disability

IMPAIRMENT	PRESENT	ABSENT	Describe physical/functional disability
Mental/Developmental Disorder			
Moderate/Severe Cognitive Disorder			
Requires assist of person to transfer			
Stage III or IV ESRD			
Stage III or IV Decubiti			
Uncontrolled seizures			
Severe SOB or continuous oxygen			
Falls History/Gait or balance disorder			
Limited ROM (See below)			
Driving restrictions			

Comments-

Muscle Strength Grading Scale (Oxford Scale):

0/5 – No Contractures
1/5 – Visible/palpable muscle contraction but no movement
2/5 – Movement with gravity eliminated
3/5 – Movement against gravity only
4/5 – Movement against gravity with some resistance
5/5 – Movement against gravity with full resistance

	UPPER EXTREMITIES		LOWER EXTREMITIES	
	Right	Left	Right	Left
A. Proximal	____	____	____	____
B. Distal	____	____	____	____

Print Physician Name/Title | Physician Signatures/Title | Phone Number | Date

Enhanced Case Management Disease Management Physician letter

Member Name-_____

Member DOB-_____

Physician Name-_____
Sent via fax: # _____ ☐ NA
Sent via mail: address _____ ☐ NA
Hand delivered: date_____ ☐ NA
Sent via email: address _____ ☐ NA

The Member above is active in the Elderly and Disabled Waiver Program. The Member entered the program on _____. Current services for this Member are listed below.

Based on specific criteria within the waiver, this member qualifies for Enhanced Case Management by virtue of reporting several chronic conditions which require medical oversight and long-term care services.

Information for the physician or other healthcare provider:

Observations noted during the home visit(s)

Medications in the home, self-reported use and prescriber:
See medication list.

For a full description of the Elderly and Disabled Waiver and available services, please visit our website at https://medicaid.georgia.gov/waiver-programs

Services provided to your patient:

☐ Personal Support Service- _____
☐ Emergency Response System- 24 hour alert system
☐ Home Delivered Meals-_____
(include frequency and meal type … low sodium, renal, diabetic etc.)
☐ Adult Day Health (center)- _____
☐ Skilled Nursing Services- _____
☐ Alternative Living Service- (24 hour personal care home)
☐ Out of Home Respite- _____

Other observations related to your patient's care needs:

Please feel free to contact the case management office with any additional questions or requests.

Sincerely,
Case Management Site info here with address and phone contact.

Instructions
Enhanced Case Management Disease Management Physician letter

Purpose: This form is used as a communication tool to the Member's Primary Care Physician to notify of entrance and ongoing placement of a client in the Enhanced Case Management

Who Complete/When Completed: Complete at initial assessment and every six months thereafter.

Instructions:

1. Complete all applicable sections. Be sure all information is included is relevant to the client's medical care. Attach medication list.

2. Submit via mail, email, fax or hand delivery to the Member's Primary Care Physician

3. File original/copy (depending on submission type) in Member file/upload to the electronic data system formal notes if applicable.

4. The form is not intended for return by the Physician but may do so if needed.

Optional

Disaster Preparedness for Elderly and Disabled Waiver Program Participants

1st- Create an Emergency Plan

❑ Meet with household members to discuss the dangers of fire, ice storms, tornados, hurricanes and other emergencies.
❑ Find the safe spots in your home for each type of disaster.
❑ Pick two emergency meeting places.
1) A place near your home in case of a fire
2) A place outside your neighborhood in case you cannot return home after a disaster
❑ Assess your ability to exit the home, do you need assistance? (wheelchair/stretcher transport/ramp etc.)
❑ Discuss what to do about power outages. What DME will not work without power (CPAP, O2)?
❑ Contact your power company and request to be on a priority list in case the power goes out.
❑ Discuss back up power options with your DME supplier.
❑ Post emergency telephone numbers near telephones that includes family/caregivers/medical related contacts/EDWP providers etc.
❑ Teach children/grandchildren how and when to call 911, police and fire.

2nd- Prepare a Disaster Supplies Kit

Assemble supplies you might need in an evacuation. Store them in an easy-to-carry container such as a backpack or duffle bag.

Include:
❑ A supply of water (one gallon per person per day) start with 3-5 days' worth, identify the storage date and replace every six months.
❑ A supply of non-perishable packaged or canned food and a non-electric can opener (soups, dry cereal, peanut butter, canned juices and milk, protein bars, ensure).
❑ A change of clothing, rain gear and sturdy shoes
❑ Blankets or sleeping bags
❑ A first aid kit and prescription medications in original containers- (7-day supply)
❑ An extra pair of glasses/contacts
❑ Hearing aid/extra batteries
❑ Cell phone/charger
❑ Moist towelettes or hand sanitizer
❑ Battery-powered radio, flashlight and plenty of extra batteries
❑ Credit cards and cash
❑ An contact list of physicians, DME/oxygen companies and service providers (include specialty clinics i.e dialysis clinic)
❑ Special items diapers, adult briefs, pads, syringes, specialized care equipment (tracheostomy clients/vent clients)
❑ Label all DME equipment (e.g. wheelchair, canes, walkers) with your name, address and phone numbers.
❑ Keep family records in a water and fire-proof container. Assign someone to grab the box in an emergency.

3rd- Create a Support /Communication Network

Do you have a support person who will agree to help you during a time of disaster? If so, make sure you know how to get in touch with the person, and that they know to check on you in the event of an emergency.

4th- Stay Informed

❑ Contact your local Emergency Management Agency and discuss how they communicate during disasters. Be sure to sign up for all local notification systems including social media.
❑ Pick one out-of-state and one local friend or relative for family members to call if separated during a disaster.
❑ Make arrangements someone knows to check on you and keep you informed during a disaster e.g. neighbor, caregiver, neighborhood watch, neighborhood block associations or faith-based organizations if you live alone.

SAMPLE

Disaster Plan For

_____

How would you survive if your water or power supply were interrupted for several days?

_____

Who will you call for assistance?

_____

Do you have cash on hand to buy ordinary supplies? _____

Do you have a disaster supplies kit prepared? _____

EMERGENCY DISASTER PLAN

Instructions

Elderly and Disabled Waiver Program

Disaster Preparedness for Elderly and Disabled Waiver Program Participants

Purpose:
To provide assistance and documentation, in writing, to the EDWP client by identifying resources and developing a plan to ensure his/her health and safety in the event of disruption in services in the event of a disaster (environmental and/or occurrence).

Who Completes/When Completed:

- At initial assessment, the RN/LPN introduces the disaster preparedness document as a part of the initial client admission packet review and requests the client to formulate his/her personal plan
- At the first quarterly face to face visit, the case manager reviews the document with the client and assists the client with writing his/her personal disaster plan
- At each subsequent Quarterly Review, the case manager (nurse or social services) will review the plan with the client and assist with making changes as needed or appropriate

Instructions for Completion:

1. Review all sections (1-4) of the Disaster Preparedness for Elderly and Disabled Waiver Program Participants with the client/care giver

2. Assist the client, as needed; with identifying his/her own unique safety risks through responses to the questions in Sections 1-4.

3. Using the sample personal "Disaster Plan", document the client's plan.

4. Include in the plan information about access to medical treatment (i.e. dialysis) or medical equipment which requires electricity to function (oxygen, ventilator, power wheel chair or power hospital bed)

5. Document the care plan (check box) to indicate the presence the client's emergency plan

6. Review the plan with the client/care giver at each care plan review and update when changes in needs, formal/informal supports and/or resources occur.

Distribution: Copy of the Emergency Plan is retained by the client in his/her home in the Client Folder

Optional

DISCHARGE PLANNING CHECKLIST

DATE: **Client Name** **Admission Date to EDWP**

I- Discharge Planning

Is client able to participate in discharge planning process? ☐ **Yes** ☐ **No**

Reason if not:

Caregiver helping with Discharge Planning if client is unable:

Relationship to client:

II- Backup Care

Can client be left alone safely? ☐ **Yes** ☐ **No** If so, for what length of time?
In the event an emergency occurs and the caregiver has to leave the home, who or what is the backup plan to provide this care until the caregiver returns? Is there another backup in the event the caregiver is the one experiencing an emergency?
How long is the backup caregiver(s) available for?
Would the backup person be able to provide nighttime care? ☐ **Yes** ☐ **No**
If not, what is the plan to ensure this care is provided if needed?
Backup caregiver name and phone number?
Does the client have emergency placement in the event he/she had to evacuate the home quickly?
☐ **Yes** ☐ **No**

III-Client's Preferences for Care Following Discharge from EDWP: (select first and second choice)

Family

Name Amount of Care
Location care will be given

Nursing Home

NH Name County

Community Resources
List names of programs requested to provide assistance

Private Arrangements/Friends
Provide agency/names

MD will determine/order care when EDWP can no longer meet client's needs

Other (specify)

Optional

IV-Follow-up
MD name and telephone number:

Resources that may be needed following discharge**:**

Special equipment that may be needed following discharge:

EDWP Providers to be contacted to assist with discharge planning if necessary:

*****Remind Client/Caregiver to inform EDWP of any changes in discharge plan during assessment/review visits*****

Optional

Instructions

Elderly and Disabled Waiver Program

DISCHARGE PLANNING CHECKLIST

Purpose: To provide assistance and written documentation to the EDWP client by identifying resources and developing a plan to ensure his/her health and safety in the event of disruption/loss of EDWP services.

Who Completes/When Completed:

- At initial assessment, the nurse introduces the document as part of the initial client admission packet review and requests the client to formulate his/her personal plan
- At the 30 Day Comprehensive Care Plan Review, the care coordinator reviews the document with the client and assists the client in writing his/her personal plan
- At each subsequent quarterly review, the case management (nurse or social services) will review the plan with the client and assist in making changes as needed or appropriate

Instructions:

Enter today's date, client's name admission date to EDWP

1. Review all sections (I-IV) of the Discharge Planning Checklist for Community Care Services Program participants with the client/care giver

2. Assist the client in identifying his/her own unique plan through responses to the questions in Sections I-IV

3. Document the care plan discharge plan section to indicate the client's discharge plan

4. Review the plan with the client/care giver at each care plan review and update when change in needs

Distribution: During the initial assessment, the original is given to client. A copy is filed in the client's case record.