

NEW YORK STATE
 DEPARTMENT OF SOCIAL SERVICES
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 Commissioner

[An Administrative Directive is a written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL NO.: 83 ADM-74
 [Income Maintenance]

TO: Commissioners of Social Services

SUBJECT: Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980:
 Long Term Home Health Care Program

DATE: December 30, 1983

SUGGESTED DISTRIBUTION: All Medical Assistance Staff
 All Services Staff

CONTACT PERSON: Any questions concerning this release should be directed to Bill Mossey, Division of Medical Assistance, by calling (800)342-3715, extension 3-5600. (See Appendix A, summary of revisions made in previous administrative directive, 78-ADM-70.)

I. PURPOSE

The purpose of this release is to acquaint districts with provisions of the major home care legislation of 1977: chapter 895 of the Laws of 1977, and chapter 636 of the Laws of 1980: The New York State LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP).

Among the topics included in this release are:

- a description of the work flow, or order of activities, with respect to the provision of care under this title;
- descriptions of social services responsibilities at each stage of the process; and,
- an explanation of how the Medicare maximization effort applies to services provided under this title.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous Reference
78 ADM-70		505.21	367.C SS Law 3600 PH Law 162 Ins. Law		

DSS-296 (REV. 8/82)

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II. BACKGROUND

The development of less costly alternatives to institutional care and methods to help the chronically ill or disabled and the infirm elderly maintain a degree of independence are issues of national concern which have gained importance in recent years. In New York State, this concern was reflected in Chapter 918 of the laws of 1972, which brought home health care into the mainstream of the health care system by defining the term "home health agency" in Article 36 of the Public Health Law and incorporating the establishment of such agencies in the certificate of need mechanism.

Effective April 1, 1978, New York State initiated a new program designed to provide an alternative for patients who are medically eligible for skilled nursing and intermediate care to stay in their own homes. The legislation is intended to provide a vital stimulus to the use of home care services by coordinating home care programs and making their availability known to potential users of the system. The underlying philosophy of the legislation is that proper delivery of health care at home can assist in changing the approach to providing services for elderly patients in institutional settings by preventing premature institutionalization for individuals who can be cared for at home.

The impetus for development and passage of this legislation was the atmosphere of growing need for long term care by New York State residents and the escalating costs of long term care. The number of elderly in the state is rising and concentrations of this age group can be found in central cities and older suburbs. The need, however, to develop services for chronically ill or elderly frail individuals is statewide, in rural as well as urban areas. Further, the state's five-year deinstitutionalization plan for mental hygiene patients has had, and will continue to have, an impact on the number of long term care beds available. The inappropriate admissions of individuals not in need of skilled nursing or intermediate care, as well as admissions of those who could be cared for at home, has further contributed to the scarcity of available care, and to the escalating cost of institutional care.

It is generally conceded that the increasing frequency with which families, particularly during the past decade, have looked to institutional forms of care for their aged and chronically ill relatives is a reflection of not only the weakening of traditional family ties, but also of the family's fears that adequate forms of care simply do not exist outside the skilled nursing and intermediate care facilities. These fears are recognized as having contributed significantly to the growth of institutional long term care. This program aims to offer a legitimate alternative to institutionalization for those who desire this option and can meet the qualifications.

The costs of financing a health care industry which emphasizes institutional care are enormous. There are, for example, 70,932 skilled nursing beds in New York State and 26,263 intermediate care beds. The average per diem rate for Medicaid patients in those beds in 1982 was \$73.98 and \$47.05, respectively. A survey revealed that the daily average number of patients across the state awaiting alternate care arrangements in hospitals is approximately 4,500. The average cost per day of caring for

those patients was \$250. Medicaid expenditures for skilled nursing care in fiscal year 1980-81 was approximately \$1.1 billion, and for intermediate care facilities \$318 million.

III. PROGRAM IMPLICATIONS

A. Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980

In the statement of intent, it is clearly indicated that this legislation represents a commitment to provide high quality home care services as an alternative to placement in either skilled nursing or health related facilities, recognizing that early provision of services to these patients and the families that support them has a preventive effect in institutionalizing patients. The legislation proposes to achieve this objective through the establishment of Long Term Home Health Care Programs (LTHHCP), the primary purpose of which will be the provision of coordinated home care services to recipients who are medically eligible for care in an institutional setting.

The following features are included in the legislation:

1. A Long Term Home Health Care Program (LTHHCP) is a coordinated plan of care and services provided at home to invalid, infirm or disabled persons who are medically eligible for placement in a skilled nursing facility or health related facility, as determined by the New York State Department of Health Form DMS-1 or its successor.

A LTHHCP may be provided by a certified home health agency (public or voluntary non-profit organization) as certified under Article 36 of the Public Health Law. A LTHHCP may also be provided by a residential health care facility (skilled nursing facility or health related facility) or hospital currently certified under Article 28 of the Public Health Law. However, no such agency, facility or hospital may provide a LTHHCP without the written authorization of the State Health Commissioner. Accordingly, some certified home health agencies may be authorized to provide a LTHHCP as well as the traditional kind of home health care services they are now providing.

2. A LTHHCP is required to provide nursing, medical social services and home health aide services, medical supplies and equipment, all other therapeutic and related services (e.g. physical therapy, speech therapy, respiratory therapy, nutritional counseling, and personal care services including homemaker and housekeeper). In addition, a LTHHCP may provide seven waived services (home maintenance tasks, home improvement services, respite care, social day care, social transportation, home delivered meals, and moving assistance). An example of the way in which these services may be made available would be that a LTHHCP might contract with an approved Social Day Care Program or a certified moving

company in order to provide a LTHHCP patient with a suitable home and adequate socialization.

3. LTHHCP services may be provided in a person's own home or in the home of a responsible relative, but not in a private proprietary home for adults, private proprietary convalescent home, residence for adults, or public home.
4. LTHHCP services can be provided to both Medicaid and non-Medicaid recipients who have been assessed as medically eligible for care at either the skilled nursing or health related facility level.
5. In addition to the financial eligibility of Medicaid users and medical eligibility of all potential users of LTHHCP services, there are two other limitations on coverage:
 - a. A LTHHCP will be available only in social services districts where there are such programs authorized by New York State Department of Health.
 - b. LTHHCP services may be authorized when the total expenditures for health and medical services called for in the comprehensive plan of care do not exceed, on an annual basis, 75% of the monthly cost of care in either a skilled nursing facility or a health related facility in the district, whichever is the appropriate level of care for the individual. The average monthly rate for each level of care in individual counties will be computed by the New York State Department of Health.

When the total monthly expenditure for all health, social and environmental services available under the program exceeds the 75% monthly maximum, LTHHCP services may be authorized if it can be reasonably anticipated that the total yearly expenditures will not exceed 75% of the yearly cost of care in a skilled nursing facility or health related facility. (The determination of the cost of care for an individual is described in Section IV-F, Required Action - Preparation of the Budget, pp. 17-19.)

6. An important LTHHCP feature is the use of a comprehensive and coordinated assessment process to formulate a summary of the required services and a plan of care.
 - a. Assessment Processes - Two distinct assessment processes are required for each individual prior to the development of summary of services requirements for the individual.
 - i. Medical Assessment - This is the initial assessment process and is accomplished by the completion and scoring of the DMS-1 or its successor. This is also

the tool that is used as an indicator for need for SNF or HRF placement. Once this determination has been made and the physician and patient approve of the home care option, a second assessment process is authorized by the local social services district.

Note: Physician Override-A physician override is necessary when a patient's predictor score does not reflect the patient's true level of care. For example, a patient with a low predictor score may require institutional care due to emotional instability or safety factors. The patient's physician designee or the local professional director may give the override.

- ii. Home Assessment - This second assessment is done in order to determine how, and if, the patient's total health and social care needs, as well as those prescribed by the physician, can be met in the home environment. It is accomplished by the joint completion of the Home Assessment Abstract (Appendix B) or its successor by the nurse representative of the LTHHCP and the professional caseworker from the LDSS. It is from the completed Home Assessment Abstract that a summary of services requirements and a plan of care shall be developed.

There are two approaches to performing the home assessment:

- LTHHCP nurse representative and a local department of social services case manager complete a joint home assessment. The local social services district then completes the summary of service requirements and social services authorization prior to the delivery of LTHHCP services or,
- The LTHHCP representative completes a preliminary assessment; based upon this assessment develops a proposed summary of service requirements and delivery of services. However, LTHHCP services are not authorized until the local social services district and the LTHHCP complete a joint home assessment. The LDSS then completes a summary of

service requirements and makes a determination as to service authorization within 30 days of receipt of the written referral. In the event that either the patient is ineligible for the program or any of the services delivered are inappropriate, the LTHHCP will be financially responsible for these unauthorized services. Both home assessment approaches are described further in Section III B Program Implications - Work Flow pp. 7-9.

- b. Summary of Service Requirements is a listing of the types, frequency, and amounts of services which will be necessary to maintain the patient at home in accordance with the physician's orders and the joint assessment. This listing can be found on the Home Assessment Abstract and should represent all the services - medical, nursing, social work, therapies, health aide, personal care, homemaking, housekeeping, drugs, and all other support services - which will be "packaged" as part of the total services to be delivered to the patient.
- c. Plan of Care is an internal, practical, clinical document (developed by the LTHHCP) describing the care to be given to the patient. This plan of care based on the summary of service requirements is drawn up by the nurse from the LTHHCP, includes goals and objectives for the patient and the staff and outlines the methodology and procedures which will be employed to reach those goals. It is a dynamic working document of the LTHHCP and will be part of each patient's record.

B. Work Flow (Process)

The following is a listing of the activities which will be associated with the provision of LTHHCP services in the order they should normally occur for potential and active medicaid clients.

1. The client, or someone on his behalf, indicates that he believes the client is eligible for the LTHHCP, or that the client is medically eligible for SNF or HRF level care.
2. A health and functional status assessment (Office of Health System Management Form DMS-1 or its successor) is completed and scored.
3. If a client is assessed as eligible for skilled nursing or health related care, and a Long Term Home Health Care Program exists in the district, the client must be made aware in writing that the services provided under this title are available as an option to the client.

NOTE: Districts must provide notification at this point to all such potential clients. It will frequently be in the client's, as well as the district's, best interest to notify individuals even earlier of the possibility of their being eligible to receive LTHHCP services. Each district must develop a formal process to assure timely client-notification.

4. The client (and/or his family, representative, etc.) must indicate whether or not he is interested in receiving LTHHCP services. If he is not interested, all activities related to this program cease. If he is interested, preparation is made for the LTHHCP home assessment.
5. For all clients indicating they desire LTHHCP services, and for whom the responsible physician has indicated that home care can appropriately meet their needs, the responsible social services district shall assure that physician's orders be obtained and require that a home assessment be done.

As mentioned above, there are two different approaches to completion of the home assessment process. Paragraphs number 6-11 outline the activities for the first approach (the joint LTHHCP/local social services district assessment and authorization prior to the delivery of services) and paragraphs number 12-19 outline the activities for the second approach (the LTHHCP assessment and delivery of LTHHCP services prior to the joint assessment and DSS authorization).

Joint DSS/LTHHCP Assessment Prior to Delivery of Service:

6. The home assessment is completed on a Home Assessment Abstract form (or its successor) by representatives of both the LTHHCP and Social Services.
7. A summary of services requirements, based on the joint assessment and the physician's orders, is developed, the construction of which is the joint responsibility of the Department of Social Services, the Long Term Home Health Care Program, and when the patient is currently in a hospital or other facility, the discharge coordinator.
8. Should the responsible physician determine that the client's health and safety needs simply cannot be met in a home care setting, the client shall be deemed inappropriate for care under this title.
9. Following development of the final summary of service requirements which list specific kinds and amounts of service to be provided, a budget review will be initiated by the local department of social services. Budget review, in this sense, means a review of the monthly cost of care to determine whether or not the total cost is within 75% of the appropriate monthly average cost for

care in a skilled nursing facility, or health related facility, whichever is appropriate. If the local social services district determines that the total yearly expenditures for providing care are not expected to exceed 75% of the yearly cost of care for a skilled nursing or health related facility, the local district may authorize LTHHCP services.

10. Upon completion of the summary of service requirements, and the social services budget determination, LDSS authorizes services and notifies the LTHHCP to begin providing care. In the event that the local DSS budget determination finds the costs of care exceeding the 75% ceiling on an annual basis, the local district continues to be responsible for finding alternative care options.

NOTE: Upon approval or denial of LTHHCP services authorization, Right to Fair Hearing Notice must be made to client in accordance with existing regulation and procedures (See Section O, p. 28)

11. The LTHHCP nurse representative is responsible for setting up health goals for the patient as well as the plan of care and specifying how service will be delivered within the home as well as assuring that staff delivering such service are doing so in a capable, effective and consistent goal-directed manner. LDSS staff will retain responsibility for social services management as described in Section IV.J, Local Social Services District Management Responsibility, p. 22.

Service Delivery Prior to a Joint Assessment and DSS Authorization

12. The LTHHCP representative performs a preliminary assessment based upon physician's orders and develops a proposed summary of service requirements.
13. Following the development of proposed summary of service requirements and approval by the physician, a LTHHCP representative will determine whether or not the total cost of care is within either the monthly 75% maximum or the annualized 75% maximum allowable in the LTHHCP.
14. If after reviewing the proposed summary of service requirements and service costs the LTHHCP representative has determined that the patient is a suitable candidate for the LTHHCP, then the LTHHCP may decide to provide LTHHCP services prior to LDSS authorization.
15. Since the joint DSS/LTHHCP assessment must be completed prior to or within thirty days after LDSS receives written notification, the LTHHCP should notify the local district as soon as possible. This notification

should immediately be followed by a written notification which includes at a minimum:

- a. Patient identification data (address, social security number, Medicaid number, and Medicare eligibility information).
 - b. Referral source.
 - c. DMS-1, completed and scored.
 - d. Physician orders.
 - e. Proposed summary of service requirements and LTHHCP budget determinations.
16. Within 30 calendar days from the receipt of a referral, the LDSS shall complete the LTHHCP eligibility determination and notify the LTHHCP concerning this decision. This eligibility determination shall be done in the same manner described above in the first assessment approach (numbers 6-11). In other words, there will be a joint DSS/LTHHCP assessment, formulation of a summary of service requirements, budget determination, LDSS authorization and implementation of a plan of care.
 17. LDSS authorizations shall be retroactive to the start of the service.
 18. As with the other assessment approach, LDSS is responsible for finding alternative care options for patients determined ineligible for the program.
 19. The provider will be financially responsible for non-authorized LTHHCP services and all services provided to patients whom LDSS deems ineligible for the program.
 20. If LDSS is late in completing assessments, the provider will only be financially responsible for non-authorized LTHHCP services provided through the thirty day period.

IV. REQUIRED ACTION

This section is intended to provide further clarification of the local district's responsibilities for medicaid eligible patients at key points in the process described above. More specifically:

A. Assessment to Determine SNF or HRF Eligibility

If a LTHHCP, as defined under Article 36 of the Public Health Law, exists in a given social services district, the LDSS official must, before considering authorization for care in either a skilled nursing or health related facility, offer LTHHCP services to all individuals for whom home care is deemed appropriate. The method of determining

who might appropriately receive care under this title involves the assessment to determine the individual's level of care needs. The assessment tool used at this stage is the DMS-1 or its successor, and its purpose is to establish whether the individual is medically eligible for an SNF or HRF.

LDSS should develop a process for patients now receiving personal care services to identify those who might better be served by the LTHHCP. Once these plans have been identified, the local district may initiate a medical assessment (DMS-1) and if appropriate, a home assessment.

The initial assessment will most commonly occur in one of two settings: when the person is a patient in a hospital, or when the person is living in his own home, or the home of a responsible relative or friend.

If the person is currently a patient in a hospital, SNF, or HRF, the DMS-1 or its successor, will be completed in the same fashion as it is currently done, most frequently by the discharge planner. However, if the person is currently in his own home or the home of a relative or responsible adult, the DMS-1 or its successor will most often be completed by the LTHHCP nurse representative or by the patient's physician.

B. Offer of Services

If after the completion of a DMS-1 or its successor, it is indicated that the patient is medically eligible for SNF or HRF level care, and if there is a LTHHCP in the social services district, the local social services official must notify the person both verbally and in writing of the availability of the LTHHCP. In addition, when there is a request for care in an SNF or HRF, and the individual has been assessed as requiring that level of care, provision must be made for verbal and written notification of the availability of LTHHCP services. Local social services districts may coordinate their efforts toward timely verbal notification of the existence of the LTHHCP in appropriate cases by working with discharge planners in facilities within their districts.

Verbal notification as to LTHHCPs should also be timely and given to patients and their families as early after admission as feasible. Notification to a patient's family is especially important when the patient's condition is such that he may be unable to fully comprehend or assimilate future planning needs and projections.

Written notification of the availability of this program is mandatory for all patients who are SNF/HRF eligible if there is a program operating in the patient's place of residence. (See DSS Forms 3057 and 3058 - Appendix D. DSS Form 3057 is required for patients in an institutional setting at the time of notification; DSS Form 3058 is for patients in a home/residence setting at the time of notification.) (Place of residence refers to the place where a patient will be

receiving services.)

While the offer of services as described above is mandatory for the patients being deemed SNF/HRF appropriate, it is suggested that actual notification be given as early as possible upon a patient's hospital admission if it is anticipated that SNF or HRF level of care may be needed on a long term basis after discharge. This may be determined by the patient's physician and/or the discharge planner taking into consideration the patient's diagnosis and anticipated needs. The timely notification of the LTHHCP as an option to institutionalization is imperative if the tide toward placing persons in facilities is to be stemmed.

C. Home Assessment

The assessment of the appropriateness of the LTHHCP in meeting the medical, psycho-social and environmental needs of the patient begins after the following steps have been completed:

1. patient (and family) have indicated a desire to utilize the LTHHCP in order that the patient can remain at home;
2. the physician has concurred that home care is appropriate for the patient;
3. the completed DMS-1 or its successor indicates eligibility for SNF or HRF level of care; and, either
4. the LDSS has authorized the initiation of the home assessment, or anticipating that the client is an appropriate candidate, the LTHHCP initiates a preliminary assessment to be followed within thirty days by a joint home assessment.

The objective of the Home Assessment Abstract (or its successor) is to determine the appropriateness of the home environment in relation to the care the patient will require from the LTHHCP and the feasibility of delivering such care within that setting. Furthermore, it is from a completed Home Assessment Abstract that the summary of service requirements is developed.

The assessment is seen as a collaborative effort between the LTHHCP which will be providing service to the patient and the LDSS. Frequently one of these parties (LTHHCP or DSS) will have had prior contact with the patient which will facilitate the assessment process. In addition, the hospital discharge planner will frequently be able to provide valuable input in the assessment process and in developing the summary of services required by the patient.

The assessment should be accompanied by physician's orders. The orders should be documented on a form which includes the physician's signature.

It shall be the responsibility of the LTHHP nurse to assure that the

orders are written clearly and concisely and reflected on page 4 of the Home Assessment Abstract.

D. Development of a Summary of Service Requirements

Upon joint completion of the Home Assessment Abstract by the nurse from the LTHHCP and the LDSS representative, a list of services needed by the patient must be developed which will adequately meet the patient's health and social service requirements. This summary of service requirements will be used by the LTHHCP nurse to devise a plan of care for the patient. This plan of care will outline specific therapeutic health and social services to be delivered, as well as patient and therapy goals.

The location of the patient will determine who participates in the home assessment process and the development of the summary of service requirements as follows:

1. If a person is currently a patient in a hospital or SNF or HRF:
 - a. the patient's physician;
 - b. the discharge coordinator of the hospital or SNF or HRF;
 - c. a representative of the LDSS; and
 - d. a nurse representative of the LTHHCP which will be providing services to the patient.
2. If the person is currently in his/her own home, or the home of a relative or a responsible adult:
 - a. the patient's physician;
 - b. a representative of the LDSS; and
 - c. a nurse representative of the LTHHCP which will be providing services to the patient.

E. Extent of Involvement

Each member of the "team" involved in the medical assessment, home assessment and summary of service requirements has specific responsibilities:

1. Physician - The importance of the physician's understanding and acceptance of the LTHHCP, as well as an awareness of how the program functions, its capabilities and limitations, cannot be overemphasized. The physician's responsibilities include:
 - a. when involved in the initial assessment (DMS-1 or its successor); the physician must indicate whether or not he deems the patient appropriate for participation in the LTHHCP;

- b. may participate in the assessment process;
 - c. provides specific written medical orders to authorize delivery of health services by the LTHHCP;
 - d. must renew all medical orders every sixty days; and
 - e. participates, if only by written renewal of orders, in the reassessment process every 120 days.
2. Discharge Planner - Participation by this person implies that the patient is currently in a hospital, SNF or HRF. When appropriate, discharge planners work closely with the patient's physician and the facility nursing staff in formulating their input into the summary of service requirements. Responsibilities may vary in different facilities but may include:
- a. providing the initial verbal/written notification of availability of LTHHCP to patients and families. (Often the discharge planner may suggest the appropriateness of the LTHHCP to the patient's physician thereby initiating the whole process);
 - b. completing DMS-1 or its successor, using data from the patient's medical record and in consultation with the physician and the nursing staff;
 - c. collaborating in completing the home assessment with the nurse representative of the LTHHCP and the DSS representative;
 - d. collaborating in completing summary of service requirements in conjunction with the nurse representative of the LTHHCP and the DSS representative; and
 - e. collaborating with nursing staff of the LTHHCP in drawing up the plan of care.
3. DSS Representative - Ideally this person, who participates in the completion of the Home Assessment Abstract will continue his/her involvement with the patient by assuming the responsibility for social services management for LTHHCP authorized patients and providing for continuity of care by this follow-through management. Specific tasks of the LDSS representative as the patient prepares to enter the LTHHCP and during the initial stages in the program include:
- a. assuring initial verbal and written notification to patient and family of availability of LTHHCP or assuring that this has been done in a timely fashion by consultation with the facility discharge planner;

- b. assuring that DMS-1 or its successor is complete and indicative of a level of care (SNF or HRF) which the LTHHCP is to provide;
 - c. assuring determination of Medicaid eligibility for potential LTHHCP clients;
 - d. requiring the initiation of the home assessment to determine appropriateness of the patient's home environment in relation to his/her medical, nursing, social and rehabilitative needs;
 - e. providing the social/environmental input into the home assessment process which shall include family interviews, home visits and collaboration and consultation with the LTHHCP nurse representative with whom the Home Assessment Abstract is jointly completed;
 - f. after developing the summary of service requirements, determines whether LTHHCP services are sufficient to meet the recipient's needs. If the patient requires the provision of other services necessary to maintain him/her in the home environment which are not part of the service package of the LTHHCP provider, but are otherwise available in the community, the LDSS case manager will work cooperatively with the representative of LTHHCP to assure that such services are provided to the patient. Such service provision may include services to other family or household members;
 - g. the preparation of a monthly or annualized budget for the patient to coincide with needs and to ascertain if the cost of care is within the 75% budget cap as specified within the State Medical Handbook. District specific SNF and HRF level budget caps are at present set annually, as of January 1, and are in effect for an entire calendar year. If the patient is not admitted to the LTHHCP, DSS involvement and responsibility continue and an alternative mode of care must be arranged.
 - h. providing overall case management as described in Section J below;
 - i. participating in the reassessment procedure every 120 days and visiting the patient in his/her home at least that often. Also authorizes reassessments if notified by the LTHHCP of a need to change the level of care.
4. Representative from the LTHHCP to be Providing Service -This person will be a registered professional nurse assigned to supervision of the case within the LTHHCP. The LTHHCP nurse representative will be directly responsible for and/or assuring the following:

- a. May be responsible for completing a preliminary assessment and determining a patient's potential eligibility for the LTHHCP prior to the joint assessment;
- b. collaborating with the DSS representative in completing the Home Assessment Abstract with special emphasis on health care needs;
- c. establishing goals for the patient and methodology for achieving these goals by a practical nursing care plan which clearly outlines the nursing, home health aide and personal care services and other therapeutic and supportive modalities. The plan should also outline the methodology of approach and practical applications. The goals should be well defined, measurable, and updated and re-evaluated at each reassessment period (120 days) and whenever indicated. This nursing care plan should be available to all providers of service and should encourage patient input and family participation;
- d. assuring via the nursing plan of care, that the physician's orders are carried out, that care is documented, and that medical orders are renewed every sixty days;
- e. notifying the LDSS representative of any change in the level of care in order to facilitate authorization for a reassessment;
- f. visiting the patient for periodic reassessment at least every 120 days in order to observe relationships between providers of care and patient environment and general condition;
- g. may be responsible for delivery of direct nursing services;
- h. providing supervision of persons providing home health aide and personal care services. This includes evaluating the ability of these persons to carry out assigned duties, to relate well to patients and to work effectively as a member of a team of health workers with particular attention to being able to carry out the plan of care.

Although they may be more frequent, the supervisory visits shall be carried out at least once every two weeks for home health aides and once every three months for personal care services. These visits should include the following:

- (1) an evaluation of the extent to which health care services included in the plan of care have been adequately delivered;

- (2) observation of the patient's surroundings and general condition in relationship to the goals of the plan of care;
 - (3) checking completion of patient reports; outlining all care given to patient, all changes in patient's condition and noting any indication for change in plan or revision of goals; and
 - (4) observation concerning the relationship between the person providing service and the patient and providing patient's family. Special attention should be given toward maintenance of family support of the patient within the program in the realization that such support is essential in the success of the LTHHCP.
- i. coordinating the delivery of all LTHHCP services and working cooperatively with the DSS case manager to integrate into the patient care plan any service provided through the LDSS.

F. Preparation of the Budget

1. Services included in a budget preparation: the computation of a LTHHCP budget should be based upon the cost of services listed in the summary of service requirements (Section 16 of the Home Assessment Abstract) regardless of payment source (Medicaid, Medicare, etc.) The following services are considered.
 - a. Physician Services - An estimate should be made of the frequency of physician visits which will be required by the patient. This should include referrals, if any, to specialists or scheduled clinic visits;
 - b. Nursing Services - The summary of service requirements will include the frequency of nursing visits for treatment and supervision, and will be paid at rates for the LTHHCP established by the Office of Health Systems Management;
 - c. Therapies - The summary of service requirements will include the type and frequency of therapies which will be used by the patient. Therapies will be paid at rates established by the Office of Health Systems Management;
 - d. Podiatry Services - The summary of service requirements will include the type and frequency of the podiatry services which will be used by the patient and all podiatric equipment. The services and equipment will be paid according to the fee schedule established by the Office of Health Systems Management.

- e. Drugs - Those which are prescribed by the patient's physician will be noted in the summary of service requirements and will be paid in accordance with the prices listed by the Department of Social Services.
- f. Personal Care Services - Will be provided or arranged by the LTHHCP, and the scope and frequency of such services will be noted in the summary of service requirements;
 - i. When such services are arranged for through voluntary or proprietary home care agencies, the services shall be paid for at rates already negotiated by the local social services commissioner and in addition shall include administrative overhead.
 - ii. When such services are arranged for through homemaker staff of the local social services district, the LTHHCP shall not bill for the service, but a prorated share of the salary (including the cost of fringe benefits) of the individual providing service shall be included in the monthly budget.
 - iii. When such services are provided directly by the LTHHCP, the services shall be paid for at rates established by the New York State Department of Health.
- g. Transportation - Ambulance service to and from an accredited hospital (as defined in Article 28 of the Public Health Law) and transportation to medicaid reimbursable services normally provided in a RHCF include but are not limited to physician, dental, laboratory, and x-ray. The cost of these services will be based on local prevailing charges or locally negotiated fees.
- h. Other General Items called for in the summary of service requirements, such as disposable medical supplies, should be estimated as closely as possible based on the local district's experience from submission of claims by pharmacies and suppliers.
- i. Durable Medical Equipment called for in the summary of service requirements, such as a bed or wheelchair, may require a single outlay at the initiation of the program or require a monthly rental fee. The cost of purchased items may be annualized for purposes of the monthly budget. (The cost may be divided by 12, and included in the budget for one year.)
- j. Waived Services - As a result of Federal waivers and New York State Law, LTHHCP may offer their patients services not normally covered under the current New

York State Medicaid program. When the New York State Department of Social Services has approved the LTHHCP's waived service delivery plan, including reimbursement rates for all or any one of the services, the LTHHCP may provide one or more of the following services approved in that plan.

- Nutrition Counseling and Education*
- Respiratory Therapy*
- Medical Social Services*
- Home Maintenance Tasks
- Respite Care
- Social Day Care
- Transportation
- Congregate Meal Services
- Moving Assistance
- Housing Improvement

* The provision of these services is required by Health Department Regulations.

- k. The costs associated with the initial assessment are not included in the monthly budget, and are described in Section N. 1. below, page 28.
 - l. Items which are not included in the summary of service requirements, and are required infrequently and incidentally, are not included in the monthly budget. Examples of such items are eyeglasses, hearing aides, dentures, or prostheses.
 - m. Other items which represent unusual expenses, not normally included in RHCF rates, may also be excluded from the budget. These items may include such services as kidney dialysis, radiation therapy, chemotherapy, and the cost of medical transportation to these services. However, since the items included in RHCF rates vary from local district to local district, the LDSS should check with New York State Department of Social Services prior to excluding any item from the patient's budget.
2. Preparation of the Monthly Budgets - Authorizations based upon monthly budgets require that the local social services district compute the monthly service costs based upon the services listed in the summary of service requirements. The monthly budget service costs shall be based upon Medicaid rates established by the Office of Health Systems Management and New York State Department of Social Services. When Medicare is the payor, the Medicare paid amount must be included in the budget. If the recipient of LTHHCP services uses services in an amount less than the 75% monthly ceiling, a "paper credit" should be accrued on his/her behalf to be used in the event of a

period of higher service needs. If the recipient budget and corresponding paper credit computation will be prorated to match the portion of the month that the patient is on the program. (e.g. for a patient admitted on June 15, the June ceiling will be one half the monthly 75% cap.)

3. Preparation of an Annualized Budget - An annualized budget determination may be made during the initial authorization or anytime after the local DSS and the LTHHCP have determined that all the patient's monthly accrued "paper credits" have been utilized and the monthly care expenditures will continue to exceed the 75% ceiling.

Authorizations based upon an annualized budget require that the LDSS and the LTHHCP determine and show in writing that the yearly cost of services in the 12 month period following the date of the assessment is not expected to exceed 75% of the annual cost of either SNF or HRF care.

The LDSS and LTHHCP should consider the following items and document their consideration on the Home Assessment Abstract for the annualized budget:

- a. The anticipated changes in patient status that would result in a decrease in the cost of care, (e.g. anticipated improvements in the patient's medical condition or projections concerning a patient's or family's ability to learn and assume a larger part of his health care).
- b. The anticipated changes in the patient's service needs (e.g. identifying expensive items that will represent a one time cost, identifying a service that the patient will no longer require).
- c. Each annualized budget should be reassessed 120 days following the date of initial authorization. At this time, the LDSS and LTHHCP will determine whether the projected changes in the patient status and service needs have taken place.
- d. In anticipating whether an annualized budget is appropriate for a patient, consideration should be given but not limited to the following types of patients:
 1. Patients for whom the monthly costs of meeting their health and medical services exceed 75% monthly ceiling but for whom it may be reasonably anticipated that there will be one time high cost items. Such items might include expensive medical equipment, moving assistance or housing improvements.
 2. Patients who will require expensive health and

medical services for a limited period of time, (e.g. a recent stroke patient requiring short term physical therapy services or a newly diagnosed diabetic patient requiring skilled nursing instruction for a limited period of time).

4. Additional Budget Determinations - It is understood that the cost of every item of medical assistance for each recipient in the LTHHCP cannot be anticipated in advance. Accordingly, unexpected costs may be incorporated into the monthly budget retroactively.

The provision of these unanticipated services will require local social services district's prior approval only when their costs exceed 10% of the 75% monthly cap.

The local social services district should authorize a reassessment when the patient's monthly budget exceeds the 75% cap by more than 10% for two consecutive months and the accrued payee credits have been used. This reassessment should determine whether the patient is eligible for LTHHCP services based on an annualized budget determination as described above.

If it is determined that the individual's needs will continue to require medical services in excess of both the monthly and yearly ceilings, LTHHCP services are no longer appropriate, alternate arrangements should be made at that time. This statement should not be misconstrued to mean that if a patient's needs cost out to over 75%, he/she must be institutionalized. Where feasible, other forms of home care may be considered.

G. Solving Differences of Opinion

If there is a difference of opinion among the persons performing the assessment concerning the kind or amount of care to be provided, the projected annualized budget, the summary of services required or the delivery of services, the issue may be referred by either party for review and resolution by the local professional director as designated within the area office of the Office of Health Systems Management, State Department of Health. In the case where this individual is not a physician or where there is no local professional director, the State Commissioner of Health shall designate a physician to act in this capacity.

H. Periodic Reassessments

After the initial medical and home assessments, development of the summary of service requirements and implementation of the plan of care, there will be a complete reassessment done every 120 days for each patient. Therefore, no single authorization for Long Term Home Health Care Program services may exceed 120 days.

The reassessment shall include the total re-evaluation of the current health, medical, nursing, social, environmental and rehabilitative needs of the patient by:

1. a nurse representative of the Long Term Home Health Care Program that is providing service to the patient. This nurse may be the person providing the coordination of the case and is responsible for assuring that the reassessment process is within the proper time limits and is done in an efficient professionally accepted manner including revision of nursing goals and updating of plan of care;
2. a representative of the local social services department who may be the case manager and who shares in the responsibility for assuring timeliness of the reassessment process. Additionally, the DSS representative is responsible for all budgeting considerations or changes in the monthly budget which may evolve from a reassessment of needs of the patient;
3. the local professional director or physician designee may also participate in the reassessment process at least to the extent that he/she denotes medical approval of the reassessment and/or any change in the summary of service requirements arising from differences of opinion.

The tool for the periodic reassessment procedure and any resultant change in service requirements should be the DMS-1 or its successor and the Home Assessment Abstract. Copies of all such reassessments shall be in the patient's record at the LTHHCP as well as at the LDSS.

I. Change in Level of Patient Care Needs

If the patient's condition changes to such a degree that the patient moves from one budget level to another (e.g. HRF to SNF), the local social services department shall be notified at the earliest possible time after the changes are observed. The change in budget level should be verified by documented completion of a new DMS-1 or its successor. "Earliest possible time" means the first working day following the noting of a change in the patient's condition.

In collaboration with the LTHHCP, the local social services district shall prepare a revised Home Assessment Abstract, a new summary of service requirement, and monthly budget.

The physician or the nurse representative of the Long Term Home Health Care Program will usually observe and report the necessity for change in budget level, but the responsibility for notifying the local social services department shall rest with the Long Term Home Health Care Program that is delivering services to the patient.

J. Local Social Services District LTHHCP Management Responsibilities

Social Services Management is an integral component of the LTHHCP. This Management combined with the LTHHCP provider Management provides the patient with a coordinated package of services.

1. Patient Notification

The local social services district management responsibility starts with the development of a notification process which assures that all potential LTHHCP recipients or their families are advised concerning the availability of LTHHCP services verbally and in writing.

2. Management of LTHHCP cases

For each potential and active LTHHCP patient, the local social services district must designate one individual who will be accountable for the completion and/or performance of the various management responsibilities listed below:

a. Medicaid Eligibility Application and Recertification:

Assisting with the Medicaid eligibility and recertification procedures and assuring that potential and active LTHHCP patients are financially eligible for Medicaid. This shall include but not be limited to:

- assisting the patients in securing the appropriate documentation and information;
- monitoring the status of the Medicaid Application (certification and application); identifying missing documents and/or information; and notifying the LTHHCP provider and patient appropriately; and
- notifying the provider and patient concerning Medicaid acceptance, denial or discontinuance; dates of Medicaid coverage; and the amount of monthly surplus income.

b. Physicians' Orders and DMS-1:

Assuring that the LTHHCP providers obtain necessary medical documentation of service need, including physician's recommendation and level of care assessment, DMS-1 (or its successor).

c. Home Assessment:

Authorizing the initial Home Assessment to determine the appropriateness of a LTHHCP.

Completing, in conjunction with the nurse from the

LTHHCP, the Home Assessment Abstract which may include family interviews, home visits and consultation with the nurse from the LTHHCP concerning the social/environmental aspects of the individual's needs.

d. Budget Computations:

Computing the monthly and/or annual budget based upon the completed summary of services requirements in the Home Assessment Abstract for comparison with appropriate ceiling; maintaining any "paper credit" accruing on behalf of the individual.

e. Authorization for LTHHCP Services:

Authorizing LTHHCP services and notifying the provider concerning admission dates.

f. Referral to Alternate Services When Patients are Determined Ineligible for LTHHCP:

With the assistance of the LTHHCP provider, referring ineligible patients to alternate services and assuring that appropriate services are provided.

g. Provision of Non-LTHHCP Services:

Assisting the LTHHCP provider in arranging for the delivery of other services not available in the LTHHCP (adult protective services, legal counseling, recreation therapy, financial counseling, friendly visitors and/or telephone reassurance).

h. Reassessment:

Participating in the periodic reassessment (every 120 days) procedure on an ongoing basis and in the event of a change in the patient's care needs.

i. Changes in Plan of Care:

Incorporating any change in the summary of service requirements into the monthly budget and authorizing any changes which exceed the authorized budget by more than 10% or fifty dollars (whichever is greater), and adjusting paper credits.

j. Monitoring:

Monitoring to assure that LTHHCP services are provided within the 75% cap; in cooperation with the LTHHCP provider, monitoring to assure services are provided in accordance with the summary of service requirements.

k. Relationship with the Patient and Family:

Maintaining a positive relationship with the patient and the family. This includes clearly identifying the names and telephone numbers, and responsibility of Social Services personnel, who will be contacting the patient. It also includes supporting the family's involvement in the program. (Maintenance of this relationship should not be taken as a substitute for the provision of Medical Social Services to the patient or family; rather it should be seen as adjunctive to and with the full knowledge and support of the LTHHCP provider.)

K. Long Term Home Health Care Program Provider Management Responsibility

In addition to the actual provision of services, LTHHCP providers have management responsibilities. These responsibilities include the following:

1. Medicaid Eligibility Application and Recertification:

Assisting the patient in completing forms and securing appropriate documentaton.

2. Physician Orders and DMS-1:

Obtaining necessary physician orders and the DMS-1 or its successor.

3. Home Assessment:

Completing, in conjunction with the social services representative, the appropriate sections of the Home Assessment Abstract.

4. Referral to Alternate Services when Patients Determined Ineligible for LTHHCP:

Assisting the LDSS in referring patients determined ineligible for the program to appropriate alternatives, and assisting the local social services district to assure that such services are provided.

5. Provision of LTHHCP and Non-LTHHCP Services:

Coordination of the provision of LTHHCP Services (nursing, home health aide, physical therapy, etc.) and with the assistance of the local social services district, non-LTHHCP Services (adult protective services, legal counseling, financial counseling, etc.).

6. Reassessment:

Participating in the periodic reassessment (every 120 days) procedure on an ongoing basis and in the event of a change in the patient's care needs.

7. Changes in Plan of Care:

Notifying the local social services districts the first working day following the noting of a change in the patient's condition and concerning any changes in the authorized summary of services. Seeking prior authorization for any service change which exceeds by 10% or more the 75% cap for the patient.

Notifying the local social services district concerning hospital admissions and other changes in status that might indicate the need for discharge.

L. Maximization of Medicare Benefits

1. Medicare Maximization:

Chapter 895 of the Laws of 1977 states that no Medicaid payment shall be made for benefits available under Medicare without documentation that Medicare claims have been filed and denied. Since the LTHHCP or any approved Medicaid provider subcontracting for certain services for the LTHHCP will be the only Medicaid billing source, each will be expected to assume responsibility for the Medicare maximization effort.

All LTHHCPs should have established Medicare home health provider status. Certified home health agencies will already have this status; some residential health care facility and hospital programs may not. Those who are not yet Medicare home health care providers, will receive this status once the State Department of Health has performed satisfactory on-site surveys and received approval from the Department of Health and Human Services. New Medicare providers will be expected to assume the responsibility for the major Medicare maximization effort starting on the date of their certification as a Medicare provider.

2. Third Party Coverage Generally:

Chapter 647 of the Laws of 1975 had amended subsection ten of Section 162 of the Insurance Law to require that insurers who issue group policies making provision for inpatient hospital care must also provide coverage for home care.

Chapter 895 further amends the Insurance Law to define what home care shall include. In doing so, the applicable features of the Long Term Home Health Care Program are repeated, thereby ensuring that benefits provided under recently issued

policies will be available for insured parties who are found eligible for the LTHHCP.

For a more detailed account of what the Insurance Law requires, districts should review the statute itself (162, d. 10). For the maximization of Third Party Resources, the local district should follow the guidelines set forth by this Department in the recently issued 82 ADM-20 and in the Third Party Resource Desk Guide.

M. Priorities

The primary emphasis of the LTHHCP will be placed upon offering services to patients currently occupying acute care beds while awaiting placement in either a skilled nursing or health related facility. There are areas within New York State where many patients are "backed-up", at significantly higher acute care costs, simply because SNF and HRF beds are not available.

It is anticipated that the offering of an alternative option, the LTHHCP, to SNF and HRF-bound patients will channel many of these patients away from institutionalization and allow them to be cared for at home.

Other groups targeted as priorities are persons in the community who become ill or disabled and who are medically eligible to be placed in an institution (SNF or HRF) as well as those persons who are currently in SNF and HRF facilities and who desire to return to their home and are deemed eligible for the program.

The LTHHCP is seen as having its greatest impact on delaying or substituting for the institutionalization of patients through early identification of eligible clients. This "preventive" approach is more clearly seen in the early identification of patients who are supported by family members. Early identification of a patient before service requirements escalate or the patient's condition deteriorates will enhance the preventive potential of LTHHCP services. Supplying support to these patients and families before the families become overburdened will enhance their efforts and increase the likelihood of their continued support. Every effort should be made to determine LTHHCP eligibility when and where patients are routinely assessed or reassessed for changes in level of care or service provision, regardless of what service or which program is currently supplying care.

N. Payment for Assessments and Reassessments

Payment for the initial assessment (via the DMS-1 Home Assessment Abstract or other successors) of a patient to determine appropriateness and extent of services by a LTHHCP shall not be included in any monthly budget. Payment for assessment shall be as follows:

1. Payment for staff participation in discharge planning is included in the current hospital facility Medicaid rate and shall not be paid as a separate service.
2. If the patient is in a hospital or facility and the physician is not on the staff, reimbursement for the initial assessment is included in the physician's visit fee.
3. If a patient is in the community and (a) the assessment takes place in a clinic, reimbursement for the initial assessment is included in the clinic rate for the care provided; (b) the assessment takes place in the home, reimbursement for a physician performed assessment is included in the physician's home visit fee; (c) the assessment takes place in the home, reimbursement for a certified home health agency nurse performed assessment is included in the CHHA home visit fee; (d) the assessment takes place in the physician's office, reimbursement for the initial assessment is included in the physician's office visit fee.
4. Reimbursement for all assessments and reassessments by LTHHCP providers shall be included in the administrative costs of the LTHHCP provider.

O. Right to Fair Hearing

Clients are entitled to notice and a fair hearing if any of the following decisions affecting their care under the LTHHCP are, or are to be, taken:

1. their application for LTHHCP services is denied;
2. LTHHCP services are to be discontinued;
3. a change from an SNF level budget to an HRF level budget

The notice shall inform clients of:

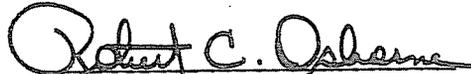
1. their rights to a local conference. This conference does not affect their rights to a fair hearing;
2. the fair hearing request process. The hearing must be requested within 60 days from the date of receipt of the notice; if the client desires services to continue pending a fair hearing, the hearing must be requested within 10 days from the date of receipt of the notice;
3. their rights to legal representation;
4. their rights to cross-examine adverse witnesses;
5. their rights to present evidence, documents and/or witnesses in their own behalf.

LDSS's must provide written notification far enough in advance as to afford clients an opportunity to request scheduling of a fair hearing while services are continued at present (former) levels. LDSS's should make an effort to:

1. keep patients well informed as to the kinds of services they are to receive and the dates upon which they can expect certain services;
2. advise clients in a positive manner as to the reasons for changes in services;
3. advise clients of scheduling changes in delivery of services already being received.

V. Effective Date

This Administrative Directive will be effective as of January 1, 1983.



Robert C. Osborne
Deputy Commissioner
Division of Medical Assistance

APPENDIX A

Summary of changes made in the revised administrative directive.

Changes required by Chapter 636 of the Laws of 1980:

1. Annualization of the Budget

Originally the cost of providing Long Term Home Care services could not exceed 75% of the monthly cost of providing HRF or SNF care. As a result of the new legislation, the cost of care can be calculated on a yearly basis, thus ensuring that short term initial costs will not preclude participation for individuals whose care needs would decrease over a longer period. (See pp. 17-18)

2. Alternate Entry Procedures

The legislation allows the LTHHCPs to admit patients following the completion of an initial assessment rather than requiring the immediate completion of a comprehensive assessment. This more flexible assessment will allow LTHHCPs to provide services to patients who require services immediately. (See Work Flow pp. 7-9)

3. Medical Eligibility for the LTHHCP

In the previous ADM, the provision of LTHHCP services was limited to patients who were SNF or HRF eligible and who would otherwise require institutional placement. This last requirement resulted in a strict interpretation. All patients who could be cared for in other home care programs (e.g. personal care services) were not considered for the LTHHCP. Under the new legislation, the patient need only be medically eligible for SNF or HRF care.

(N.B. the 75% cap on costs of care and other provisions still remains.)

4. LTHHCP services can be provided to non-Medicaid patients (p. 5)

Administrative Changes

1. Clarification of Items included within patient budget determinations (pp. 12-16)
2. Clarification of the following issues: local social services and Long Term Home Health Care Provider Management Roles (pp. 19-20), physician override (p. 6), and Medicare Maximization (p. 20).
3. Reporting Requirements added.

The basic program features remain the same. (See pp. 3-6 for summary)

-a coordinated package of services

-a program available only to patients who are medically eligible for SNF or HRF care;

APPENDIX A

-a joint DSS/LTHHCP home assessment and development of a summary of services plan prior to DSS authorization;

-75% cap on the cost of providing LTHHCP services;

-case management, 24 hour coverage.

7. To be completed by S S W

OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.

If none will assist explain in narrative.

Name	Age	Relation-ship	Days/hours at home	Days/hours will assist
1.				
2.				
3.				
4.				

8. To be completed by S S W

SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

Name	Address	Age	Relationship	Days/Hours Assisting
1.				
2.				
3.				
4.				
5.				

9. To be completed by S S W

COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.				
2.				
3.				
4.				

10. To be completed by S S W and R.N.

PATIENT TRAITS:

	Yes	No	? N/A	If you check No, ? N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts Diagnosis				
Motivated to remain at home				

11. To be completed by S S W and R.N. as appropriate.

FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because _____
b. Is capable of providing care (physically & emotionally)				If no, because _____
c. Will keep patient home if not involved with care				Because _____
d. Will give care if support services given				How much _____
e. Requires instruction to provide care				In what—who will give _____

12. To be completed by R.N.

HOME/Place where care will be provided:

	Yes	No.	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, others (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: _____

13. To be completed by R.N.

RECOVERY POTENTIAL ANTICIPATED

COMMENTS

Full recovery _____	<input type="checkbox"/>	_____
Recovery with patient managed residual _____	<input type="checkbox"/>	_____
Limited recovery managed by others _____	<input type="checkbox"/>	_____
Deterioration _____	<input type="checkbox"/>	_____

14. To be completed by RN - SSW to complete "D" as appropriate

FOR THE PATIENT TO REMAIN AT HOME - SERVICES REQUIRED

WHO WILL PROVIDE

SERVICES REQUIRED			WHO WILL PROVIDE		
	YES	NO	TYPE/FREQ/DUR	AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O ₂ , medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

15. To be completed by SSW and RN.

DMS Predictor Score _____ Override necessary Yes No

Can patients health/safety needs be met through home care now? Yes No

If no, give specific reason why not _____

Institutional care required now? Yes No If yes, give specific reason why. _____

Level of institutional care determined by your professional judgment: SNF HRF DCF

Can the patient be considered at a later time for home care? Yes No N/A

16. To be completed by SSW
SUMMARY OF SERVICE REQUIREMENTS

Indicate services required, schedule and charges (allowable charge in area)

Services	Provided By	Hrs./Days/Wk.	Date Effective	Est Dur.	Unit Cost	Payment by			
						MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication									
1.									
2.									
3.									
Medical Equipment									
1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services									
1.									
2.									
SUBTOTAL									
Structural Modification									
Other (Specify)									
1.									
2.									

SUBTOTAL _____

TOTAL COST _____

17. To be completed by SSW and RN

Person who will relieve in case of emergency

Name	Address	Telephone	Relationship

Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:

_____ R.N.

_____ Agency

_____ Date Completed

_____ Telephone No.

_____ Local DSS Staff

_____ District

_____ Date Completed

_____ Telephone No.

_____ Supervisor DSS

_____ District

_____ Date

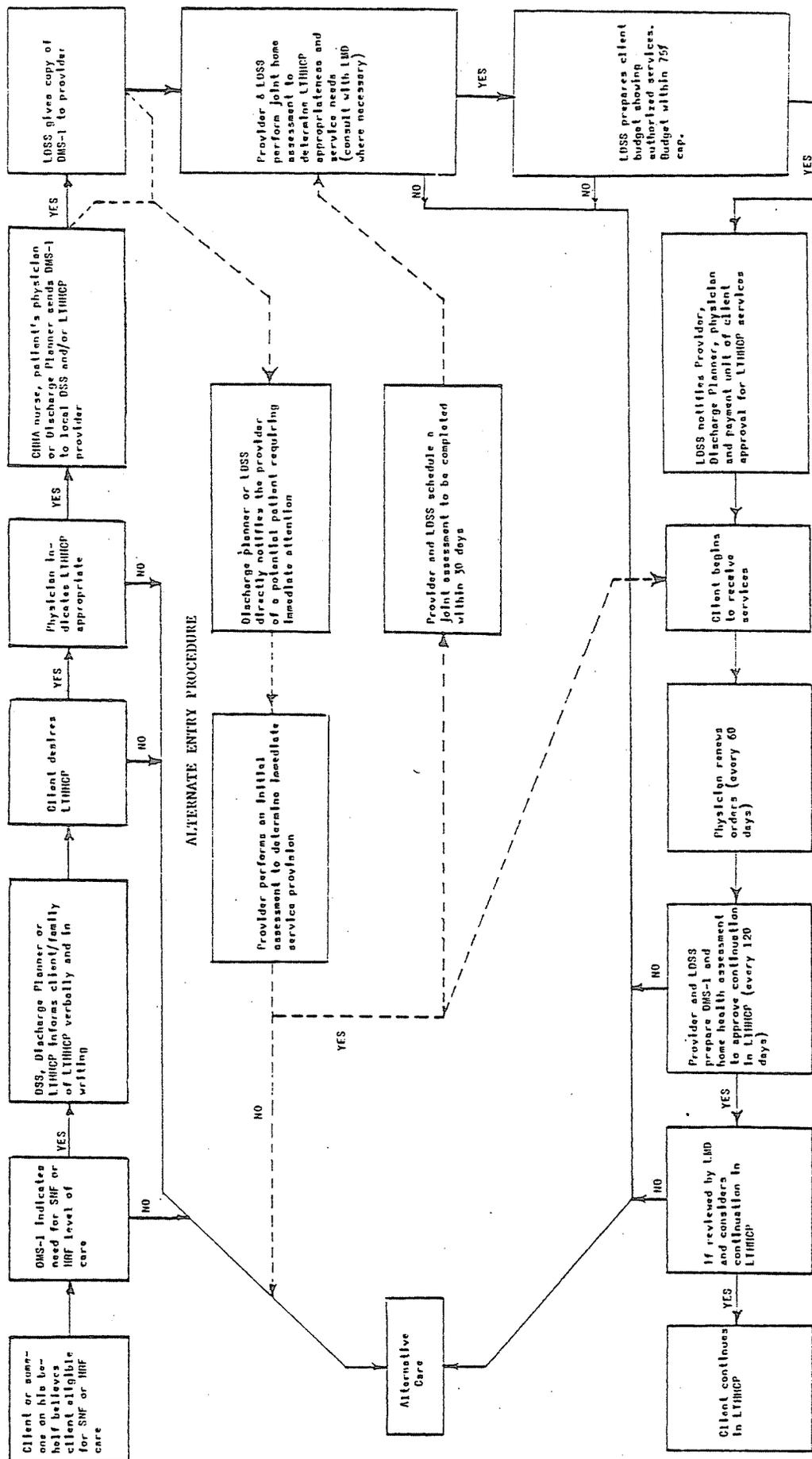
_____ Telephone No.

Authorization to provide services:

_____ Local DSS Commissioner or Designee

_____ Date

CLIENT ENTRY INTO LONG TERM HOME HEALTH CARE PROGRAM



* CIMA (Certified Home Health Agency)

LONG TERM HOME HEALTH CARE PROGRAM
(LTHHCP) - CHECKLIST

INSTITUTIONALIZED PATIENT

This form is to be completed by the discharge planner for patients who are Medicaid recipients and who have been determined as requiring SNF or HRF level care when there is a LTHHCP in the social services district. This form should be completed on all patients who meet the above criteria even if it has been determined that home care is not a viable alternative for the patient. The form will be used as an evaluation tool for the LTHHCP. When complete, it should be forwarded, together with the DMS-1, to the social services office.

PATIENT'S NAME	
HOME ADDRESS	
PRESENT LOCATION	
Date admitted to present location	
HOSPITAL NUMBER:	MEDICAID NUMBER:

1	Date of DMS-1 completion indicating SNF/HRF level of care	
	DMS-1 Score (Attach form)	
2	Date <input type="checkbox"/> Patient <input type="checkbox"/> Family notified verbally and in writing of a LTHHCP option	
	<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected	REASON FOR REJECTION
	SIGNATURE/TITLE	
3	Date LTHHCP option for this patient was discussed with physician	
	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	REASON PHYSICIAN DISAPPROVED
	NAME OF PHYSICIAN	
		SIGNATURE/TITLE

If numbers 2 and 3 are affirmative, number 4 MUST be completed.
If either number 2 or 3 are rejections, forward this form and completed DMS-1 to LOCAL Department of Social Services.

4	Date local social services notified of this potential LTHHCP patient (telephone notification is acceptable)	
	NAME OF LOCAL DSS STAFF NOTIFIED	SIGNATURE/TITLE
5	Date of Patient Discharge	COMMENTS ON DISCHARGE
	DESTINATION	
	SIGNATURE/TITLE	

When completed, attach DMS-1 and send both forms to local social services office.

DSS-3058 (10/78)

**LONG TERM HOME HEALTH CARE PROGRAM
(LTHHCP) - CHECKLIST**

PATIENT AT HOME

PATIENT'S NAME		MEDICAID NO.	
HOME ADDRESS			
a. Date of initial contact with LTHHC or CHHA			
b. CONTACT (request for service/placement) MADE BY			
c. ATTACH COPY OF DMS-1		DATE OF DMS-1	DMS-1 SCORE

This form is to be completed by the nurse from the LTHHCP or CHHA who is assessing the patient for level of care needs (DMS-1). The form is to be done on all Medicaid Patients who have been determined as requiring SNF or HRF level of care when there is a LTHHCP in the social services district. It must be completed whenever the DMS-1 indicates SNF or HRF level of care is appropriate even if home care is not viewed as a viable alternative. This form will be used as an evaluation tool for the LTHHCP as well as assisting in meeting the requirements for notification to all SNF/HRF eligibles of the alternatives in the LTHHC Program.

2	Date <input type="checkbox"/> Patient notified verbally and in writing of LTHHCP option		
	Date <input type="checkbox"/> Family notified verbally and in writing of LTHHCP option		
	<input type="checkbox"/> Accepted	REASON FOR REJECTION	SIGNATURE/TITLE
	<input type="checkbox"/> Rejected		
Date LTHHCP option for this patient was discussed with physician			
3	PHYSICIAN <input type="checkbox"/> Approved	REASON PHYSICIAN DISAPPROVES	NAME OF PHYSICIAN
	<input type="checkbox"/> Disapproved		SIGNATURE/TITLE

If numbers 2 and 3 are affirmative, number 4 MUST be completed.
If either number 2 or 3 are rejections, forward this form and completed DMS-1 to LOCAL Department of Social Services.

4	Date local social services notified of this potential LTHHCP patient (telephone notification is acceptable)	
	NAME OF LOCAL DSS STAFF NOTIFIED	SIGNATURE/TITLE
5	Date of completion of Home Assessment Abstract (HAA)	By Registered Nurse
		By DSS Caseworker
COMMENTS		
6	DECISION ON PLACEMENT	DATE
	COMMENT	SIGNATURE/TITLE

When completed, attach DMS-1 and send both forms to local social services office.