

ILLINOIS DEPARTMENT ON AGING (IDoA)  
**DIVISION OF HOME AND COMMUNITY SERVICES**

<b>Title:</b> Community Care Program (CCP) Participant Verification of Services—update January 2014	<b>CREATED:</b> January 21, 2014 <b>By:</b> Joseph Mason	
	<b>ELECTRONIC FILE NAME:</b> CCP Verification of Services update.1.14	
	<b>EFFECTIVE DATE:</b> April 1, 2014	
<b>OPERATIONS POLICY:</b> IDoA will implement policy and procedure for a CCP participant’s verification of services.	<b>Last Revisions:</b> N/A	<b>By:</b> N/A
	<b>Approved By:</b> Mary Killough	<b>Date:</b> January 21, 2014
<b>Search Word(s):</b> Verification of services	<b>Pertains to:</b> <input checked="" type="checkbox"/> CCU <input checked="" type="checkbox"/> In-Home Service <input type="checkbox"/> Adult Day Service <input type="checkbox"/> Emergency Home Response Service <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Other: Managed Care Organizations (MCOs)	
<b>REQUIREMENT:</b> Each In-Home Service agency will follow IDoA’s policy and procedure for verification of service by a CCP participant.	<b>RULE REFERENCE:</b> <b>OTHER REFERENCE(S):</b> Electronic Visit Verification (EVV) Standards April 1, 2013	
	<b>Rescinds Previous IDoA Policy:</b>	
	<input type="checkbox"/> N/A	<input checked="" type="checkbox"/> Yes
	<b>Title:</b> Community Care Program (CCP) Participant Verification of Services	<b>Date:</b> October 29, 2013

**PURPOSE:**

The purpose of this policy is to notify In-Home Service agencies of the procedure for a Community Care Program (CCP) participant to verify service received by the Homecare Aide (HCA). Electronic Visit Verification (EVV) Standards policy was sent to all In-Home Service agencies on April 1, 2013, to be effective July 1, 2013. The EVV system is designed to electronically track and document time spent by a HCA

in the CCP participant's home. This policy has been updated and the effective date changed to reflect questions expressed by CCP In-Home Service providers.

## **POLICY:**

With the advent of the EVV system, a CCP participant is no longer required to verify time spent by a HCA in a participant's home. This has eliminated the requirement for a paper Hours of Service Calendar (HOSC). However, IDoA is requiring In-Home Service providers to implement procedures for a CCP participant to verify services are being received in accordance with the CCP Plan of Care (POC) prior to the elimination of the paper HOSC. The procedures must contain provisions that ensure usage of a HIPAA compliant and secured system that will protect the CCP Participant/authorized representative identification and other individual privacy information when completing electronic verification of services received. (Note: Only In-Home Service agencies with a fully operational EVV system may implement this policy. All other In-Home Service agencies must follow the paper HOSC until their EVV system is fully operational.)

## **PROCEDURES:**

### **PROVIDER RESPONSIBILITIES**

The following procedures will be utilized by In-Home Service provider agencies regarding a CCP participant verifying service provided by a HCA.

- 1) Paper HOSCs verifying the time the HCA arrived and departed the participant's residence are no longer required as these are tracked by the EVV system utilized by the provider agency.
- 2) A CCP participant/authorized representative is required to verify the service received each time a HCA is present in the participant's residence.
- 3) The verification must reflect tasks (i.e. laundry, assisted with bathing) which have been completed by the HCA. The individual amount of time for each task does not have to be verified.
- 4) The following methods are acceptable verification of service:
  - a) An In-Home Service provider may utilize a secured, HIPAA and ADA compliant method to capture electronic participant/authorized representative verification. This verification should be done at the end of the completed visit. The In-Home Service provider should work with the EVV company they are utilizing on the best method for their system and may have more than one option to offer maximum reliability and flexibility with various technology platforms. Examples of the electronic verification methods for participant/authorized representative include, but are not limited to, voice biometrics (voice print), mobile e-signature, fingerprint technology, or internet portal verification. If electronic verification is utilized, a baseline for

the method must be established when the participant's services are initiated. The verification method must enable the participant/authorized representative to have a unique and protected identification to protect identities and help prevent against fraud, and must be able to record each verification. The verification data must be able to be uploaded into a secured computer/data system by the provider agency. The data must be collected and reviewed by a homecare supervisor a minimum of one time a month.

**OR**

- b) An In-Home Service provider may utilize a paper form and signature of a CCP participant/authorized representative. Each In-Home Service provider may develop its own paper format. However, each form must contain the following elements: date of service, tasks completed, CCP participant/authorized representative signature, HCA signature, and homecare supervisor signature. The data must be collected and reviewed by a homecare supervisor a minimum of one time a month.
- 5) In-Home Service providers have until the effective date of this updated policy to implement this procedure. Documentation of verification of tasks described in this policy will be subject to review for compliance after the effective date of this updated policy.
- 6) The method of verification must be available for review upon request by IDoA or its designee.
- 7) When a discrepancy occurs between the tasks verified and the participant's POC from the CCU, the homecare supervisor shall discuss this with the HCA. The reason for a discrepancy must be documented if the task is not completed according to the POC. For example, if housework one time a week is on the CCU POC and no housework is performed by the HCA for a week's period, the reason must be documented, i.e. family performed, participant refused, etc. Service must be provided as authorized by the POC.
- 8) The homecare supervisor should contact the CCU if tasks are consistently not completed in accordance with the CCU POC. Infrequent deviations may occur such as when a task indicated on the POC has already been completed by someone else or the participant needs extra personal care due to a health concern. Infrequent deviations, such as the examples provided above, are not required to be reported to the CCU. However, if a provider agency notices a recurring pattern of deviations, the provider should contact the CCU for an adjustment to the Client Agreement and POC. Provider agencies are encouraged to notify the CCU if they are uncertain if a deviation is considered infrequent or a recurring pattern. The homecare supervisor should document such communication in the participant's file.

## **CCU RESPONSIBILITY:**

- 1) CCU Care Coordinators are required to utilize the Service Authorization Guidelines outlined in the policy dated April 2, 2013, titled "Community Care Program (CCP) Service Authorization Guidelines."
- 2) When a homecare supervisor contacts a Care Coordinator to request an adjustment to the POC, the Care Coordinator is required to contact the participant/authorized representative within fifteen (15) calendar days of the request.
- 3) The Care Coordinator is required to complete a new Client Agreement and/or POC to reflect the changes and distribute the revised forms as noted in the CCP Forms Instructions dated July 2012.

ILLINOIS DEPARTMENT ON AGING (IDoA)  
**DIVISION OF HOME AND COMMUNITY SERVICES**

<b>Title:</b> Annual Quality Assurance Surveys	<b>CREATED:</b> January 25, 2011 <b>By:</b> R. Morgan	
	<b>ELECTRONIC FILE NAME:</b> Annual QA Surveys 1.11	
	<b>EFFECTIVE DATE:</b> January 25, 2011	
<b>OPERATIONS POLICY:</b> IDoA will implement policy and procedure for annual quality assurance surveys.	<b>Last Revisions:</b> N/A	<b>By:</b> N/A
	<b>Approved By:</b> M. Killough	<b>Date:</b> January 25, 2011
<b>SEARCH WORD(S):</b> Satisfaction Surveys Surveys Quality Assurance Surveys	<b>Pertains to:</b> <input checked="" type="checkbox"/> CCU <input checked="" type="checkbox"/> In-Home Service <input checked="" type="checkbox"/> Adult Day Service <input checked="" type="checkbox"/> Emergency Home Response Service <input type="checkbox"/> Other	
<b>REQUIREMENT:</b> Each Care Coordination Unit and CCP provider will follow IDoA's policy and procedure and make any necessary changes to their quality assurance survey system.	<b>RULE REFERENCE:</b> 240.1510 f)	
	<b>OTHER REFERENCE(S):</b>	
	<b>Rescinds Previous IDoA Policy:</b>	
	<input type="checkbox"/> N/A	<input checked="" type="checkbox"/> Yes
<b>Title:</b> Annual Quality Assurance Surveys		<b>Date:</b> Dec. 7, 2009

**PURPOSE:**

The purpose of this policy is to establish procedures regarding quality assurance surveys (customer satisfaction surveys) required by Administrative Rule and Medicaid Waiver requirements. Illinois Department on Aging (IDoA) Administrative Rule requires that provider agencies conduct annual quality assurance surveys for Community Care Program (CCP) participants.

A quality assurance survey, or "client satisfaction survey" as it is commonly called, is a tool that can be used by agencies to measure the quality of the services being

provided. The results of the survey will enable agencies, and the Department, measure the effectiveness of delivered services, isolate service patterns across regions, participants and staff, and identify and remediate systemic issues. Requesting feedback from participants provides an avenue for them to share thoughts on their service and offer suggestions for improvement. Administrative Rule requires all Care Coordination Units (CCUs) and provider agencies to conduct quality assurance surveys at least annually.

### **POLICY:**

IDoA, in conjunction with the CCUs and provider agencies, will conduct and tabulate the data for the surveys. Each CCU and provider agency is responsible for ensuring that the following procedures are followed.

### **PROCEDURES:**

The following will be the procedure utilized by IDoA for quality satisfaction assurance administration and collection.

- 1) The Department will provide CCUs and provider agencies with the list of participants to be surveyed by July 1<sup>st</sup> of each calendar year. This list will be broken down by contract number and will be electronically mailed to the agencies. Each agency is required to verify participant information and addresses and return the information to IDoA within 10 calendar days. Failure to respond within the designated timeframes could result in contract action.
- 2) Quality Assurance surveys will be conducted by IDoA annually during the month of September. Twenty-five percent of active participants shall be surveyed annually. The Department will distribute the surveys via mail by August 31st of each calendar year. The mailing will include a survey for care coordination, a provider survey related to the service type the participant receives, and a stamped envelope for returning the surveys to IDoA.
- 3) Surveys have been developed and authorized for each specific service type. Care Coordinators and provider staff should discuss the survey process with the participants and emphasize the importance of completing the surveys and submitting their comments. Care Coordinators, homecare aides and agency staff shall be instructed that they are not to affect the outcomes of the survey and that the participant, or a family member, should complete the survey when the Care Coordinator, homecare aide, or agency staff person is not present.
- 4) In order to help IDoA achieve a high return response rate during the survey process, agencies shall develop policies, procedures and best practices on activities used to increase response rates by their agencies. Examples of policies, procedures or best practices could include: training Care Coordinators/direct service workers to discuss with the participants the importance of completing and returning the surveys, reminding the

participants during the surveying period to complete the surveys, and educating the Care Coordinators/direct service workers on the importance of the surveys, etc.

- 5) After the surveys are tabulated, data will be provided to CCUs and provider agencies by contract number.
- 6) Agencies are required to develop a policy that shall include:
  - How information obtained through the surveys will be utilized within the agency to make changes to the agency's service provision; and
  - How responses from disgruntled participants, participants that report fraudulent activities, or other negative responses will be addressed.
- 7) CCUs and provider agencies are required to keep documentation of actions taken to support that their policy was followed. This documentation will be reviewed during quality assurance reviews conducted by IDoA or its designee and may be required to be submitted to IDoA upon request.
- 8) In addition to the IDoA survey, CCUs and provider agencies may chose to conduct their own participant satisfaction surveys. Agency surveys may not be conducted during the same survey period as IDoA and notifications must clearly identify that the surveys are being conducted by the provider agency/CCU and not IDoA. Agencies that choose to conduct their own participant satisfaction surveys shall develop policies outlining the procedures that will be used relating to distribution, sampling, analysis, and remediation of the surveys. Documentation of agency surveys may be reviewed by IDoA upon request.

ILLINOIS DEPARTMENT ON AGING (IDoA)  
**DIVISION OF HOME AND COMMUNITY SERVICES**

<b>Title:</b> Limitations on Marketing and Recruiting Activities Under the Community Care Program	<b>CREATED:</b> <b>By:</b> Jose Jimenez	
	<b>ELECTRONIC FILE NAME:</b> Marketing & recruiting limitations	
	<b>EFFECTIVE DATE: OCTOBER 1, 2016</b>	
<b>OPERATIONS POLICY:</b> IDoA will implement a policy and procedure for the enforcement of limitations on marketing and recruiting activities under the Community Care Program and assurance of providing participants with freedom of choice and informed choice process as required by the HCBS Elderly Waiver.	<b>Last Revisions:</b> N/A	<b>By:</b> N/A
	<b>Approved By:</b> Jennifer Reif	<b>Date:</b> September 21, 2016
<b>SEARCH WORD(S):</b> Marketing Activities Recruiting Activities Freedom of Choice Informed Choice	<b>Pertains to:</b> <input checked="" type="checkbox"/> CCU <input checked="" type="checkbox"/> In-Home Service <input checked="" type="checkbox"/> Adult Day Service <input checked="" type="checkbox"/> Emergency Home Response Service <input checked="" type="checkbox"/> Other—MCO for Informational purposes only	
<b>REQUIREMENT:</b> Each Care Coordination Unit and service provider agency will follow IDoA's policy and procedure regarding limitations on marketing and recruiting activities under the Community Care Program.	<b>RULE REFERENCE:</b> 240.1510(v) 240.330 240.340	
	<b>OTHER REFERENCE(S):</b> 42 USC 1396n(d)(2)(C)	
	<b>Rescinds Previous IDoA Policy:</b>	
	<input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Yes
<b>Title:</b>	<b>Date:</b>	

**PURPOSE:**

The purpose of this policy is to provide clarification regarding limitations on marketing and recruiting activities by Care Coordination Units (CCUs) and Community Care Program (CCP) service provider agencies (providers) and Home

and Community Based Services (HCBS) Elderly Waiver. The policy also further clarifies the requirements to ensure participants:

- 1) have a freedom of choice of providers; and
- 2) are able to make an informed choice regarding available services and supports.

All actions by CCUs and providers must comply with freedom of choice for participants.

### **POLICY:**

CCUs and providers cannot engage in marketing and recruiting activities that will impact the right and ability of a participant to have freedom of choice in selecting an authorized provider in his or her geographic area of residence under the CCP.

This policy applies to any and all employees of the CCU and provider, including direct service, supervisory, and management staff.

**Violations of this policy may result in contract action by IDoA, up to and including termination.**

### **PROCEDURES:**

#### **CARE COORDINATION UNITS:**

Care Coordinators are responsible for ensuring the individual and family/authorized representatives are informed of *all* choices that may address the goals and outcomes identified in the person centered plan. Information about all available providers must be provided by the Care Coordinators prior to a participant's final selection regarding services.

Care Coordinators are also responsible for assisting any CCP participant:

- 1) who requests a transfer to another provider; and/or
- 2) whose current provider will no longer be servicing the geographic area.

If a CCU provides other services, it must:

- 1) maintain separate files for its work with the Department and the other services;
- 2) assure via policy and practice that CCU files cannot be accessed by non-CCU staff;
- 3) store files in a secure location; and
- 4) obtain a signed Release of Information from the participant/authorized representative prior to any referral being made for other services.

CCUs must comply with the following limitations regarding marketing and recruiting activities:

- 1) Staff of the CCU must not engage in marketing or recruitment activities at another IDoA contracted entity's building or property.
- 2) Marketing or recruiting material cannot list and/or make reference to the name of another IDoA contracted entity.
- 3) Confidentiality of participant information must be strictly maintained by observing appropriate administrative, physical and technical safeguards. A CCU/employee cannot internally use or provide a list of CCP participants to any other entity to identify potential clients for other services.

**COMMUNITY CARE PROGRAM PROVIDERS:**

Providers must not begin CCP services for an individual until the CCU has completed and forwarded the necessary paperwork to approve eligibility.

Providers must comply with the following limitations regarding marketing and recruiting activities:

- 1) If a participant requests a change in a provider, the participant/authorized representative is required to contact the CCU. Staff of the provider must not take any actions to influence the decision of the participant/authorized representative.
- 2) Staff of the provider must not engage in marketing or recruitment activities at another IDoA contracted entity's building or property.
- 3) Marketing or recruiting material cannot list and/or make reference to the name of another IDoA contracted entity.
- 4) Staff of a provider must not provide misleading or incorrect information regarding the transfer process of a participant under the CCP. A provider must not state a participant will be guaranteed the same assigned staff, the same days/hours of service or that all participants are required to transfer to the same provider in the event of a change in ownership or operation of a business, etc.
- 5) A provider is not allowed to recruit/hire staff from another provider, or offer a sign-on bonus or other compensation, contingent upon that direct service, supervisory, or management staff encouraging participants to request changes and follow them to a new provider.
- 6) Confidentiality of participant information must be strictly maintained by observing appropriate administrative, physical and technical safeguards. A provider/employee cannot internally use or provide a list of CCP participants to any other entity to identify potential clients for other services.

- 7) If a provider has other services provided by their agency, the provider must:
  - a) maintain separate files for its work with the Department and the other services;
  - b) assure via policy and practice that agency files cannot be accessed by non-agency staff;
  - c) store files in a secure location; and
  - d) obtain a signed Release of Information from the participant/authorized representative prior to any referral being made for other services.
  
- 8) All providers must develop and comply with marketing standards for services that:
  - require all persons involved with marketing and sales efforts to refrain from incomplete service comparisons or otherwise misleading representations (twisting) and high pressure sales tactics (playing on explicit or implicit fear and threats);
  - ensure the confidentiality and security of sensitive personal identification, financial and health information of current and prospective program participants that is obtained during discussions;
  - prohibit unsolicited telephone calls (cold-calling) and door-to-door solicitations; sales activities, as opposed to educational or informational activities, at community meetings, educational events and health care facilities; and cross-selling of non-CCP-related services to current and prospective program participants;
  - prohibit the use of independent agents for marketing of CCP-related services to participants; and
  - limit the value of any incentives and promotional products offered to current and prospective program participants.
  
- 9) If a CCP participant/authorized representative requests additional services outside of the CCP Plan of Care, a separate private pay contract must be entered into between the participant/authorized representative and agency.

Illinois Department on Aging

# CCP Forms Instructions & Training Document

Screen shots created from Client Forms Manager

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**Comprehensive Assessment (Page 8):**

**III BEHAVIORAL HEALTH (CONTINUED): MINI-MENTAL STATE EXAMINATION**

Date 01/04/2012 ID.# 222-33-4444

Care Coordinator is to administer all 11 questions equivalent to a score of 30.

Client Name: Anna Smith

- 5 (S) 1. What is the (year) (season) (day) (date) (month)?  
2012 Winter Weds 4th Jan
- 5 (S) 2. Where are we (state) (county) (town) (nursing facility/hospital) (floor)?  
IL Sangam Spgfld 23bayb lane
- 2 (S) 3. Name 3 objects. Allow 1 second to say each. Ask the client all 3 after you have said them. Give 1 point for each CORRECT answer in the first trial only. Then repeat the 3 objects until the client learns all 3. Count trials and repeat the 3 objects until the client learns all 3. Count trials and record. Trials 2
- 4 (S) 4. Spell "WORLD" backwards. Score 1 point for each letter in the CORRECT order.  
D l - o w  
 "D" "L" "R" "O" "W"
- 3 (S) 5. Ask for the three objects repeated in question 3. Give 1 point for each CORRECT answer.
- 2 (S) 6. Identify a pencil and a watch.
- 1 (S) 7. Repeat the following: "No ifs, ands or buts."

- 3 (S) 8. Follow a 3-stage command: "Take a paper in your right hand, fold it in half and put it in your lap."  
 1 (S) 9. Read and obey the following: CLOSE YOUR EYES.  
 1 (S) 10. Write a sentence.  
 0 (S) 11. Copy a design.

Maximum score is 30. Enter TOTAL correct answers for MMSE score. →→→ 27

1. For MMSE box below: If score is equal or more than "21" - enter "0"; if score is "20" or less - enter "10"  
 2. For the MMSE Plus score: Add an additional 10 points to the total MMSE Box below, if appropriate documentation is provided for all three listed below. (Rule 240:715, d) 1) C)

Court adjudication as incompetent or disabled; Physician/Psychiatrist certifies need for 24 hour supervision; and, Physician/Psychiatrist certifies presence of Alzheimer's disease, ODS, or dementia.

A NON-COGNITIVE PROBLEM is affecting the MMSE score:  Yes  No If yes, check the correct non-cognitive problem below:  
 Vision/Hearing Problem  Language Barrier  Low Education/Can't Read  Physical Impairment  Other: \_\_\_\_\_

If Mini-Mental State Examination score total is: 21-30, proceed with the DON; informant not needed. 20 points or less: An informant may be needed.

1. Informant Available:  Yes  No 2. Informant Used:  Yes  No 3. Name: Jennifer Ryan 4. Relationship: Dtr

**E. DETERMINATION OF NEED** (Functional Status - Activities of Daily Living/Instrumental Activities of Daily Living)

FUNCTION	A. LEVEL OF IMPAIRMENT				B. UNMET NEED FOR CARE				Service by CCP	FREQUENCY-for specific needs only	Service by Other	Notes:
1. Eating	0	1	2	3	0	1	2	3			Prt. manages	difficulty cutting
2. Bathing	0	1	2	3	0	1	2	3	IHS		Dtr/weekends	unsteady, brkn hip,
3. Grooming	0	1	2	3	0	1	2	3	IHS		Beautshp 1/wk	
4. Dressing	0	1	2	3	0	1	2	3	IHS		Dtr/wkends	HH helps 2X week/T & Thur
5. Transferring	0	1	2	3	0	1	2	3	IHS			unsteady at times
6. Continence	0	1	2	3	0	1	2	3			Depends	slow mobility
7. Managing Money	0	1	2	3	0	1	2	3			dtr/son	
8. Telephoning	0	1	2	3	0	1	2	3			dtr/cell ph	slow/uses cell phone
9. Preparing Meals	0	1	2	3	0	1	2	3	IHS		prep dinners asnd	dtr/HDM 5x/wk
10. Laundry	0	1	2	3	0	1	2	3	IHS		dtr when able	
11. Housework	0	1	2	3	0	1	2	3	IHS			
12. Outside Home	0	1	2	3	0	1	2	3	IHS		Dtr on wkends	
13. Routine Health	0	1	2	3	0	1	2	3			Dtr reminds	
14. Special Health	0	1	2	3	0	1	2	3	IHS		HH RN/Therapy	unstable Blood sugar
15. Being Alone	0	1	2	3	0	1	2	3	EH			fear of fall, unsteady

TOTAL	0	7	6	15	0	5	6	3				
MMSE	A	MMSE/A TOTAL	B	TOTAL DON SCORE	IL-402-1230 (Rev 7/09)							
0	28	28	14	42								

**Mini-Mental State Examination (MMSE)** – Care Coordinators should complete the MMSE, in its entirety, on all participants. All correct answers should be scored. Directions for scoring the MMSE can be found in the CCP Training Manual.

**A Non-Cognitive Problem** – If a participant's MMSE score was affected because of the existence of a non-cognitive problem, "Yes" should be marked and the reason identified. If "Other" is chosen then a description should be given. This information will aid Care Coordinators and ADS providers in using the MMSE tool more effectively by preventing misinterpretations and erroneous "diagnosing", especially in the consideration of whether or not a participant is capable of making their own decisions.

**Informant Information** - If a participant's MMSE score total is 20 points or less an informant may be needed. Indicate if an informant was available and if an informant was used. If an informant is used then the informant's name and relationship should be entered.

**Determination of Need** – "Service by CCP" and "Service by Other" columns:

Below are the active options Care Coordinators should use in the “Service by CCP” drop down fields.

MCC	Managed Care (demo program)
CBR	Community Care in Residential Settings (formerly Community Based Residential Facilities)
IHS	In-Home Service
ADS	Adult Day Service
SC	Senior Companion
EHM	Emergency Home Response Monthly
MM	Money Management demo program

There are 6 additional choices that will show up, however those are terminated programs or service codes that should not be used by Care Coordinators. The Department will be removing these additional abbreviations in the next Client Forms Manager version.

The “Service by CCP” column indicates what CCP provider type will be performing the service, ADS = Adult Day Service, IHS= In-Home Services (Home Care Aide), EHM = Emergency Home Response Service (Monthly), etc.

The “Service by Other” column is to be used to indicate formal/informal supports such as family members or any other agencies (outside of CCP) assisting the participant with the task.

For each function that has a B side score of 1-3, the Care Coordinator must ensure that the appropriate service type is selected in the “Service by CCP” column and that any additional services by other sources is indicated in the “Service by Other” column. If a function has an A side score and a B side score of a 0 due to family assistance or other Non-CCP services then obviously no CCP services are necessary, but the documentation of “family assists” or “HDM”, etc. should be recorded in the “Service by Other” column. If a participant has an A side score but refuses assistance then the B side score should be scored a zero and “Participant refuses” or “Participant manages” should be documented in the “Service by Other” column. Assistive devices should be included in the “Service by Other” column.

“Frequency” Column – The “Frequency” column indicates how often the service is to be provided. It only needs to be used when a Care Coordinator needs to indicate a specific frequency of tasks. For example, if a participant that would spend all their authorized hours shopping instead of completing other tasks on their POC a Care Coordinator may want to indicate a minimum/maximum frequency on shopping and other essential tasks. However, in most cases, Care Coordinators should encourage participants to self direct their own care by allowing them to determine their own frequencies of receiving assistance with each task. If service by CCP is indicated under “outside home” then the Care Coordinator should indicate whether transport or escort is needed.

**“Notes” Column** - The “Notes” column can be used to give information to the provider. It is not required to be completed for each task. General notes about a participant’s abilities are collected and recorded throughout the CCC assessment tool so it is not necessary to include them again on the DON. This column should be used only to provide information to the providers that will be useful when providing service to the participants. Care Coordinators should use caution when documenting notes. Everything written in this column is printed out on the Plan of Care Notification form (POCNF) for the participant/family to see and will be given to the provider agency. There is an additional notes field on the POCNF if needed. Special care should be taken when using abbreviations and acronyms. A Care Coordinator may know that “SOB” stands for “shortness of breath” but a client or family member reading the POCNF may think it is a derogatory statement about the participant or family member. Care Coordinators should review the POCNF prior to printing it out to make sure that the notes section reads as they intended it to read.

**Disposition** - CCUs keep a copy in their records. ADS providers receive a copy of the entire MMSE & DON page in addition to the POCNF to be utilized in completing the individualized POCs. Other service providers will receive the service information from the DON on the POCNF.



Care Coordinators are required to provide all appropriate brochures and the Medicaid Estate Recovery Letter to the participant. The participant's signature on this form serves as the case file documentation that the required brochures were given and explained to the participant.

**Medicaid Status Box** - The Medicaid Program Status box shall be completed by the Care Coordinator indicating that the Medicaid Estate Recovery letter was given to the participant and the participant's Medicaid status information. If a Medicaid number was entered on page 2 of the CCC assessment under "Recipient Number" that number will pre-populate to the "Current Medicaid Number" box. If the pre-populated number is not correct, do not change it on the Consent form. Care Coordinators must go back and change it on Page 2 of the CCC Assessment. If a Medicaid exemption exists that allows a participants to not apply for Medicaid then the Care Coordinators must document the reason in this box. If no exemption exists, then the status of the participant's Medicaid application must be indicated in the appropriate area within this box along with the appropriate date. "Given" means the application was given to the participant to complete. "Mailed in date" should be checked if the CCU has taken responsibility for mailing in the application for the participant. "Completed date" should be entered if the CCU completes the application during the home visit with the participant. "Copy in file" should be used if the CCU obtains a copy of the application and places it participant's file as proof of application. It is not expected that Care Coordinators would go back and fill in dates in this section once an assessment has been processed completely.

**Disposition** - The Consent Form should be signed and dated by both the participant and the Care Coordinator upon completion. The form shall be retained in the participant's CCP record with the rest of the assessment.

# CCP Financial Data:

**CCP Financial Data** • Do not complete for Interim/TSI • For CCU File Only Client Name: Anna Smith

NON-EXEMPT ASSETS										
1. <u>Saving Account</u> <u>Checking Account</u> <u>Cash on Hand</u> Life Insurance (Cash Value) <u>Pre-Paid Burial Policy</u>										
<u>CDs + Stocks</u> Bonds Trusts IRAs Real Estate (Other than Homestead) Other (Specify)										
2. Personal + Real Property/Assets Specify Type of Holding	3. TOTAL Actual Value	4. Appl./Client Ownership		5. Spouse Ownership		6. All Other Ownership		7. Document Verification		8. Date Verified
		%	\$	%	\$	%	\$	Location	Type, Date, No., etc.	
checking	\$ 3346.93	100	\$ 3346.93		\$ .		\$ .	Nations	acct 1000112	01/04/2012
CD	\$ 5103.62	100	\$ 5103.62		\$ .		\$ .	Nations	#23431 (2/2014)	01/04/2012
Prepaid burial	\$ 3500.00	100	\$ 3500.00		\$ .		\$ .	SpgfldFun	Policy 456321	01/04/2012
Cash on hand	\$ 15.00	100	\$ 15.00		\$ .		\$ .	Home	Cash	01/04/2012
<b>9. TOTAL</b>	<b>\$ 11965.55</b>		<b>\$ 11965.55</b>		<b>\$ .</b>		<b>\$ .</b>			

Case Notes: Prepaid burial for \$5,000 (\$1,500 exemption). CD for \$5,000 matures in Feb 2014. Viewed all documents at the house. Bank statement from Dec. 2011. Statement indicated no questionable deductions.  
Interest on CDs accumulates back into CD.

MONTHLY INCOME									
Wages/Salaries <u>Social Security</u> SSDI V.A. <u>Pension</u> Interest Other (Specify)									
Income Source (Monthly Net)	Date Verified	Document Type, Date, Number, etc.	Monthly Income			Total Family Income			
			Applicant/Client	Spouse	Family				
SSI	___/___/___		\$ .			\$ .			
Social Security	01/04/2012	Bank Statement	\$ 700.00	\$ .	\$ .	\$ 700.			
Pension (Sears)	01/04/2012	Bank Statement	\$ 350.00	\$ .	\$ .	\$ 350.			
	___/___/___		\$ .	\$ .	\$ .	\$ .			
..... TOTAL INCOME			\$ 1050.	\$ .	\$ .	\$ 1050.			
..... (Less Earned Income Deduction)*			\$ .	\$ .	\$ .	\$ .			
..... TOTAL ADJUSTED INCOME			\$ 1050.	\$ 0.	\$ 0.	\$ 1050.			
..... ANNUALIZED AMOUNT=TOTAL ADJUSTED INCOME X 12			\$ 12600.	\$ 0.	\$ 0.	\$ 12600.			
..... (Less Annualized Protected Income)			\$ 0.00	\$ .	\$ .	\$ 0.			
..... ANNUAL AVAILABLE INCOME			\$ 12600.	\$ 0.00	\$ 0.00	\$ 12600.			

Earned Income: \$20 gross monthly earned income and an additional one-half of the next \$60 or (for the blind) the first \$85 and one-half of the remaining gross monthly income. (Reference Rule 240.835)

Case Notes: SS and Pension checks are both direct deposit and were verified on bank statement from Dec/11.

IL-402-1237 (02/09)

The CCP Financial Data form must be completed upon every assessment where the participant will receive CCP services except for Temporary Service Increase (TSI) and Interim. Care Coordinators are required to collect all income and asset information on participants (even participants on Medicaid). It is not acceptable to write "Medicaid" through the section and not complete the information. It is also not acceptable to routinely list that a participant has "No" assets. Participants generally have some assets even if it is only a minimal amount of cash on hand, and that minimal amount still needs to be documented. It is essential that this information be correct. Financial information collected through this form is used by the Department to make policy decisions. If Care Coordinators routinely indicate that participants have no assets then the Department's data mistakenly shows that a high majority of our participants are Medicaid eligible and therefore would not lose services if the program became a "Medicaid only" program. Care Coordinators are required to explain to participants that verifying income and assets are a requirement of receiving service through the CCP and that verification is not optional. Due diligence should be used in identifying all forms of income and assets a participant has or receives.

If others are present during this part of the assessment, do not assume they are aware of the participant's financial status. Respect the participant's confidentiality by asking for privacy during these questions. Do not assume that somebody with a Power of Attorney (POA) has or should have access to the participant's financial and personal information. Ask to see the financial POA before sharing information unless the participant grants permission.

**Non-Exempt Assets** – In section 1, Care Coordinators should indicate all of the non-exempt assets that a participant has by clicking on the appropriate asset. Details about each asset circled should be included in Sections 2 through 8. Total Actual Value (Section 3) should reflect the actual value of the asset, ie, savings account balance, value of the CD, cash value of the Life Insurance, etc. Care Coordinators should remember that a participant is entitled to a \$1,500 exemption for **either** a life insurance cash value **or** a prepaid burial plan. The exemption is an “either/or” exemption. A participant cannot receive an exemption for both assets. If an exemption is used, the Care Coordinator should reduce the Total Actual Value (Section 3) of the asset by \$1,500 and document the exemption in the Case Notes sections. The computer software will automatically calculate the totals in Section 9. Any pertinent information such as account numbers, clarification on ownership, etc should be documented in the Document Verification (Section 7) or in the case notes sections.

**Asset Ownership** – When assets are reviewed, Care Coordinators must determine the manner in which the asset is held. Generally there are two types of ownership, “Joint Tenancy” and “Tenancy in Common.”

**Joint Tenancy** – Generally, joint assets are held in joint tenancy (with the right of survivorship) or tenancy in common. Most often, if the account includes a child's name in “Joint Tenancy” the account is usually identified by “or” separating the names. In this instance, all of the assets are available to the client, and must be counted as such.

**Tenancy in Common** – Usually tenancy in common is identified by “and” separating the names. In this instance, each account holder owns an interest less than the total, and equal to the number of account names. Therefore, if one client and one child is listed, each would have access to ½ of the account (with three owners, each would have access to 1/3 of the assets). No owner can access his/her share without the consent of the other owner(s).

The Care Coordinator shall enter into Section 4 the percentage of ownership the participant holds in the asset and the dollar amount it represents. Any additional ownership in the asset and the dollar amount it represents shall be entered into sections 5 and/or 6.

**Document & Date Verification** – These sections should be completed by the Care Coordinator for each non-exempt asset recorded. The location of the document verification doesn't necessarily mean the location where the documentation was viewed, which would in most cases be the participant's home. This field should represent the location of the asset. For example, if you verified a savings account by using a participant's bank statement then the name of the bank should be listed in the location field. The asset is “located” at that bank. The account number, date of the bank statement etc should be recorded in the “Type, Date, No, etc.” field. The Date Verified (field #8) should be the date that the Care Coordinator actually verified the asset's worth. If the Care Coordinator has to obtain a release of information and retrieve banking information from the bank this date should be the date that the bank information was obtained, not the date of the home visit.

**Case Notes** - Care Coordinators may use the notes sections of the CCP Financial Data form to clarify asset or income information and to provide additional information. Care Coordinators are not required to use the case notes section on the CCP Financial Data form. However, this space is a convenient space to explain or clarify areas. For example, Care Coordinators should explain if the \$1,500 prepaid burial exemption was used so that others realize that the exemption has been utilized. Care Coordinators could also indicate in this section that an asset listed on a past assessment no longer exists because the participant cashed it in. This would provide documentation that the Care Coordinator did in fact ask about the missing asset upon reassessment.

**Monthly Income** – Care Coordinators should indicate all of the Monthly Income types that a participant receives by clicking on the appropriate income source. The two most common income sources (SSI and Social Security) have been included on the form already. Income **must** be verified by the care coordinator even though the CCP does not have income restrictions. Care Coordinators must document the source of verification, date, account number, etc. where the income was documented (i.e., bank statement for direct deposit, social security award letter, etc.). Income should be recorded in monthly net amount for the participant, spouse, and any family members living in the home contributing to the family income. A good rule of thumb is that if family members are claimed on the participant's taxes, their income is counted as family income. However, do not list income specifically designated for grandchildren being raised by the grandparent/participant.

The computer software will automatically calculate the totals and record an annual amount of income. At this time, Care Coordinators are not required to enter Protected Income, so a zero should be entered in this field. Any pertinent information such as account numbers, clarification on income, etc should be documented in case notes section. Upon completion, the pertinent financial details will transfer from the Total Family Income column on the CCP Financial Data page to the top of the Client Agreement. Care Coordinators should verify that all information on this form is correct prior to finalization.

**Disposition** – CCUs should keep this form in the participant's record with the rest of the CCP assessment forms. This information is **not** to be shared with the provider agencies.

# CCP Client Agreement:

## ILLINOIS DEPARTMENT ON AGING COMMUNITY CARE PROGRAM - CLIENT AGREEMENT

<b>APPLICANT/CLIENT'S NAME, ADDRESS:</b> Anna Smith 23 Bayberry Lane Springfield IL 62702-1271		<b>Office Use Only:</b> I.D.# <u>222-33-4444</u> Fee Schedule <u>A</u> Family Size <u>01</u> Total Income: \$ <u>12600.</u> Protected Income: \$ <u>0.</u> Available Income: \$ <u>12600.</u> <b>Assessment Type:</b> <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Interim <input type="checkbox"/> TSI <input type="checkbox"/> Redetermination <input type="checkbox"/> PSI Interim: <input type="checkbox"/> 2 days <input type="checkbox"/> 15 days			
<b>PART A. SERVICE TYPE; FREQUENCY; AND PROVIDER CERTIFICATION: — YOUR SERVICE(S) WILL BE:</b>					
<u>IHS</u> Type	<u>3</u> Units per day	<u>9</u> Units per week	<u>45</u> Units per month	\$ <u>772.</u> Total Cost	\$ <u>0.</u> Co-Pay
1 Provider Name: Superior Home Care		Service Start Date: ___/___/___		Signature _____ Date ___/___/___	
Phone: (217) 788-7777					
_____ Type	_____ Units per day	_____ Units per week	_____ Units per month	\$ _____ Total Cost	\$ _____ Co-Pay
2 Provider Name: _____		Service Start Date: ___/___/___		Signature _____ Date ___/___/___	
Phone: ( ) - _____					
_____ Type	_____ Units per day	_____ Units per week	_____ Units per month	\$ _____ Total Cost	\$ _____ Co-Pay
3 Provider Name: _____		Service Start Date: ___/___/___		Signature _____ Date ___/___/___	
Phone: ( ) - _____					
_____ Type	_____ Units per day	_____ Units per week	_____ Units per month	\$ _____ Total Cost	\$ _____ Co-Pay
4 Provider Name: _____		Service Start Date: ___/___/___		Signature _____ Date ___/___/___	
Phone: ( ) - _____					
<input checked="" type="checkbox"/> EHRs - <input checked="" type="checkbox"/> Installation = One-time \$30 Monthly = <input type="checkbox"/> \$14 (shared service) or <input checked="" type="checkbox"/> \$28 (unshared service)				\$ <u>28.</u> Total Cost	\$ _____ Co-Pay
5 Provider Name: Emergency Monitoring LTD		Service Start Date: ___/___/___		Signature _____ Date ___/___/___	
Phone: (309) 874-4444					
<b>CARE COORDINATOR:</b> The client named above is eligible according to the rules of the Illinois Department on Aging for the service as defined above. Prepared by: _____ Date: ___/___/___					
If determined eligible, I agree to the service type(s), frequencies, and the client monthly cost of care as set forth in this Client Agreement.  <input checked="" type="checkbox"/> _____ Signature of Applicant/Client (or Authorized Representative) DATE: ___/___/___			<b>Part B. COST OF ALL CLIENT SERVICES AND CLIENT CO-PAYMENT:</b> The total monthly cost of care will not exceed... \$ <u>800.</u> The client monthly cost of care will not exceed... \$ <u>0.</u> The state of Illinois will pay... \$ <u>800.</u>		
<b>CCU Name/Address/Phone:</b> Capital City CCU 401 Capital Ave PO Box 11 Springfield, IL 62701 (217) 785-2222					

THE ABOVE SIGNATURE(S) IS/ARE VALID IN FAX OR ORIGINAL FORM.

The Illinois Department on Aging does not discriminate to programs or treatment of employment in programs or activities in compliance with appropriate State and Federal statutes. If you feel you have been discriminated against, you have a right to file a complaint with the Illinois Department on Aging. For information, call the Senior HelpLine: 1-800-252-8966 (Voice); 1-888-206-1327 (TTY)

The CCP Client Agreement must be completed upon every assessment where the participant will receive CCP services, including provider transfers. The CCP Client Agreement serves as the contract between the participant, the CCU, and the provider agencies to authorize agreed upon services. It is essential that this form is filled out completely and correctly to avoid billing errors and delays in services. The participant's name, address, ID number, family size and income information will automatically populate. Care Coordinators will have to enter the appropriate fee schedule (see chart below) for the participant, based on the participant's DON score and family size. All services will be recorded on one Client Agreement so that all providers are aware of the other CCP services that a participant is receiving.

### One Person in the Family Receiving CCP Services

Fee Schedule - A	Less than 57 points on the DON
Fee Schedule - B	57 or more points on the DON

**Two Persons Receiving CCP Services**

Fee Schedule - C	Both persons have less than 57 points on the DON
Fee Schedule - D	Both persons have 57 or more points on the DON
Fee Schedule - E	One person has less than 57 and one person has 57 or more on the DON

**Service Type (Part A)** – This section of the CCP Client Agreement is where Care Coordinators authorize service providers and hours of service. Care Coordinators should be careful in completing this section. Care Coordinators should ensure that the appropriate provider has been authorized based off the participant’s choice indicated on the Consent Form and that the hours adequately reflect the hours agreed upon during the assessment. The Care Coordinator should choose the appropriate CCP service type from the drop down box for service type. The number of hours per day, week and per month should be authorized by the Care Coordinator. Care Coordinators should make sure that the monthly units are derived using a 5 full weeks month to ensure that no billing errors occur. The computer software will automatically figure the total cost of service for that provider based on the rate of reimbursement for each service type. The provider name and phone number for the local office should be recorded in sections 1, 2, 3, 4 or 5 (for EHRS providers). Care Coordinators should **NOT** enter a date in the “Service Start Date” or Sign and Date the form in this section. The Provider Agency will sign, date and fill in the “Service Start Date” indicating when the services started for the participant (See circled area in example above). The Care Coordinator should only sign and date the form in the box marked “Care Coordinator, prepared by.”

If split hours are necessary, Care Coordinators should enter only the weekly and monthly totals and then document in the notes section of the Plan of Care Notification Form, the detailed varied hours (i.e. 2 hrs X 2 days and 3 hrs X 1 day). Only one line should be entered on the Client Agreement.

The participant or authorized representative should sign and date the CCP Client Agreement form in the box with the “X”. The Care Coordinator should ensure that whoever is signing the Client Agreement will be the individual responsible for signing the Hours of Service Calendars (HOSCs) unless the POCNF notes/special instructions section reveals someone other than the participant.

**Disposition** – The CCP Client Agreement form should be copied and sent/faxed or scanned/emailed (password protected) to each of the provider agencies listed. The provider agencies are required to sign, date and document the “Service Start Date” – the date services actually started or increase in service began – and return a copy of the Client Agreement form back to the CCU by mail, fax, or email (password protected) for their records. However, it is the responsibility of the CCU to verify that the provider agency received the documentation if faxed or email. CCUs are encouraged to have a policy/procedure in place to confirm receipt of all electronic transmissions. Possession of an original signature document is no longer required. Provider

agencies must return a copy of the signed Client Agreement within 5 days of service initiation. Copies or facsimiles are acceptable for either the provider or CCU. The CCU is required to ensure that all providers listed on the Client Agreement return their signed copies and that a copy of each is sent to the participant so they have documentation of starting service dates. If service remains the same from the previous assessment, providers are still required to date, sign, and return the Client Agreement to the CCU. In this instance, the provider should use the same date as the Care Coordinator signed Client Agreement. The CCU and each provider agency are required to maintain signed copies of Client Agreements in each participant's file.

## Input Screen for Plan of Care Notification:

CCP - Plan of Care Notification (Input Screen) Save Close

**Community Care Program Plan of Care Notification Input Screen**

Client Name:  Client ID:

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Type Action: <input type="text" value="01 - New Case"/>	Application Date: <input type="text" value="01/04/2012"/>	Eligibility Determination Date: <input type="text" value="01/04/2012"/>
Type Reason: <input type="text" value="000 - New Case."/>	DPADays of Delay: <input type="text" value="0"/>	Eligibility Notification Date: <input type="text" value="01/04/2012"/>
Billing Code: <input type="text" value="360 - Comp. Assessment"/>	Client Days of Delay: <input type="text" value="0"/>	Referral Date: <input type="text" value="12/30/2011"/>
CCU Contract#: <input type="text" value="U120700010"/>	Number Receiving CCP Services: <input type="text" value="01"/>	Companion Plan of Care: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Program Type: <input type="text" value="11 - Regular CCP Pro"/>		

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Assessment Type:

Service type	Action	Effective service date (ESD)
<input type="text" value="21-Homemaker"/>	<input type="text" value="Begin"/>	<input type="text" value="15 calendar days from ,"/>
<input type="text" value="36-EHRS Installation and"/>	<input type="text" value="Begin"/>	<input type="text" value="15 calendar days from ,"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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Reason:

Notes/Special Instructions not entered on DON:

IL-402-1251 (01/09) Update

The CCP Plan of Care/Notification Form Input Screen must be completed upon every assessment where the participant will receive CCP services, including provider transfers. This screen is used to create sections C, D, and the Notes section of the Plan of Care Notification Form (POCNF). It is essential that all information on this screen is entered correctly. Care Coordinators must ensure that the dates used on this screen are accurate since this screen creates the timeframes that provider agencies and CCUs must follow according to Administrative Rules. To access this Input Screen, Care Coordinators must click on the "Update" button at the bottom of the POCNF form. (The POCNF will be blank for new participants.)

**Type Action/Type Reason** – Care Coordinators should choose the most appropriate code from these two drop down boxes based on the type of assessment they are conducting and the reason for the assessment. It is very important

that Care Coordinators assure that they are using the most appropriate code. IDOA uses this information for data tracking and policy making decisions. Care Coordinators should not just routinely utilize the same codes for the same type of assessment. For example, all prescreens should not necessarily always be a 25/70 (Chose nursing facility due to complex medical needs). If another reason better explains the reason for admission to the nursing facility then that code should be used. Correct use of the codes could assist Transition Coordinators in identifying potential residents that may be appropriate for transitioning back into the community. (See Attachment A for a listing of Type Action/Type Reason and billing codes). On a redetermination, if there is an increase in the total monthly cost of care then the Type Action/Action Reason is an increase (10/13). If there is a decrease in the total monthly cost of care then the Type Action/Action Reason is a decrease (10/11).

**Billing Code** – Care Coordinators should choose the most appropriate code for billing. Utilizing the proper billing code is essential for your agency to receive the proper reimbursement for completion of the assessment. Also, the correct use of codes helps IDOA develop policies and manage the program appropriately. (See Attachment A for a listing of Type Action/Type Reason and billing codes).

**CCU Contract #** - This field automatically populates with the agency’s CCU contract. A Care Coordinator working at a CCU with multiple CCU contract numbers should verify that the correct CCU contract number has been chosen.

**Program Type** – Care Coordinators should choose program type 11 for Regular CCP unless otherwise instructed by IDOA policy for participants under special circumstances. IDOA occasionally utilizes additional program type codes when tracking specific program participants is required (i.e., Katrina evacuees, Enhanced Transition program, etc.).

**Application Date** – Care Coordinators should use the date that the CCU contacts the participant following the referral/intake to schedule an appointment. For example, this date would be the date that the Care Coordinator or Case Aide contacts the participant to schedule a home visit after receiving a referral from a Home Health Agency for a participant. According to CCP timeframes, this date must be within 5 calendar days of the Referral date. This date can be the same as the Referral Date if the CCU schedules the appointment during the first initial call to the CCU for assistance. After the initial assessment, this date will not change on future reassessments.

**DPA Days of Delay** – Care Coordinators should document the number of calendar days that the eligibility determination was delayed due to DPA (HFS, the Medicaid agency) delay. This represents the number of days past CCP rule time frame that DHS determines spousal impoverishment eligibility. Care Coordinators should enter “0” if there were no days of delay.

**Client Days of Delay** – Care Coordinators should document the number of calendar days that the eligibility determination was delayed due to client delay in obtaining paperwork, access, etc. Participants are afforded 60 calendar days of client delay before their case will be denied or terminated. Care Coordinators should enter “0” if there were no days of delay.

**Number Receiving CCP Services** – Care Coordinators should document the number of people within the home that are receiving CCP services.

**Eligibility Determination Date** – Care Coordinators should document the date that the participant was determined eligible for CCP services. This is the date that all information has been collected, verified and paperwork completed and should match the date signed by the care coordinator on the client agreement. According to CCP timeframes, this date must be within 30 calendar days of the Application date.

**Eligibility Notification Date** – Care Coordinators should document the date that the providers were notified of the eligibility determination. If eligibility can be determined at the home visit and the provider can be notified that

same day, documents can be printed out and left with the participant in their home. The POCNF must be mailed/faxed on the eligibility notification date. According to CCP timeframes, this date must be within 15 calendar days of the Eligibility Determination Date.

**Referral Date** – Care Coordinators should document the date that the CCU is first contacted about the participant. This date is sometimes referred to as the “Intake Date”. For example, this date would be the date that a daughter calls the CCU seeking information about services for her mother. After the initial assessment, this date will not change on future reassessments.

**Companion Plan of Care** – Care Coordinators should check the appropriate box indicating if the Plan of Care will be a Companion Plan of Care. For example, the participant’s sister also lives in the home and receives CCP services. Both sisters would have Companion Plans of Care since many of the tasks (housekeeping, laundry, shopping, meal preparation) would be duplicative and could be done for both participants at the same time.

**Assessment Type** – Care Coordinators should choose the appropriate assessment type from the drop down box.

Interim	Interim should be chosen when a presumptive eligibility assessment was completed for participants who are at imminent risk of entering a nursing home within 72 hours. Interim assessments will not have all pages of the CCC tool completed and financial eligibility may not be completely verified at this point.
Initial	Initial should be chosen for all participants that initially starting services.
Reassessment	Reassessment should be chosen whenever a participant requires an annual reevaluation or a needs based assessment.
Other	Other should be chosen whenever a participant’s services have been suspended.
Denial	A denial code should be used whenever a participant has requested services and been denied due to not meeting eligibility requirements or due to participant request.
Redetermination with Termination	Redetermination with Termination should be chosen when reassessments are completed on participants and a participant has elected to terminate services or no longer meets eligibility requirements.

**Service Type , Action & Effective Date (ESD)** - Care Coordinators should choose the appropriate service type from the drop down box under “Service Type”. If a participant receives more than one CCP service then multiple lines will be necessary. For each service type the appropriate “Action” should be chosen in the Action column and the appropriate effective date of service. These three columns will be used to build sentences in Section D of the POCNF so the participants and provider agencies clearly know what actions are occurring with their services.

For example, if a participant wishes to transfer in-home service providers, the Care Coordinator should choose the Service Type “21” and the Action “Be Transferred” (for the current existing provider) and then “15 calendar days from eligibility” (if the participant and the provider mutually agree to waive the 15 day adverse action then “Same Day” should be chosen and an option box of “15 day adverse action waived” will show up and should be marked). The Care Coordinator then needs to enter a 2<sup>nd</sup> line of in-home service for the new provider with a “21” in the Service Type and a “Begin” in the Action column and “15 calendar days from eligibility” in the Effective Service date

column. This will effectively terminate the services of the current provider and authorize services for the new provider agency.

If you are terminating all services, it is essential to choose “redetermination with termination” so that all services are removed from the POCNF.

**Reason** – This section should be used by the Care Coordinator to explain the reason for the assessment and eligibility determination. Care Coordinators are required to complete the reason for each POCNF explaining any changes in service, especially adverse actions. Care Coordinators should justify the changes using language the participant can easily understand and avoid vague and broad references.

**Notes/Special Instructions not entered on DON** – The “Notes/Special Instructions” section may contain additional instructions for the provider agencies. Care Coordinators are required to enter if someone else besides the participant is authorized to sign the Hours of Service Calendar. Care Coordinators should include any notes/instructions that will be of benefit for the provider agency to have (i.e., participant has large dogs, provide directions to the home, participant requires a special diet, home care aides need to enter through back door, or participant is unavailable for service every Friday due to dialysis, etc.). If more room is needed, a referral form should be used and a notation made in the Notes/Special Instructions section indicating that a referral form is included.

**Saving the File** – Care Coordinators may save the file at anytime during the assessment and are encouraged to save frequently throughout the assessment process. If this is the first time the file is saved, the software will ask you to name the file. The Input Screen must be saved by clicking the Save button at the top right corner of the screen to generate the POCNF.

# CCP Plan of Care/Notification Form (POCNF):

## Community Care Program - Plan of Care Notification Form

**A. Applicant/Client Name/Address:**

Anna Smith  
23 Bayberry Lane, Springfield, IL, 627021271

**B. CCU/CMU Name/Address/Phone:**

Capital City CCU  
401 Capital Ave, PO Box 11, Springfield, IL, 62701, (217) 785-2222

C. Office Use Only Box: **Client ID:** 222-33-4444 **Eligibility Notification Date:** 01/04/2012 **Number Receiving CCP Services:** 01

**D. Eligibility Finding**

Initial: Based on your Initial determination on 01/04/2012,

Your In-Home Services (homemaker) service was approved to Begin on or before 01/19/2012

Your Emergency Home Response System Installation and Training of Equipment service was approved to Begin on or before 01/19/2012

**Reason:** New participant to Community Care Program

**YOUR RIGHTS:** You have the right to object to the above action(s) (excluding suspension) by submitting your appeal in writing to the Illinois Department on Aging, 421 East Capitol Avenue, #100, Springfield, IL 62701-1789, or you may contact the Department's **Senior Helpline**, 1-800-252-8966 (Voice); 1-888-206-1327 (TTY), within sixty (60) calendar days following the date of this Notice. If you have been receiving services and you appeal within ten (10) calendar days of the date of this Notice, services may be continued at the previous level. See the informational pamphlet for additional details.

**E. Areas of Assistance**

**Companion Plan of Care**  Yes  No

The client needs assistance with eating provided by Pnt. manages. difficulty cutting.

The client needs assistance with bathing provided by In-Home Services (homemaker). Additional service provided by Dtr/weekends. unsteady, brkn hip.

The client needs assistance with grooming provided by In-Home Services (homemaker). Additional service provided by Beautshp 1/wk.

The client needs assistance with dressing provided by In-Home Services (homemaker) HH helps 2X week/T & Thur. Additional service provided by Dtr/weekends.

The client needs assistance with transferring provided by In-Home Services (homemaker).

The client needs assistance with continence provided by Depends. slow mobility.

The client needs assistance with managing money provided by dtr/son.

The client needs assistance with telephoning provided by dtr/cell ph. slow/uses cell phone.

The client needs assistance with preparing meals provided by In-Home Services (homemaker) prep dinners asnd. Additional service provided by dtr/HDM 5x/wk.

The client needs assistance with laundry provided by In-Home Services (homemaker). Additional service provided by dtr when able.

The client needs assistance with housework provided by In-Home Services (homemaker). Additional service provided by dtr when able.

The client needs assistance outside the home provided by In-Home Services (homemaker). Additional service provided by Dtr on weekends.

The client needs assistance with special health provided by In-Home Services (homemaker) look for signs of low BS. Additional service provided by HH RNT/therapy-

unstable Blood sugar.

The client needs assistance with being alone provided by Emergency Home Response System Monthly Units(s) of Service. fear of fall, unsteady.

**Notice:** If you have been found eligible for Community Care services, you should begin receiving services within fifteen (15) calendar day of the date of this Notice. If a homemaker has not come to help you within fifteen (15) calendar days, you may hire your own homemaker (including a friend or relative) to provide the amount and type of Community Care services specified in this Notice. The Department on Aging will pay the homemaker you have hired to the extent authorized by the Client Agreement. Payment shall continue until such time as the Department's approved provider initiates provision of Community Care services to you.

II -402-1251 (01/09) Update |

The CCP Plan of Care/Notification Form (POCNF) must be completed upon every assessment where the participant will receive CCP services, including provider transfers. The POCNF is created using information entered on DON (page 8 of the CCC assessment tool) and the Input Screen. The POCNF is automatically generated after all the necessary information has been entered into the data fields on the DON and the Input Screen. To access the Input Screen, Care Coordinators must click the "Update" button on the bottom of the POCNF. The POCNF will be blank for new participants until the Input Screen has been completed.

All information on the POCNF is automatically populated by the computer software. If information is incorrect, the Care Coordinator will have to return to the appropriate page to correct the data.

**Section D** – This section of the POCNF explains the eligibility determination of the assessment for the participant. The information entered into the Input Screen is used to form sentences that are easy for the participant and the provider to understand for each service type. This section also provides the reason for the eligibility determination and provides the participant with information regarding their right to appeal. Care Coordinators should explain to participants their right to appeal and the process required to file an appeal. See Right To Appeal Brochure for additional information.

**Section E** – This section of the POCNF uses the information from the DON (page 8 of the CCC assessment) . If a Care Coordinator has inadvertently omitted information on the DON, an error warning will appear in red indicating that a field is missing. The Care Coordinator should return to page 8 of the CCC assessment and correct the error on the DON. Any item scored on Side A of the DON will appear as a sentence on the POCNF. Sometimes when the notes section of the DON is translated into sentences in Section E harmless abbreviations or acronyms can now be read as derogatory statements about the participant or family member. Care Coordinators should review Section E of the POCNF prior to printing it out to make sure that the notes section reads as they intended it to read. This section may be continued onto a second page depending on the amount of tasks a participant needs assistance with. Care Coordinators should ensure that all pages of POCNF are printed. The last page of the POCNF will contain Section F which requires a Care Coordinator’s signature.

Example of page 2 of the POCNF:

Client Name: Anna Smith

Notes/Special Instructions: Services need to be on M-W-F (if poss)HH is present in the home on T-Th.Dtr covers wkends.

F. Case Coordination Unit Staff Signature: \_\_\_\_\_

**Notice:** If you have been found eligible for Community Care services, you should begin receiving services within fifteen (15) calendar day of the date of this Notice. If a homemaker has not come to help you within fifteen (15) calendar days, you may hire your own homemaker (including a friend or relative) to provide the amount and type of Community Care services specified in this Notice. The Department on Aging will pay the homemaker you have hired to the extent authorized by the Client Agreement. Payment shall continue until such time as the Department's approved provider initiates provision of Community Care services to you.

The “Notes/Special Instructions” section may contain additional instructions for the provider agencies, including if someone else besides the participant is authorized to sign the Hours of Service Calendar. Care Coordinators should include any notes/instructions that will be of benefit for the provider agency to have (i.e., participant has large dogs, home care aides need to enter through back door, or participant is unavailable for service every Friday due to dialysis, etc.).

The POCNF cannot be pre-printed or manually completed. **Eligibility must be determined and the provider must be notified in order to enter the appropriate dates and print a completed form for the participant and the provider.**

**Disposition** – The POCNF should be printed out, copied and sent on the notification date to the participant and all provider agencies listed on the Client Agreement. The CCU should retain a copy of the POCNF for their records. CCUs can mail/fax or email (password protected) the POCNF to providers. However, it is the responsibility of the CCU to verify that the provider agency received the documentation if faxed or email. CCUs are encouraged to have a policy/procedure in place to confirm receipt of all electronic transmissions. CCUs are required to obtain documentation by either signed receipt or certified mail receipt for all determinations that have an adverse action/negative impact impact on the participant.

**Providers should assure the Care Coordinator’s signature is at the bottom of the POCNF. If not, the provider should ask the CCU for the second page.**



# CCP CAT Data Form:

## COMPREHENSIVE CARE COORDINATION – CASE AUTHORIZATION TRANSACTION (CAT) DATA

Client Name: Anna Smith SSN: 222-33-4444

Type Action:	01
Type Reason:	000
Billing Code:	360
CCU Contract #:	U120700010
Program Type:	11
Application Date:	01/04/2012
Referral Date:	12/30/2011
Eligibility Determination Date:	01/04/2012
DPA Days of Delay:	0
Client Days of Delay:	0

This form is populated from the Input form on the POCNF and is used for data entry to create the CAT. Care Coordinators need to verify the information on this form is correct. Depending on each CCU's preference, Care Coordinators may be requested to print this form when they print the assessment. This form will be used to generate the billing payment for the CCU so it is essential that the information be accurate.

# Release of Information (Optional Form):



## RELEASE OF INFORMATION FORM

<b>Date:</b> 01/04/2012	<b>Date of Birth:</b> (If Applicable) 06/12/1935	<b>I.D. Number:</b> (If Applicable) 222-33-4444
I, <u>Anna Smith</u> hereby give permission to (Name of Applicant/Client)		
<u>Nations Bank</u> , to release or obtain (Person, Organization, Agency)		
information concerning <u>my bank account balances and CD balance</u> to (Specify)		
<u>Capital City Care Coordination Unit</u> (Person, Organization, or Agency)		
Present Street Address <u>23 Bayberry Lane</u>	Former Address (if recent)	
City/State/Zip <u>Springfield 62702-1271</u>	Month/Day/Year ____/____/____	
Signature of Applicant/Client <u>X</u>	OR Authorized Representative	
Witness to Signature: <u>X</u>		
Signature: _____ Date: ____/____/____		

THE ABOVE SIGNATURE(S) IS/ARE VALID IN FAX OR ORIGINAL FORM.

THIS RELEASE OF INFORMATION IS VALID FOR 15 MONTHS FROM THE SIGNATURE DATE.

The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in programs or activities in compliance with appropriate State and Federal

### Release of Information Form:

The Release of Information (ROI) form is an optional form that is only required when releasing or obtaining confidential participant information. Care Coordinators are required to fully explain the purpose of the ROI and in what manner it will be used. The participant’s demographic information pre-populates to the form from the assessment information. Care Coordinators will need to complete a separate ROI for each agency/entity to be contacted regarding the participant. Care Coordinators should list the specific information being requested if possible. The ROI form must be signed by the participant or authorized representative. A witness to the participant or authorized representative’s signature is only required when a participant signs with an X. Care Coordinators may act as a witness to signature. The final signature on the form should be signed and dated by the Care Coordinator.

**Disposition** – The ROI form must be presented to the agency/entity that the Care Coordinator is requesting information from. All originals of ROIs should be kept in the participant’s file at the CCUs since they are valid for 15 months from the participant’s signature. ROIs may be faxed and emailed (password protected) if necessary.

### Physician Statement (Optional Form):



Most fields on the form will automatically populate, however, the Care Coordinator is required to complete the physician name, address, phone number and fax number and ensure that all other information is completed.

The Physician/Registered Nurse/Nurse Practitioner/Christian Science Practitioner will complete the information in the box at the bottom of the form, sign and date the form.

**Disposition:** - The CCU should send the Physician Statement along with information explaining why the Care Coordinator feels a safe plan of care cannot be developed. This form may be faxed and should remain in the participant's file.

# Referral Form (Optional Form):

Illinois Department on Aging

## Referral Form

**(Press Firmly)  
Referral**

Date: 01/04/2012

To: Superior Home Care From: Capital City CCU  
(Agency) (Agency)  
Contact Telephone: Contact Telephone:  
Person: Chris Talkington (217) 788-7777 Person: Michael Reynolds (217) 785-2222  
(If Known)

### Client Information

Name: Anna Smith  
Address 23 Bayberry Lane  
City: Springfield Zip Code 62702-1271  
Telephone (217) 555-1212 Identification No.: 222-33-4444

Statement of Need New participant for your agency. Dtr is currently taking off work to help prt until services can start. We would appreciate services to start as soon as possible. HH assists prt with many tasks on Tues & Thur when they are there. IHS are needed on M-W-F if possible. Dtr covers weekends. Call if questions. Thank you.

Signature: 

### Response

To: \_\_\_\_\_ From: \_\_\_\_\_  
Agency Agency  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Referral Form may be used by Care Coordinators and CCP service providers as a tool for communication between the CCU, CCP providers and/or other service providers. This form can help a CCU and/or service provider track communication responses and ensure follow-up has occurred. The agency initiating the form should complete the referral section of the form indicating which agencies are involved in the communication, the client information section and the statement of need. The agency receiving the Referral form should respond back using the lower half of the Referral form to document their response.

**Disposition:** - Each agency involved in the communication should keep a copy of the Referral form in the participant's file to serve as documentation of communication of the issue.

## Nursing Facility Screens:

**SERVICE SELECTION AND CERTIFICATION**

Last Name: Smith First Name: Anna SSN 222-33-4444

I have been advised that I may choose community-based services, supportive living facility services or nursing facility placement. I understand that I have the right to change my mind at any time.

- I choose **COMMUNITY-BASED SERVICES**
- I choose **SUPPORTIVE LIVING FACILITY SERVICES**
- I choose **ORS COMMUNITY-BASED SERVICES**. Hospital Name: \_\_\_\_\_ Phone#: \_\_\_\_\_
- I choose **NURSING FACILITY** placement. Facility Name: Springfield Area Rehab. Center Phone#: (217) 555-1111  
I understand my nursing facility stay may be short term.  I request that a Care Coordinator follow-up within 21 days.
- I choose **NEITHER** community-based services nor nursing facility placement.
- I certify that I have received and reviewed the following brochure: **Notice of Privacy Practices**.
- I certify that, to the best of my knowledge and belief, the information provided is true, correct and complete. I understand the information will be disclosed only for the purposes of administration of services and I may be asked to verify the information I have provided.

Signature of Person Assessed  
OR  
Authorized Representative:

**X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CASE NOTED SIGNATURE:** - Complete this section if needed -

- Person being assessed physically/cognitively unable to sign no Authorized Representative present
- Person being assessed refused to sign
- Witnessed person's X as signature or verbal approval Care Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

IL-402-1317 (Rev. 03/08)

**Service Selection and Certification** – Part of the mission of the IDOA is to assist older adults to remain in the community as long as they safely can. Once an older adult enters a nursing facility, it becomes harder to transition them back into the community. Therefore, prescreening should be viewed as an opportunity to prevent unnecessary institutionalizations. All options for community based services must be explained in detail to the participant and participant must be afforded choice of available services. If a participant chooses nursing facility placement then the name and phone number of the facility must be entered in the Service Selection and Certification section. Participants may request a Care Coordinator conduct a face-to-face follow-up within a specified number of days (to be determined by the participant). Some CCUs may be required to conduct follow-ups based upon promises made in their Request for Proposal (RFP). If at the time of follow-up, the participant is not ready for discharge, an additional follow-up may be requested. Care Coordinators should be diligent in their efforts to assist a participant’s return to the community.

**Care Coordinators should refer to IDOA Policy “Choices for Care” dated July 29, 2008 for additional information and required forms (See Attachment C).** Care Coordinators must also certify that the participants have received the Notice of Privacy Practices brochure and that the information provided is true. The participant or authorized representative is required to sign and date the form in the box with the “X”. If a participant is unable to sign the form then the Care Coordinator is required to complete the “Case Noted Signature” box marking the appropriate box.

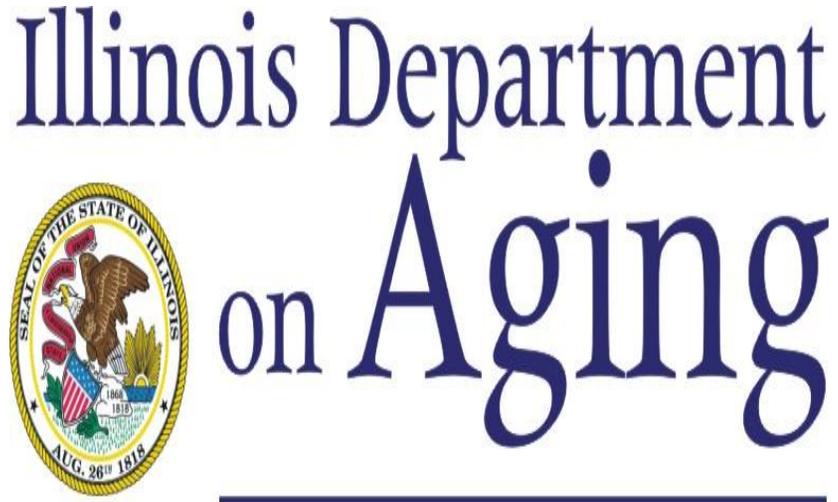
**Disposition:** - The Nursing Facility Screen Form should be printed for signature by the person assessed/authorized representative. A copy should be maintained in the participant’s file.

## IDOA Timeframes:

Referral is made (request for services)	CCU has <b><u>5 calendar days</u></b> from the referral date to respond to the referral by contacting the participant (preferably a phone call).
Initial Assessment	CCU has <b><u>30 calendar days</u></b> to complete an Initial Assessment from the date of the request for services.
Implementation of Goals of Care	CCU has <b><u>15 calendar days</u></b> to make referrals & implement goals of care from the date the participant signed the Goals of Care on page 20 of the CCC tool. This includes all referrals to CCP providers and to non-CCP providers.
Service Start Date	CCP Providers have <b><u>15 calendar days</u></b> from the date of notification to begin providing services to a participant.
Client delay	Participant has <b><u>60 calendar days</u></b> from the signature on the Goals of Care to provide documentation verifying eligibility. Client Delay only pertains to CCP cases.

# Illinois Department on Aging Community Care Program (CCP) Service Authorization Guidelines

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May 1, 2013

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## Introduction

**Purpose:** To authorize services for the Community Care Program (CCP) consistently by Care Coordinators across all Care Coordination Units.

**Background:** Previous tools including the Department sanctioned Best Practices Time for Task guidance developed by the ICCCU as well as guidance in the Community Care Program Handbook under 1251 Plan of Care and 1253 Client Agreement are being clarified and strengthened via the mandated use of the attached guidelines for authorization of CCP services. The guidelines do not impact access or eligibility to the Community Care Program (CCP), Determination of Need (DON) or the Service Cost Maximums. The guidelines are to strengthen quality improvement, assure consistent application of service task approvals across the state and to assure that services are approved according to an individual's need while promoting health, safety and welfare of the CCP participants.

### Services that fall under the Service Cost Maximum

In-home Services offers non-medical support by supervised homecare aides who have received specialized training. Homecare aides perform/assist in a participant's personal care tasks, such as dressing, bathing and grooming, and environmental tasks, such as meal preparation, laundry, light housekeeping and shopping.

The Companion Plan of Care, a companionship of care plans, is a time and cost saving measure, allowing for hours to be used for other services. The Companion Plan of Care is put into place when two or more CCP participants receive homecare services. Non-personal tasks are combined to receive fewer hours for the same task within a single home. Examples include: cleaning the same kitchen, laundry, and cooking a meal for two participants at the same time.

CCP services that also fall within a participant's Service Cost Maximum are Emergency Home Response Service (EHRS) and Adult Day Service (ADS).

Emergency Home Response Service is a 24-hour electronic device that enables eligible participants to secure help in an emergency.

Adult Day Service is the care and supervision of participants in a group setting outside the participant's home. Services may include social activities, transportation, a hot meal, bathing, and medication management assistance. The ADS takes the Care Coordinator's Plan of Care and conducts an Individualized Plan of Care which specifies the participant's needs within this service.

If the participant needs multiple CCP services he or she will be authorized in the most cost effective manner which may include one or all of the CCP services. An example of when multiple services may be required to establish a cost effective plan of care is a participant who requires home care assistant to dress to go to ADS and also uses EHRS when home alone due to frequent falls.

## Guideline Overview:

**Side A** of the DON score should only reflect the person's level of ability to complete the task.

**Side B** of the DON score should only reflect what **Unmet Needs** the person has in completing the task.

The time that it takes to provide the necessary support (help) for the person to complete the task may vary when taking into account several categories of participant conditions.

### Section I – DON Part B side (ADLs/IADLs) Guidance

Section A clarifications provide guidance on assigning service authorization for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) for developing the service plans. Section A focuses on the Level of Need defined by the B-Side (Need for Support) of the 15 ADLs/IADLs on the DON. Each ADL and IADL side-B DON score corresponds to a level of need; LOW, MODERATE or HIGH. The B-side scores are identified by low need (score of 1 on side B), moderate need (score of 2 on side B) and High need (score of 3 on side B). Each of the three groupings has guidance for task assignments. In addition, the guidelines also provide directions on when additional documentation is required to support the authorization.

### Section II – Support for Time Considerations Guidance

This section provides additional considerations in cognitive and medical conditions when determining the time necessary to provide unmet assistance for the participant to complete the task. The expanded definitions in this section provide assistance in not only identifying conditions that may require additional time, but allow flexibility in creating a person-centered plan of care based on the individual needs of the participant. Supporting document or justification of authorization is critical in applying the service authorizations uniformly and consistently and will be reviewed during quality assurance reviews. It is also critical to consider how service tasks may overlap when considering service authorization, assigning services to consider how times may overlap under the ADLs/IADLs. It is critical for Care Coordinators to consider how ADL/IADL service tasks may overlap when authorizing times for the service plan. Situations where multi-tasking or service overlaps occur should be reflected in the services authorized, e.g., the in-home service provider while folding laundry gives eating cues to the participant. The authorization of time would be split proportionately between these two tasks.

**Section I – DON Part B side (ADLs/IADLs) Guidance**

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>1. EATING</b></p> <p><i>Review Participant’s Needs;</i></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance with utensils, adaptive equipment, cutting food &amp; beverages-special diet/food/liquid modifications</li> <li>- dexterity issues</li> <li>- instructions needed</li> <li>- physical assistance needed</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>1-21 times per week</p> <p>15-30 minutes</p> <p>Occasional reassurance</p> <p>Occasional rest breaks</p> <p>Occasional encouragement for participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance with utensils or reminders in managing food or liquids per needs</p>	<p>1-21 times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>31-45 minutes</p> <p>Per medical need (documentation required)</p> <p>Moderate reassurance</p> <p>Moderate rest breaks</p> <p>Moderate encouragement for participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance with utensils or reminders in managing food or liquids per needs</p>	<p>1-21 times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>46-60 minutes</p> <p>Per medical need (documentation required)</p> <p>Frequent reassurance</p> <p>Frequent rest breaks</p> <p>Frequent encouragement for participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete assistance with utensils or reminders in managing food or liquids per needs</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>2. BATHING</b></p> <p><i>Minimum standards - once per week</i></p> <p><u><i>Review Participant's Needs;</i></u></p> <ul style="list-style-type: none"> <li><i>- encouragement</i></li> <li><i>- assistance in &amp; out tub/shower</i></li> <li><i>-assistive device needs</i></li> <li><i>- mobility &amp; balance issues</i></li> <li><i>- instructions needed</i></li> <li><i>- physical assistance needed</i></li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p> <p><i>**Participants with dementia often need extra reassurances of step by step process when water is involved.</i></p>	<p>Once per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>15-30 minutes</p> <p>Occasional reassurance**</p> <p>Occasional rest breaks</p> <p>Occasional encouragement for participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance in bathing of individual</p>	<p>1-2 times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>31-45 minutes</p> <p>Moderate reassurance**</p> <p>Moderate rest breaks</p> <p>Moderate encouragement for participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Partial bathing of individual</p>	<p>3 times a week or more</p> <p>Documentation of medical need required for increased frequency and time</p> <p>46-60 minutes</p> <p>Frequent reassurance**</p> <p>Frequent rest breaks</p> <p>Frequent encouragement for Participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Completely bathe the individual</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>3. GROOMING</b></p> <p><u>Review Participant's Needs;</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance with grooming and hygiene activities</li> <li>- ability to grasp or use hygiene utensils</li> <li>- instructions needed</li> <li>- physical assistance needed</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p> <p><i>**Participants with dementia often need extra reassurances of step by step process when water is involved.</i></p>	<p>1-7 times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>5-10 minutes</p> <p>Occasional reassurance**</p> <p>Occasional encouragement for participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance in grooming task</p>	<p>1-7 times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>11-21 minutes</p> <p>Moderate reassurance**</p> <p>Moderate encouragement for participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Partial assistance in grooming task</p>	<p>As needed per medical need</p> <p>Documentation of medical need required for increased frequency and time</p> <p>22-30 minutes</p> <p>Frequent reassurance**</p> <p>Frequent encouragement for participation</p> <p>Incontinence more than once per day AND requires assistance for peri hygiene</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete assistance in grooming tasks</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>4. DRESSING</b></p> <p><i>Review Participant's Needs;</i></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance with buttons, zippers, pulling &amp; overhead</li> <li>- flexibility and dexterity issues</li> <li>- use of adaptive equipment</li> <li>- instructions needed</li> <li>- physical assistance needed</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>1-14 times per week</p> <p>If greater than 14 times then documentation of medical need required</p> <p>5-10 minutes</p> <p>Occasional reassurance</p> <p>Occasional rest breaks</p> <p>Occasional encouragement for Participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance with clothing</p>	<p>1-14 times per week</p> <p>If greater than 14 times then documentation of medical need required</p> <p>11-20 minutes</p> <p>Moderate reassurance</p> <p>Moderate rest breaks</p> <p>Moderate encouragement for Participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance with clothing</p>	<p>Documentation of medical need required for increased frequency and time</p> <p>21-25 minutes</p> <p>Frequent reassurance</p> <p>Frequent rest breaks</p> <p>Frequent encouragement for Participation</p> <p>If incontinent more than once per day and resulting in soiled clothing and requiring more frequent assistance in dressing</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete assistance in dressing of the individual</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>5. TRANSFERRING</b>  <i>[Assistance in and out of usual sleeping place]</i></p> <p><u>Review Participant's Needs;</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance from one surface to another</li> <li>- mobility &amp; balance issues</li> <li>- instructions needed</li> <li>-use of adaptive equipment</li> <li>-stand by assistance only for safety</li> <li>- physical assistance needed</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>1-7 times per week</p> <p>0-5 minutes</p> <p>Occasional reassurance</p> <p>Occasional rest breaks</p> <p>Occasional encouragement for participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance in and out of the usual sleeping place</p>	<p>1-7- times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>6-15 minutes</p> <p>Moderate reassurance</p> <p>Moderate rest breaks</p> <p>Moderate encouragement for participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance in and out of the usual sleeping place</p>	<p>Documentation of medical need required for increased frequency and time</p> <p>16-21 minutes</p> <p>Frequent reassurance</p> <p>Frequent rest breaks</p> <p>Frequent encouragement for participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete transfer required in out of the usual sleeping place</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>6. CONTINENCE (Toileting)</b></p> <p><u>Review Participant's Needs:</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance to and from restroom</li> <li>- mobility &amp; balance issues</li> <li>- instructions needed</li> <li>- physical assistance needed</li> <li>- frequency and extent of incontinence</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>As needed</p> <p>0-5 minutes</p> <p>Occasional reassurance</p> <p>Occasional encouragement for participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance with toileting</p>	<p>As needed</p> <p>6-15 minutes</p> <p>Moderate reassurance</p> <p>Moderate encouragement for participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance with toileting</p>	<p>As needed per medical need</p> <p>Documentation of medical need required for increased frequency and time</p> <p>16-21 minutes</p> <p>Frequent reassurance</p> <p>Frequent encouragement for participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete assistance with toileting</p>

**7. Managing Money**

***Not completed by CCP providers. Money Management is a Demonstration Project.***

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>8. TELEPHONING</b></p> <p><i>Communicating for essential needs</i></p> <p><u>Review Participant's Needs;</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance with equipment (push buttons/hand unit)</li> <li>- dexterity issues</li> <li>- instructions needed</li> <li>- physical assistance needed</li> <li>- operating phone</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>As needed</p> <p>0-5 minutes</p> <p>Occasional reassurance</p> <p>Occasional encouragement for participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance with equipment.</p>	<p>As needed</p> <p>0-5 minutes</p> <p>Moderate reassurance</p> <p>Moderate encouragement for participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance with equipment.</p>	<p>As needed</p> <p>6-10 minutes</p> <p>Frequent reassurance</p> <p>Frequent encouragement for participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Completing the entire task</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>9. PREPARING MEALS</b></p> <p><u>Review Participant's Needs:</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance in lifting, reaching &amp; grasping</li> <li>- mobility, dexterity &amp; balance issues</li> <li>- adaptive equipment use</li> <li>- cognitive ability for safety awareness</li> <li>- physical assistance needed</li> <li>- in following diet restrictions</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>1-21 times per week</p> <p>0-15 minutes</p> <p>Occasional encouragement for participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance with meal preparation</p>	<p>1-21 times per week</p> <p>1 hour per hot meal / 15 minutes for cold meal</p> <p>1.5 if pre-prepping an additional meal</p> <p>Moderate encouragement for participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance with meal preparation</p>	<p>1-21 times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>1 hour per hot meal/15 minutes for cold meal</p> <p>1.5 if pre-prepping an additional meal</p> <p>Frequent encouragement for participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete all meal prep</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>10. LAUNDRY</b></p> <p><i>Minimum standards - once per week</i></p> <p><u><i>Review Participant's Needs;</i></u></p> <ul style="list-style-type: none"> <li><i>- encouragement</i></li> <li><i>- assistance with laundry tasks</i></li> <li><i>-add travel time of offsite laundry</i></li> <li><i>- mobility &amp; balance issues</i></li> <li><i>- instructions needed</i></li> <li><i>- physical assistance needed</i></li> <li><i>-location of facility</i></li> <li><i>-incontinence more than once per day</i></li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>Once per week</p> <p>15-30 minutes</p> <p>Occasional reassurance</p> <p>Occasional rest breaks</p> <p>Occasional encouragement for Participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance with laundry tasks</p>	<p>1-2 times per week or more</p> <p>Documentation of medical need required for increased frequency and time</p> <p>Up to 2 hours</p> <p>Moderate encouragement for Participation</p> <p>Frequency may increase due to incontinence soiled clothing</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance with laundry tasks</p>	<p>As needed per medical need</p> <p>Documentation of medical need required for increased frequency and time</p> <p>2 hours or above</p> <p>Frequent encouragement for Participation</p> <p>Frequency may increase due to incontinence soiled clothing</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete all laundry tasks</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>11. HOUSEWORK</b></p> <p><u>Review Participant's Needs;</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance with routine cleaning tasks</li> <li>- mobility &amp; balance issues</li> <li>- instructions needed</li> <li>- physical assistance needed</li> <li>- incontinence</li> </ul> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>Once per week</p> <p>1- 2 hours</p> <p>Up to 2.5 with extra bathroom</p> <p>Occasional encouragement for Participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance with routine cleaning tasks</p>	<p>1-2 times per week</p> <p>Documentation of medical need required for increased frequency and time</p> <p>1- 2 hours</p> <p>Up to 2.5 with extra bathroom</p> <p>Moderate encouragement for Participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance with routine cleaning tasks</p>	<p>More than 2 times per week -As needed per medical need</p> <p>Documentation of medical need required for increased frequency and time</p> <p>1- 2 hours</p> <p>Up to 2.5 with extra bathroom</p> <p>Frequent encouragement for Participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Completion of routine cleaning tasks</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>12. OUTSIDE HOME</b></p> <p><u>Review Participant's Needs:</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance in &amp; out of vehicle or residence</li> <li>- consider any special transportation needs and/or distance required</li> <li>- mobility &amp; balance issues</li> <li>- assistive devices needed</li> <li>- instructions needed</li> <li>- physical assistance needed</li> </ul> <p>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</p>	<p>Once per week</p> <p>0.5-2 hours depending on distance and time required</p> <p>Occasional reassurance</p> <p>Occasional rest breaks</p> <p>Occasional encouragement for Participation</p> <p>Cueing</p> <p>Or</p> <p>Minimal assistance in or out of vehicle or residence</p>	<p>1-2 times per week</p> <p>0.5-2 hours depending on distance and time required</p> <p>Moderate reassurance</p> <p>Moderate rest breaks</p> <p>Moderate encouragement for Participation</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate assistance in or out of vehicle or residence</p>	<p>More than 2 times per week - As needed per medical need</p> <p>Documentation of medical need required for increased frequency and time</p> <p>0.5-2 hours depending on distance and time required</p> <p>Frequent reassurance</p> <p>Frequent rest breaks</p> <p>Frequent encouragement for Participation</p> <p>Full step by step instruction</p> <p>Or</p> <p>Complete assistance in or out of vehicle or residence</p>

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>13. ROUTINE HEALTH</b></p> <p><u>Review Participant's Needs:</u></p> <ul style="list-style-type: none"> <li>- encouragement</li> <li>- assistance with medication reminders or removing caps from medication bottles</li> <li>- dexterity issues</li> <li>- instructions needed</li> <li>- physical assistance needed</li> <li>- scheduling and adherence to medication schedule</li> </ul> <p>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</p>	<p>As needed</p> <p>5 minutes</p> <p>Occasional (less than or up to once per visit) encouragement for activities</p> <p>Cueing</p> <p>Or</p> <p>Minimal reminders and uncapping medication bottles or unpackaging of injection materials</p>	<p>As needed</p> <p>6-10 minutes</p> <p>Moderate (two to three times per visit) encouragement for activities</p> <p>Moderate frequency of instructions</p> <p>Or</p> <p>Moderate reminders and additional uncapping medication bottles or unpack aging of injection materials</p>	<p>As needed per medical need</p> <p>Documentation of medical need required for increased frequency and time</p> <p>11-16 minutes</p> <p>Frequent (multiple, almost continually times per visit)encouragement for activities</p> <p>Full step by step instruction</p> <p>Or</p> <p>Full reminders and uncapping medication bottles when needed or unpack aging of injection materials</p>

**14. SPECIAL HEALTH**

*Task in this category completed by ADS medical Staff only.*

Level of Need B-Side DON Score	Low Need 1	Moderate Need 2	High Need 3
<p><b>15. BEING ALONE</b>  <i>In-home services may be used for caregiver respite, when participant cannot be left alone, &amp; when there are no adult day services in the area</i></p> <p><i>*See Section II for COGNITIVE and MEDICAL conditions that affect time for task</i></p>	<p>Cognitive impairments may impact time needed</p> <p>Cannot reach emergency services in an expedient manner</p>	<p>Cognitive impairments may impact time needed</p> <p>Inconsistent ability to recognize danger or reach emergency services in an expedient manner</p>	<p>Cognitive impairments may impact time needed</p> <p>Cannot recognize danger or reach emergency services in an expedient manner</p>

## Section II: Support for Time Consideration Guidance

**Side A** of the DON score should only reflect the person's level of ability to complete the task.

**Side B** of the DON score should only reflect what **Unmet Needs** the person has in completing the task.

The time that it takes to provide the necessary support (help) for the person to complete the task may vary when taking into account several types of participant conditions.

Additional considerations must be given when determining the time necessary to assist the participant to complete the task. Each Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) side-B DON score corresponds to a level of need; LOW, MODERATE or HIGH. The ADL/IADL guidelines also outline areas where additional supporting documentation is needed.

### Expanded definitions of cognitive and medical conditions

These conditions may require additional levels of care in time or frequency.

- Cognition:
  - Confusion about one's location, personal information, orientation to month/day/year, or decreased memory
  - Decreased ability to follow instructions (impaired comprehension), decreased or slow thinking (impaired processing, reaction time), decreased ability to perform logical steps of activity (sequencing impairment), decreased attention to task (attention deficit), repeatedly dozes off (lethargic).
  - Severe cases may include combative behavior during care assistance.
- Depression:
  - Slow moving or sluggishness that appears unrelated to physical impairments
  - Lack of compliance with plan of care
  - Isolation which increases participant risk
- Medical or impairments requiring extended support for time:
  - **Cancer** (e.g. hospice or chemotherapy)
  - **Joint conditions** (e.g. Osteo/Rheumatoid Arthritis) because of pain or limitations in range of motion the participant may move more slowly or need extra time in dressing, bathing transfers)

- **Pulmonary disorders** (e.g. Emphysema, Chronic Bronchitis, Chronic Obstructive Pulmonary Disease [COPD]). These conditions may require frequent rest breaks during ADL/IADLs due to participant becoming winded upon effort or movement. Regulating water temperature, venting steam from room, limiting duration in shower to prevent breathing difficulties may require more assistance.
- **Swallowing disorders** that relate to eating (may require cuing, monitoring or performing for the participant (e.g. tucking chin when swallowing, small bites, clearing palate (mouth) between bites, preparing thickened liquids or altered food consistency needs, requires rest breaks.)
- **Other Eating related conditions**- requiring more time or assistance: e.g. setting up adaptive equipment for self feeding, poor hand to mouth coordination, hand/arm tremors, dental problems that cause difficulty chewing, assistance with cutting food, poor appetite or failure to thrive.
- **Diabetes** - Frequency and thoroughness of bathing needed due to higher risk for infection, or slow wound healing. Conducting skin inspection for locating early skin abrasions (especially around toe nails), applying lotion to control dry skin, applying powder between skin folds to prevent skin breakdown, monitoring foot and nail care to prevent abrasions/infections.
- **Circulatory/ Heart conditions** - May require additional time in ADL/IADLs (e.g. dressing for tight fitting support hose reducing edema and bathing such as conditions requiring more frequent rest breaks, limiting heat/steam exposure.
- **Incontinence or intestinal disorders** (e.g. colitis, Crohn's disease) – assistance in time and frequency may impact bathing, dressing, personal hygiene, homemaking (frequent floor soiling, bed making, laundry).
- **Neurological conditions** (e.g. Multiple Sclerosis, Parkinson's, Traumatic Brain Injury) may impact endurance, strength, fine motor and gross motor skills and cognition increasing time necessary for ADL/IADL's.
- **Renal Disease** (e.g. dialysis)
- **Sensory:** Vision disorders (e.g. blindness, cataracts, glaucoma, macular degeneration, other visual impairment) may require additional orientation while assisting the person or giving choices. Severe hearing deficits may require additional time when assistance is required in using multiple means of communication and frequent repetition of instructions or choices for assistance with ADL/IADL. Neuropathy – inability or reduced sensation may result in frequent spills due to dropping items impacting homemaking and need for assistance.
- **Communication:** Slow expression or understanding (receptive communication) of needs or severe communication deficits (e.g. aphasia) may require more with participant's care.
- **Mobility/Balance disorders** – May require extra time or frequency due to slow or unsteady movement (walking or wheeling). Frequent fall history or a fall evaluation places the person at risk of falls.
- **Pain Syndrome** (e.g. fibromyalgia, chronic pain) may necessitate additional time taken for ADL/IADL performance.
- **Frequently admitted to hospital or ED** – recent history of frequent visits to the hospital emergency department and/or hospitalizations may require additional care planning to ensure the participant's needs are managed to avoid these events
- **Poor adherence to medication schedule** – increased frequency of care to ensure that the participant is able to obtain and safely administer needed medications.