3

CASE MANAGEMENT

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ADULT SERVICES CASE MANAGEMENT

3.1 Case management

The case management process is a systematic approach essential to effective service delivery that actively involves the service worker, the adult, and the adult's family in developing, achieving, and maintaining meaningful goals. The purpose of case management is to structure the service worker's focus and activities to assist the adult in reaching his or her goals and to assure that the adult receives appropriate services in a timely manner.

3.2 Definitions

The following terms are defined in state regulation 22 VAC30-130, Adult Services Standards, *unless indicated otherwise*.

Term	Definition
Activities of Daily Living or ADLs	Bathing, dressing, toileting, transferring, eating/feeding, and bowel and bladder continence.
Adult	An individual 18 years of age or older, or younger than 18 years of age if legally emancipated.
Adult Foster Care	*Room and board, supervision, and special services to an adult who has a physical or mental condition. Adult foster care may be provided by a single provider for up to three adults (22 VAC 30-120-10).*

Term	Definition
Adult Services	Services that are provided by local departments of social services to adults with an impairment.
Adult with an impairment	An adult whose physical or mental capacity is diminished to the extent that the adult needs counseling or supervisory assistance or assistance with ADLs or instrumental activities of daily living
Auxiliary Grants or AG	Cash payments made to certain aged, blind, or disabled individuals who receive benefits under Title XVI of the Social Security Act, as amended, or would be eligible to receive these benefits except for excess income.
Chore Services	Non-routine, heavy home maintenance services provided to adults, including minor repair work on furniture and appliances in the adult's home; carrying coal, wood, or water; chopping wood; removing snow; yard maintenance; and painting.
Companion Services	Services to an adult, including light housekeeping, companionship, shopping, meal preparation, transportation, laundry, money management, and assistance with ADLs.
Department	Department for Aging and Rehabilitative Services
Department Designated Case Management System	The official state automated computer system for adult services that collects and maintains information on adult services provided by the local department. ***Note: The case management system is called PeerPlace***.
Eligibility Based on Income	An eligibility category under which the adult's eligibility for services is based upon an income scale issued annually by the department.
Home-based Services	Companion, chore, and homemaker services that allow adults to attain or maintain self-care and are likely to prevent or reduce dependency.
Homemaker Services	Services that provide the adult instruction in or the performance of activities to maintain a household. Homemaker services may include personal care, home management, household maintenance, nutrition, and consumer or hygiene education.

Term	Definition
Income Maintenance	An eligibility category under which the adult is eligible for a service because the adult receives Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) or AG.
Instrumental Activities of Daily Living or IADLs	Tasks such as meal preparation, shopping, housekeeping, money management, transportation, using the telephone, home maintenance, and laundry.
Local Board	Local board of social services representing one or more counties or cities.
Local Department	The local department of social services of any county or city in this Commonwealth.
Public Assistance	TANF, AG, medical assistance, energy assistance, supplemental nutritional assistance program, employment services, child care, and general relief.
Responsible Person	An individual who is authorized under state or federal law to make decisions concerning the adult and to receive information about the adult.
Service Plan	A written plan to address the needs of the adult
Social Supports	Individuals or organizations who routinely provide assistance or support to the adult.
Uniform Assessment Instrument or UAI	The Department-designated assessment form. It is used to record information about the adult's level of service needs.
Universal Access	An eligibility category under which the adult is eligible for services without consideration of the adult's income.

3.3 Confidentiality

The Code of Virginia and federal laws and regulations require that LDSS keep an individual's information confidential. With certain Adult Protective Services (APS) program exceptions, the adult shall give written permission before information may be obtained from other sources or shared with another person or agency. The form, entitled "Consent to Exchange Information" is located on the DSS intranet and DARS public site and shall be used when sharing information. A copy of the completed Consent to Exchange Information form shall be uploaded to the attachments tab in the client registration. See Chapter 6, "Confidentiality" for additional information on confidentiality.

3.4 Adult services intake

> (22VAC30-130-20). Intake is designed to provide a timely, coordinated method for the adult to request services or assistance or to obtain sufficient information about other resources.
>
> The local department shall be responsible for performing intake activities. These activities may include information and referral or initial assessment for assistance as indicated by the adult's situation.

Upon determining that the request for assistance or services is not an APS report, the worker proceeds with the Adult Services *(AS)* intake process. The initial contact may be made by telephone, office visit, and/or through a referral from another agency. Services provided may include information and referral, initial screening and assessment, crisis intervention, and assistance with emergency needs if indicated by the case situation or assessment.

3.4.1 Information and referral

Information and referral is one way to handle a request for services that are not arranged or provided by the LDSS. Providing information and referral helps the individual locate and use resources to meet his or her needs. Any adult is eligible for information and referral assistance, regardless of income or eligibility for benefit or service programs.

A worker is not required to register a client in PeerPlace for information and referral. If assistance is needed beyond information and referral, the adult shall complete a Service Application.

3.4.1.1 Information

The service worker provides information on the availability, accessibility, and use of resources. This may be all the individual needs to make his or her own arrangements to access a resource.

3.4.1.2 Referral

The service worker contacts a resource and helps the adult arrange to receive the needed service. This is appropriate for individuals who are unable to use the information without additional help.

The Statewide Information and Referral (I&R) System, also known as 211, provides citizens of the Commonwealth with free and confidential information and referral to health and human service resources. To access 211, individuals may dial “211” on their phone or visit the 211 website.

3.5 Services and activities

Local departments shall provide the following ~~adult services~~:

- Screenings for long-term care services and supports pursuant to §32.1-330 of the Code of Virginia
- Public pay assisted living facility assessments pursuant to §63.2-1804 of the Code of Virginia
- Review of annual reports submitted by guardians pursuant to §64.2-2020 of the Code of Virginia
- Home-based services (HBS) to the extent that federal or state funding is available, as requested by an adult with an impairment who meets financial and functional eligibility criteria. (22 VAC 30-130-30).

The Department of Medical Assistance Services (DMAS) Screening Manual for Medicaid Long-term Services and Supports (LTSS) Chapter IV provides guidance regarding Medicaid LTSS screenings. The LTSS Screening Manual is located on the DMAS MES public portal.

LDSS should follow the Public Pay Assisted Living Facilities (ALF) Assessment Manual for procedures on assessment and placement in ALFs for AG applicants and recipients. The ALF Assessment Manual is located on the DARS public site.

LDSS should use Chapter 7, Guardianship and Conservatorship for procedures on petitioning for guardianship and conservatorship and review of annual guardian report forms.

3.5.1 Optional services

> *(§63.2-1601 of the Code of Virginia). Each local board is authorized to provide adult foster care services that may include recruitment, approval, and supervision subject to the supervision and in accordance with regulations of the Commissioner for Aging and Rehabilitative Services as provided in Article 4 (§ 51.5-144 et seq.) of Chapter 14 of Title 51.5.*

3.6 AS Application

> (22VAC30-130-40). To request home-based services, the adult or the adult's responsible person shall submit a service application (Application for Adult Services Form) to the local department.

- The service application shall be on a form provided by the department.
- The local department shall document receipt of the application in the department-designated case management system.
- A service application shall not be required to request *an LTSS* screening, for an *ALF* assessment, or for review of an annual guardian report. (22 VAC-30-130-40).
    - **Note:** Pursuant to state law, a request for a screening shall be processed as quickly as possible, but no later than 30 days from the date the screening was requested.
    - If additional services are requested beyond the reassessment, screening or guardianship report review, a signed service application shall be obtained.

Anyone may apply for services. There shall be no requirement as to citizenship or length of residence in the jurisdiction. The adult may request an application in person, by mail, or by telephone. Telephone calls to the LDSS are not considered an "application" unless the request is for a *Medicaid LTSS* screening. A Service Application, which includes the consent form, is available on the DSS intranet and the DARS public site.

- LDSS shall accept all applications.

- The LDSS shall give the adult the opportunity to complete an application in-person at the LDSS. An application requested by mail or telephone shall be mailed to the adult the same day. The individual should be informed that applications are also available on the DARS public site.

- The LDSS shall assist the individual with completing the application if the individual requests assistance. A home visit may be necessary if the individual is unable to get to the LDSS. If the individual is capable, the worker shall discuss the service request with the individual to ensure that the services requested or applied for are desired by the individual.

- The following shall be explained at intake:

    - How eligibility is determined.

    - Rights and responsibilities of the individual applying for services. Rights and responsibilities are listed on the service application.

- The individual shall be referred to public assistance programs or other financial assistance when appropriate.

3.6.1 Service application initiated by the individual

If the individual or responsible person applies for services, a service application shall be completed. Once the signed service application is received the LDSS shall upload it under the attachments tab in the AS Registration. The LDSS shall consider an application as “pending” until the LDSS has determined eligibility for the service.

3.6.2 LDSS-initiated service application

The LDSS may initiate a service application on behalf of an adult when the applicant is unable to sign the application or is incapacitated.

3.6.3 Date of application

The date of application is one of following:

- The day the completed and signed Service Application is received by the LDSS.

- The date of the receipt of a valid APS *report*. The report serves as the application until a disposition is made. If the disposition is “Needs Protective Services and Accepts,” the worker will obtain a signed and dated application from the individual or his representative or the worker will complete a department-initiated application.

3.6.4 When a new application is needed

A new application is needed only when a case is properly closed and the individual wishes to reapply for services. A new application is not needed when a new service is added to the service plan.

3.7 Determining eligibility for *HBS*

> (22VAC30-130-30). Local boards shall establish a local home-based services policy that includes the types of home-based services that are offered in the locality, the functional eligibility criteria, and the financial eligibility criteria as decided by the local board.

LDSS should review the HBS policy annually to ensure it reflects the LDSS's mission, the community's needs, and state law and regulations. The policy should specify the maximum number of hours of HBS per adult per week and the rate of pay for a provider. A provider shall be paid at least the Virginia minimum wage. The APS Division AS Specialist is available to provide technical assistance to LDSS regarding the HBS policy at the time it is developed or revised.

3.7.1 Timeframe to determine eligibility

> (22VAC30-130-40). Determinations for functional eligibility and financial eligibility are separate processes but shall be pursued simultaneously. Functional and financial eligibility shall be determined as promptly as possible. The local department shall notify the adult of its eligibility determination decision no later than 45 days from the date the application is received by the local department.

A service case is opened based on eligibility, determination of need, and the availability and intent to deliver the service. Processed applications shall be uploaded to the AS Registration screen in PeerPlace.

3.7.2 Service population and criteria

See Section 3.2 for AS definition.

An individual does not need to be determined eligible for Social Security or SSA, Supplemental Security Income or SSI, or Social Security Disability Income or SSDI benefits prior to receiving services from the LDSS. *Individuals whose SSI payment is temporarily reduced or temporarily terminated due to an overpayment, may continue to be eligible for services.*

HBS shall not be available to adults who reside in an institutional setting including a nursing facility, assisted living facility, or hospital (22 VAC 30-130-40).

An adult is eligible to receive HBS if the adult's residence is owned or jointly owned by the adult, the adult rents or shares rent in the residence, or the adult lives in the residence of a relative or friend, and the adult meets other eligibility requirements.

Eligibility for LDSS HBS does not necessarily preclude an adult's eligibility for home-based Medicaid LTSS, such as CCC Plus waiver. If an adult is eligible for other services (such as home-based Medicaid LTSS) but cannot afford the co-payment or chooses HBS in lieu of Medicaid LTSS, the LDSS cannot deny services to that adult if he or she meets eligibility requirements for the requested service(s) and funding for services is available. However, The LDSS shall terminate HBS when the adult chooses to receive home-based Medicaid LTSS and those services can meet the adult's needs.

3.8 Financial eligibility for HBS

> (22VAC30-130-30). The local department, upon the decision of the local board, may choose to offer home-based services under universal access. If the local department does not offer home-based services under universal access, the adult shall be evaluated by the local department under the eligibility categories of income maintenance or eligibility based on income. Adults who are not eligible under universal access or income maintenance shall be evaluated by the local department under the eligibility based on income category.
>
> (22VAC30-130-40). The local department shall determine the adult's financial eligibility for home-based services.

Eligibility for services shall be determined by a service worker or a volunteer under the supervision of a service worker. Eligibility shall be documented in PeerPlace using ASAPS Financial Eligibility in the client profile.

To receive services an individual shall meet one of three financial eligibility categories:

- Universal Access
- Income Maintenance
- Eligibility Based on Income

3.8.1 Universal access

> (22VAC30-130-40). If the local department chooses to offer home-based services under universal access, the adult is financially eligible for home-based services without consideration of the adult's income.

An individual who requests an LTSS screening is not required to apply for Medicaid prior to the screening. Therefore, the worker shall select universal access for screenings.

3.8.2 Income maintenance

> (22VAC30-130-40). If the local department chooses to offer home-based services under income maintenance, the local department shall verify and document the adult's source of income in the department-designated case management system, and document whether the adult is eligible for an Auxiliary Grant, Temporary Assistance for Needy Families, or Supplemental Security Income. Adults who receive an Auxiliary Grant, Temporary Assistance for Needy Families, or Supplemental Security Income meet the financial eligibility requirement for home-based services offered under the income maintenance category.

3.8.2.1 Verification of receipt of income maintenance

- The service worker views written verification or verifies the SSA income information by accessing SVES, SOLQ, or the SDX listing.
- AG eligibility should be verified by Benefit Programs staff at the LDSS that processed the individual's AG application.

3.8.3 Eligibility based on income

> (22VAC30-130-40). If the local department chooses to offer home-based services under eligibility based on income, each local board shall select a threshold percentage of the median income to evaluate financial eligibility for adults. The department shall provide a scale of the median income for a family of four in Virginia as updated periodically in the Federal Register by the U.S. Department of Health and Human Services annually to local departments to use to determine financial eligibility. The adult's income, not resources, shall be counted when determining the adult's financial eligibility. The local department shall verify and document the adult's income in the department-designated case management system.

Certain income shall be disregarded when determining financial eligibility for *HBS* in eligibility based on income category. (22 VAC-30-130-40). See Appendix B for the disregarded income list.

Eligibility in this category is determined by measuring the gross income and the number in the family unit against the State Median Income (SMI) chart. The APS Division announces the updated Federal Fiscal Year (FFY) SMI by a broadcast each year prior to September 1. The SMI chart is available in PeerPlace and the VDSS

intranet. The local board selects the percentage cut-off point used and records this decision in the board minutes.

3.8.3.1 Verification of income eligibility and determination of monthly income

- Count only income (not resources). Income counted or excluded is listed in Appendix B. Income shall be verified, and the individual is expected to assist with the verification process. To obtain a monthly income, multiply a weekly income by 4 and 1/3.

- To verify income, viewing of recent written verification is acceptable.

    - If income fluctuates, the amount should be averaged over a period sufficient to take fluctuations into consideration. Usually three (3) months is sufficient; however, for farm income or seasonal employment, a year may be necessary.

    - Accept an individual's statement (preferably in writing) that he or she has no income unless there is reason to doubt the statement.

3.8.3.2 Family size and income

- The family is the basic unit for social services delivery. Family means any individual adult, spouses, adults, or adult(s) with minor children or minor grandchildren who function as a family unit.

- For purposes of determining financial eligibility, base the family size on the number of family members in the case.

- Count the income from those family members as well as income received from any legally responsible adult who may not be living in the family. Count income from family members temporarily absent from the household for whom the family claims financial responsibility for tax purposes.

3.9 AFC

Individuals seeking AFC placement must be assessed prior to placement using the UAI and meet residential level of care at a minimum. The assessment shall be updated annually. Local board policy should address the financial eligibility criteria for that LDSS's AFC program. The LDSS may rely on more than one of the funding sources listed below.

An agreement stating the amount to be paid by the adult shall be in writing and fully explained to the adult. A sample form "Agreement for AFC" is available on DSS intranet. Any modification in the amount to be paid shall be indicated on the agreement.

3.9.1 Local-only funding eligibility

Eligible individuals are those adults who meet local board policy, and who are assessed to need the service.

3.9.2 AG eligibility

Eligible individuals are those adults who meet the criteria for a payment under the AG Program (to be determined by the eligibility worker), and local board policy, and who are assessed to need the service. The LDSS where an individual resided prior to entering an institution or AFC is responsible for determining the individual's eligibility for AG and issuing the AG payment. An LDSS that offers AFC must ensure follow AG Program regulations if the AFC provider accepts AG.

Both the service worker and the eligibility worker shall coordinate efforts to determine the adult's financial eligibility for AG. Whoever has contact with the adult first shall refer the adult to the other.

Upon notification that the adult is eligible for AG, the service worker shall assist with the adult's admission to the AFC. The service worker shall provide verification of the adult's admission to the eligibility worker. The eligibility worker shall approve the case and determine the amount of the AG payment.

The AFC provider shall not receive more than the established AG rate. The AG payment shall be provided directly to the adult or responsible part who then pays the provider.

AFC providers shall provide each AG recipient and his authorized representative with a written list of the goods and services that shall be covered by the AG including a clear statement that the facility shall not charge an individual or the individual's family or authorized representative additional amounts for goods or services included on such list. This statement shall be signed by the AG recipient or authorized representative as acknowledgment of receipt and shall be made available to the department upon request. (22 VAC 30-80-45).

3.9.3 Private pay

Eligible individuals are those adults who are incapable of independent living or unable to remain safely in their own homes and have the resources to pay for a private placement in an approved AFC home. This option should be outlined in the LDSS's AFC local policy and approved by the local board of social services.

3.10 Facilitating the AFC admission

LDSS shall consider the following prior to the adult's admission to an AFC home:

- *The adult's assessed need(s).*
- *Compatibility with the provider and other individuals residing in the AFC home.*
- *Ability of the AFC provider to provide any needed special services as identified by the assessment.*

3.10.1 Medical examination - AFC

Each adult in an AFC home shall submit a medical statement from a licensed health care profession that contains the following information:

- *Date of last physical examination (must have been within 60 days of admission in AFC).*
- *Diagnoses of significant medical conditions.*
- *Documentation that the adult is believed to be free from tuberculosis in a communicable form.*
- *Recommendation for care including medication, diet, and therapy(ies).*

3.11 LDSS Coordination with CSB for AFC

LDSS may coordinate with CSBs on the provision of AFC for adult with mental illness and/or intellectual disability. If the LDSS should enter into an agreement with the CSB to specify which agency will be responsible for assessment, placement, service monitoring, and discharge. Only the LDSS is able to approve an AFC provider.

3.12 Auxiliary Grant Supportive Housing (AGSH)

Supportive Housing (SH) was added as an approved setting to the AG program in 2016. SH is defined as a residential setting with access to supportive services for an AG recipient in which tenancy as described in §37.2-421.1 of the Code of Virginia is provided or facilitated by a provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services that has entered into an agreement with the Department Behavioral Health and Developmental Services (DBHDS) pursuant to §37.2-421.1 of the Code of Virginia.

At the time of the initial assessment or annual reassessment, the individual may apply to live in AGSH. The qualified assessor will evaluate the individual's level of care and will make a referral to the AGSH provider. The AGSH provider will conduct an SH evaluation.

Currently, AGSH is only available to 120 individuals and is only provided by certain entities approved by DBHDS. The list of DBDHS AGSH providers is available on the DARS public site and the DSS intranet. The AGSH Operational Manual is available on DSS intranet.

3.13 Registering cases in PeerPlace

Register the individual in the appropriate PeerPlace Program according to the adult's needs. The worker may register an individual in multiple programs depending on the individual's situation.

- AS Program: Individual is requesting services such as *HBS*, *LTSS* screening, ALF assessment, *AFC*, or another service such as LDSS monitoring.
- APS Program: Individual is the subject of an APS report. If report is valid, an investigation is conducted and if services are accepted, APS Program service plan is used.
- Guardianship Program: Individual has a guardian who is submitting an annual report.

3.13.1 Opening a case

For purposes of opening a case in PeerPlace, each individual has a separate registration. For example, if one spouse needs companion services and the other spouse does not, a registration would only be opened on the spouse needing services. If both spouses needed services, two separate registrations would be opened in PeerPlace.

However, when determining eligibility, spouses are considered a family of two and this should be reflected in the section "Number in Family Unit" in the Financial Eligibility section.

- Adult children are always considered a family of one.
- Spouses raising one minor child would be considered a family of three.
- A single adult raising one minor grandchild would be considered a family of two.

3.13.1.1 Documenting the opening of a case in PeerPlace

Enter a case opening statement in the client registration notes which may include the following:

- Initial contact with the agency using names and relationships
- Services requested
- Pertinent details concerning the client and the requested services
- System searches completed
- Informal and formal supports
- Information and referrals provided
- Income and resources

3.13.2 Effective dates and annual redetermination dates

The effective date is the date that the service began for the current eligibility period. The effective date for Universal Access is usually the date of the service application and the date that financial eligibility conditions are established for Income Maintenance and Eligibility Based on Income cases. The annual redetermination date is one year and one day less than the effective date.

See Section *3.23* for information on redetermination of eligibility.

3.14 Fraud

The LDSS shall explain to individuals applying for *AS* the importance of providing accurate and thorough information and of notifying the LDSS of changes during service delivery. Anyone who causes the LDSS to make an improper vendor payment by withholding information or by providing false information may be required to repay the amount of the improper payment. Section 63.2-522 of the Code of Virginia deems any person guilty of larceny who obtains assistance or benefits by means of a willful false statement or who knowingly fails to notify the LDSS of a change in circumstances that could affect eligibility for assistance. Individuals deemed guilty of larceny, upon conviction, are subject to penalties as specified in the § 18.2-95 of the Code of Virginia.

3.15 Assessment process

3.15.1 Basis

The assessment process is a mutual process between the service worker and the adult that begins at intake. Completing the assessment is the first step in service planning. The purpose of assessment is to determine whether the adult is in need of services, and, if so, to identify what services are needed. When an individual applies for a service, a preliminary assessment shall be made to determine the presenting issue(s) or immediate need(s).

The assessment *also documents* the long-range service objectives, the selection of services to fulfill those objectives, and the choices of resources to be used. *The assessment* may include observations, client and collateral statements, noted behaviors, formal assessment tools, professional consultations, and supporting documents. These activities will be reflected in the completed service plan. Assessment is an ongoing process and should take place throughout the entire case management process and is essential to service planning.

3.15.2 The *UAI*

> (22VAC30-130-40). The local department shall assess the adult using the UAI, the department-designated form, including evaluating the adult's degree of independence or need for assistance with performing ADLs and IADLs.

The definitions used and procedures for completing the UAI are found in the User's Manual: Virginia Uniform Assessment Instrument. The User's Manual is available on the VDSS intranet and the DARS public site. The following guidance addresses the circumstances for UAI completion by an LDSS:

- The **entire** UAI shall be completed when the adult is being assessed for HBC, AFC, or adult day services purchased by the LDSS.
- If the APS investigation disposition is "needs and accepts" and services are provided, then the **entire** UAI shall be completed.
- The UAI shall be completed in accordance with the Department of Medical Assistance Services (DMAS) regulations and guidance for all Medicaid LTSS Screenings. Medicaid LTSS screenings are entered into the eMLS system. LDSS workers who are part of a screening team are not required to enter the UAI into PeerPlace as long as the individual is seeking a screening only and not receiving other services (e.g. homemaker or adult protective services). However, the LDSS worker is still required to register the adult in the *AS* program in PeerPlace. A brief case note should

document that the individual's UAI is located in eMLS as well as the eMLS Assessment Tracking Number (ATN). **Note: Do not enter case documentation for screenings for individuals under age 18 (child screenings) into PeerPlace**. The LDSS may establish their own method to track child screenings.

- Pages 1 through 4 and 12 shall be completed when*:*
    - The client is registered in the AS Program, the LDSS is **not** purchasing any services, and is **only** assisting the adult with issues such as SSI or Social Security applications or other non-purchased service activities; or
    - The client is registered in the AS Program and the LDSS is **only** addressing a short-term crisis, including arranging for or making a utility or rental payment.
- The UAI shall be completed for ALF assessments per guidance in the ALF Assessment Manual. For ALF assessments, the UAI is used for the initial assessment and one reassessment. The UAI shall be entered into PeerPlace. A PeerPlace UAI may be copied for purposes of the ALF reassessment and then updated.

The UAI is not required for a Guardianship Report case if review of the guardian report is the only reason the LDSS is following the adult.

3.15.3 Assessment areas

There are five assessment areas of the UAI.

3.15.3.1 Physical environment (section 1 of UAI)

An assessment of the individual's physical environment provides information about safety and health risks. When assessing the physical environment, the worker should consider:

- An evaluation of the dwelling for structural soundness, safety hazards, utilities, cleanliness, and barriers to mobility or use.
- Identification of type and feasibility of needed improvements or changes to the individual's environment.

3.15.3.2 Functional status (section 2 of UAI)

An assessment of the individual's ability to manage activities of daily living (ADLs) and instrumental activities of daily living (IADLs) shall be made when

assessing an individual's need for services. Some areas to consider when assessing functional capacity include:

- The physical, emotional, and cognitive status of the individual, assessing how well he or she performs the various ADL tasks including bathing, dressing, eating/feeding, toileting, transferring in and out of a bed or chair, and maintaining continence.

- The physical, emotional, and cognitive status of the individual, assessing how well he or she performs the various IADL tasks which include meal preparation, housework, laundry, shopping, transportation, money management, using the telephone, and/or home maintenance.

3.15.3.3 Physical health assessment (section 3 of the UAI)

The assessment of physical health may be based on the individual's reports of illness, disabilities, and symptoms, the individual's friends or family members, the individual's physician with an authorized release of information, other contacts or records, or based on worker observations. Some areas to consider when assessing physical health include:

- The individual's current medical condition, including any diagnosis or prognosis available, and any services being used.

- Symptoms observed by the worker that may not have been diagnosed or treated, including signs of physical injury.

- The number and type of medication(s) the individual is currently taking (prescription and non-prescription) and whether medication is being prescribed by multiple physicians. (**Note**: The worker may ask to see medication containers to get more accurate information.)

- Diet and eating habits (nutrition).

- The individual's general appearance and whether it is consistent with the adult's circumstances and environment.

- The adult's need for assistive devices (e.g., eyeglasses, hearing aids, dentures, mobility aid to compensate for physical impairments, etc.).

3.15.3.4 Psychosocial (mental health) assessment (section 4 of the UAI)

The worker's assessment of an individual's psychological functioning cannot take the place of a formal clinical evaluation. However, the worker's findings

may suggest that a psychiatric *condition* is present and contributing to the individual's need for services. This assessment can also provide the worker with documentation for recommending a more complete assessment by health professionals to rule out organic and/or physical causes of psychological symptoms. Some areas to consider when assessing psychosocial status include:

- Evidence that the individual is lonely, isolated, or lacking stimulation.
- The individual's perceived emotional or behavioral condition(s).
- Any manifestations of emotional, mental, or behavioral ~~problems~~ *conditions* (e.g., insomnia, nightmares, crying spells, depression, agitation, unusual fears, thoughts, or perceptions, delusions, hallucinations, etc.).
- Any major life change/crisis in the year (e.g., death of a significant person, divorce, loss of income, a move, an illness, institutional placement, etc.).
- A suspected untreated mental illness where the individual likely needs, but is not receiving, psychotropic medications or other appropriate treatment.
- Use of any psychotropic medication(s), who prescribed them, and for what purpose.
- The individual's orientation to person, place, and time as well as memory and judgment capacity.

3.15.3.5 Support systems (sections 1, 4, and 5 of the UAI)

The support systems assessment includes an assessment of the individual's family and community support system. It is important that the worker identify those family, friends, neighbors, faith-based, and other voluntary groups and formal supports that comprise the individual's social network. Some areas to consider when assessing support system(s) include:

- Any strong dynamics among family members/caregiver(s)/formal support systems as related to the care of the individual.
- Frequency and quality of contacts from informal and formal support systems.

- Social contacts and activities the individual has in the community and changes in the pattern of these contacts.

3.16 The service plan

> (22VAC30-130-50). If an adult is determined eligible for home-based services, the local department shall develop a service plan, enter the plan into the department-designated case management system, and review the plan at least annually.

- A variety of interventions including referral to public assistance and other resources, case management, and other programs may be provided depending on the adult's needs. (22 VAC 30-130-50).

- The services or activities may be provided directly by local department staff or volunteers, purchased from local department approved providers or contracted vendors, or provided through referral to other community resources. (22 VAC 30-130-50).

A service plan includes the services to be provided, resources to be used to meet the presenting or immediate *need*, and an identification of initial target dates. The service plan may be printed from PeerPlace. It is recommended that the adult or the responsible person sign a completed service plan.

3.16.1 Service plan requirements

- Within 15 days of the date of eligibility, the worker shall enter the service plan in PeerPlace.

> (22VAC30-130-50). A service plan shall not be required when the only intervention or activity provided by the local department is screening for long-term services and supports, public pay assisted living facility annual assessment, or review of an annual guardian report.

- The details in the service plan will vary according to the individual's situation and will be based on the assessment of the individual's strengths and needs.

- The local department, the adult, and the adult's family, the responsible person, or other social supports, if applicable, shall collaborate to evaluate progress toward meeting the goals and objectives of the service plan. (22 VAC 30-130-50).

- The local department shall document progress toward meeting service plan goals and objectives at least quarterly in the department-designated case management system. (22 VAC 30-130-50).

- For any services for which a payment is made on behalf of an adult, the service, service provider, and payment authorization shall be documented in the service plan. Any local department hard copy records documenting the provision of *AS* shall be made available to the department upon requests. (22 VAC 30-130-50).

- The service plan shall address the long-term and short-term needs of the adult. Components of the plan include:

  - Goal(s).

  - Unmet need(s).

  - Objective(s).

  - Task(s) (e.g., services to be provided, service-related activities, resources to be used).

  - Target dates are estimated dates for task completion.

  - Dates resolved indicate when the objectives are met and closes out the services.

  - Evaluation of services once tasks are completed.

Goals and objectives are developed after the UAI is completed and a determination made regarding the services needed and the adult's preferences.

3.16.2 Goals, unmet needs, objectives, tasks, and target dates

3.16.2.1 Goals

The following are goals for *AS* cases:

- To assist the individual to remain in his or her own home as long as possible provided that this is the most appropriate plan of care.

- To restore or retain the individual's independent functioning to the greatest extent possible.

- To assist in arranging out-of-home placement when that is appropriate and the individual or the guardian consents.

The goal “other” may be selected as appropriate.

See Chapter 2 for service plan goals for APS cases.

3.16.2.2 Unmet needs

An unmet need is an identified need that is not currently being met in a way that assures the safety and well-being of the adult. Unmet needs appear in section 5 (Assessment Summary) of the UAI. Unmet needs identified on the UAI should be in the service plan.

3.16.2.3 Objectives

- Objectives reflect the desired outcome(s) of service delivery. Objectives and services selected should be relevant to the goal.
- Each objective shall state clearly WHAT will happen to accomplish the goal(s).
- Objectives should be:
    - Identified by the individual or representative and worker to eliminate or diminish identified unmet need(s).
    - Supportive of the goal(s) selected.
    - Stated in terms of measurable result(s) to be achieved or desired outcome(s).
    - As behaviorally specific as possible.
    - Updated as the individual’s situation changes.
        - Example of an objective: The client will obtain medical care to manage health issues.

3.16.2.4 Tasks

Tasks describe the actual provision of services, identifying HOW to achieve each objective, WHO will be involved in accomplishing each objective, WHERE services will be provided, and WHEN services will be provided. Tasks shall be specific and measurable. All service types shall be selected from the drop-down menu in the PeerPlace service plan. Services definitions are available on the APS Division site on the DSS intranet.

Note: Expenditures of funds on behalf of an individual shall be documented in the service plan in PeerPlace. Identify the appropriate provider, funding source, rate of pay, and hours for each service task.

- Example of a service: Transportation.
- Example task: Worker will assist client in securing transportation to medical appointment.
- Example Provider: Yellow Cab
- Example funding source: 83306 Adult Services - Prevention Services
- Example hours per week: 4
- Example rate of pay: $10.00

If a provider is being paid by public or private insurance, out of pocket, or some other means, “Other” should be chosen as the funding source.

3.16.2.5 Start and target dates

The service plan shall include dates for services to start and target dates for achievement of objectives. Target dates should be realistic. Target dates for ongoing tasks such as HBS should not exceed the redetermination date.

3.16.2.6 Date resolved

The date resolved will indicate when the objective is met and closes out the service task in the service plan.

3.16.2.7 Evaluation of services

The evaluation of services will provide a brief description of the status of the task at its conclusion, and whether objectives were accomplished in a timely manner. When all services have been completed and evaluated, the worker shall close the service plan in PeerPlace.

- Example: AS prevention funds were utilized to pay for cab fare for client’s medical appointment with Dr. Smith on 3/3/22. Client received needed medical treatment and updated prescriptions.

3.16.2.8 Sample Service plan

The guide “AS Service Plans in PeerPlace” located on the PeerPlace page on DSS intranet contains example screen shots of service plans.

After you have added all the Unmet Needs and supporting Services, you can print the Service Plan. Click on one of the links under the **Print Options** section of the Service Plan Summary screen. **DO NOT use the Print icon at the top of the screen**.

3.17 Service delivery

Services shall be provided directly, by referral, or by purchase as required to assure appropriate service delivery and resource utilization necessary for implementation of the service plan.

3.17.1 Direct services

Direct services are those services provided, arranged, monitored, and/or referred by the LDSS staff as outlined in the service plan.

3.17.2 Referrals

Referrals are made when the worker directs the adult to an outside source for assistance.

3.17.3 Purchased services

Purchased services are purchased by LDSS for adults from approved providers, including department-approved providers and providers with whom the LDSS contracts. A Purchase of Services Order is available on the VDSS intranet. *The Local Finance Guidelines Manual, Section 5.20-Purchase of Services, is also available on the DSS intranet.*

Adult Services Approved Providers, Chapter 5, addresses the approval process for locally approved homemaker, chore, and companion providers and AFC providers.

3.17.4 Ongoing service planning and delivery

Following the initiation of the service plan, the assessment is to continue on a mutual basis between the individual and worker to document further service needs as a basis for the setting of long-range service objectives, the selection of services to fulfill those objectives, and the choices of resources to be used.

3.18 Waiting lists

If LDSS funds are inadequate to maintain the level of service to adults, LDSS should maintain a waiting list. A date-based methodology (e.g., date in which application is

received) is just one example of how an LDSS may organize its wait list. The LDSS shall uniformly apply wait list criteria to all individuals requesting the service. The LDSS should review the waiting list at least annually.

The service worker should indicate on the service plan if the service request is not available, and the individual is on a waiting list. If the worker selects waiting list "yes" on the service plan, the worker does not close the service plan. If the worker closes the service plan, the wait-listed service will not be counted or identified when running reports.

3.19 Required contacts

For *AS* and *APS*, contact includes communication with the adult, the adult's legal representative or the adult's designated primary caregiver. More frequent contact should occur as needed. All contacts should be documented in the appropriate PeerPlace screen.

- Adult Services: Contacts and case actions shall be documented in the *AS* client registration notes.
- APS Investigations: Contacts and case actions shall be documented in the APS investigation notes.
- Ongoing APS: Contacts and case actions shall be documented in the APS client registration notes.

The worker shall make timely, regular contacts with providers to monitor the provision of services and the well-being of the individual. The worker should verify by observation or personal interview that the adult is receiving the planned services and identify any changes in his or her situation. Required provider monitoring contacts should be documented on the Compliance Form for Agency Approved Providers (See Chapter 5). Ideally provider monitoring contacts are documented in the PeerPlace provider screens.

3.19.1 Types of contact

To meet the requirement for appropriate contact with the adult, the contact shall occur with the adult, the adult's legal representative, or the adult's designated primary caregiver shall be in the form of face-to-face, home visit, office visit, phone to/from. *It is* best practice that face-to-face contact with the adult be in-person.

All contacts, including other types of contacts such as fax to/from and email to/from shall also be documented in the appropriate PeerPlace program registration notes. Contacts should be conducted for the purpose of determining the individual's progress toward achieving objectives stated in the service plan.

The following table identifies who is considered a legal representative or designated primary caregiver:

Legal Representative	Designated Primary Caregiver
Power of Attorney, guardian, and conservator	Father, mother, daughter, son, spouse, wife, and husband

3.19.2 Monthly versus quarterly contacts

PeerPlace automatically assigns the intensity level of service plans and is dependent on the PeerPlace program. Services identified as “intense” require monthly contact. Services identified as a “less intense” require quarterly contact. The worker may make more frequent contact depending on the individual’s situation. Services listed in APS program service plans are designated as “intense.” Services listed in AS program service plans (e.g., homemaker or LDSS monitoring) are designated as “less intense.”

3.19.3 Collateral contacts

Collateral contacts with other interested parties, vendors of service, other community providers/agencies, volunteers working with the individual, and the court may include face-to-face, telephone conversations, and written or email correspondence.

3.19.4 Written correspondence

Written correspondences, including letter to/from, fax to/from, and email to/from and collateral contacts do not count as monthly or quarterly contacts.

3.19.5 Regular quarterly contact not required

Regular quarterly contacts are not required for ALF Reassessments only and Guardianship only cases.

3.19.6 When a contact is not made as required

The case record shall specify why a required contact was not made (e.g., the adult could not be located). Document efforts made to complete the required contact and gather information to locate the client including the communication method or number of attempts.

3.20 Case Documentation

All documentation should follow professional guidelines, be completed in a timely manner, use professional voice, and include relevant details required for the LDSS record.

The record may be part of an audit or court proceedings and provides evidence that mandated requirements have been completed. The record informs AS and APS assessment and service planning.

3.20.1 Timeframe for documentation

Documentation should occur on the day contact is made or within 24-48 hours but no later than 7 days after the contact. The LDSS is encouraged to utilize transcription services, if available, to assist with documentation.

3.21 Attachments

Documents such as faxes, history and physicals, physician notes, service applications, invoices, purchase orders, legal documents, advanced directives, and financial statements should be uploaded to the attachments section in the client registration of PeerPlace.

3.22 Monitoring

Monitoring is the process by which the service worker maintains contact with the individual, support systems, and service provider(s) to ensure the efficient and effective delivery of services relating to the achievement of the stated objectives. The monitoring function shall begin upon delivery of service(s) and shall be continuous. The LDSS will be responsible for the monitoring of service delivery whenever it uses a vendor or non-agency provider to offer services to an individual.

Monitoring contacts are documented in the client registration notes. Every contact should be documented. Documentation should include who was contacted, the details of the client's environment, functioning, physical, and emotional well-being, resources, and supports. Include the client or responsible party's evaluation of the services being delivered as part of the service plan.

3.23 Redetermination

ASAPS Financial Eligibility shall be performed at least annually. Redetermination shall be conducted in the same manner as the initial determinations (the adult does not have to sign a new service application). ASAPS Financial Eligibility is required at the annual redetermination before the service plan can be updated. The ASAPS Financial

Eligibility will populate on the service plan screen for completion. Initial ASAPS Financial Eligibility is recorded in the "ASAPS Financial Eligibility" section on the client profile screen in PeerPlace. The effective date and redetermination dates on the ASAPS Financial Eligibility screen in PeerPlace are updated to reflect the updated/new eligibility period.

If information is received in the interim that affects eligibility, redetermination shall be performed **within 30 days** of receipt of information.

3.24 Reassessment

The service worker shall reassess active cases when there is significant change in the individual's circumstances, but no less than once every 12 months. A significant change in an individual's condition occurs when the change is expected to last more than 30 days or appears to warrant a change in the individual's service plan or level of care. The reassessment shall include an updated UAI and an update of the service plan as appropriate.

Based on the UAI annual reassessment, the worker shall document:

- Service plan updates, with task completion dates, target dates, and evaluation of services adjusted as needed. If the client is receiving ongoing services without change, such as companion services, that extend year to year, the task target completion date should be updated to reflect the extension of the continuing service, while leaving the task start date unchanged. Document in the client registration notes that the service plan has been updated.
    - Example: Previous task start date: 11/1/2020, target completion date: 10/31/2021
    - At reassessment, enter target completion date 10/31/2021 if all other task information remains constant

  If the client is receiving ongoing services and there are changes such as a different companion provider, funding source, or rate of pay, enter the date resolved and evaluation of service for the current service plan task. This will close the task. Then create a new task with the updated information and new task start and target dates. Document in the client registration notes that the service plan has been updated.

- A description of the individual's current situation in the AS registration notes with input from the individual and family, if applicable, to determine if there are needs which should be addressed.

- Whether additional services are needed. If so, the service plan shall be revised accordingly. If services are no longer needed, the service plan and the case shall be closed.

3.25 Closure of an *AS* registration

The local department shall close the adult's case in the department-designated case management system in the following circumstances, including:

- When the adult dies;
- When the adult with capacity or the adult's responsible person requests closure;
- When the local department is unable to locate the adult and attempts to contact the adult are unsuccessful;
- When the adult is no longer functionally or financially eligible for the service;
- When the local department has no funding to provide HBS;
- When the service or activity identified on the service plan is complete; or
- With the exception of annual guardian report reviews, when the adult relocates to another state. (22VAC30-130-60).
- If a Notice of Action (NOA) is required, the client shall be permitted to exercise appeal options (if appealing is an option) before the registration is closed. If the adult is not entitled to an appeal, the worker shall close the service plan and the registration. Refer to *Section 3.27* for further NOA guidance.

3.25.1 Documenting the case closure

Document a closing statement in the registration notes describing client's circumstances at case closure. Include any case closing notifications to the client or responsible party, information and referral, supports in place, relocation information, or notifications to other LDSS at case closure.

3.26 Relocation

If a relocation is temporary, the original jurisdiction keeps the case, and depending on the distance, provides any needed services or requests the new jurisdiction to assist. Service payments are the responsibility of the original jurisdiction in this situation.

A permanent relocation means the individual will be residing in a new locality. When the individual no longer needs services, the LDSS previously providing services shall close

the registration. When services continue to be needed, the individual may apply for AS in the jurisdiction where the individual now resides. Only APS reports can be transferred in the PeerPlace system. An ongoing APS registration cannot be transferred if the adult moves during service provision. Guardianship Report Tracking or ALF reassessment services in the PeerPlace program are not transferable. The Supervisor/Program Admin or APS regional consultant may assist with transferring a record in PeerPlace.

When an individual plans a permanent relocation to a facility in another jurisdiction and the individual will need services in the new jurisdiction, the LDSS involved should assist each other with needs concerning the individual's admission. If services will be needed, the sending LDSS should notify the receiving LDSS of the expected date of the admission, the facility selected, and the services (e.g. ALF reassessment) needed.

The worker in the original jurisdiction may offer to assist in completing a service application for the new jurisdiction if one is needed.

3.27 Notice of action

> (22VAC30-130-60). The local department shall notify the adult on a form approved by the department when the local department takes an action regarding home-based services pursuant to § 51.5-147 of the Code of Virginia.

- NOA shall be used for any applicant or recipient of HBS and AFC services as they may appeal an LDSS case action decision pursuant to § 51.5-147 of the Code of Virginia.
- The (NOA) form for Service Programs is available on the VDSS intranet and the DARS website.

3.27.1 Documenting the NOA

Document the NOA in the client registration notes. Response to the NOA shall be documented in the registration notes. Upload the NOA under the attachments link in the PP client registration.

3.27.2 Withdrawal of application

- The individual may withdraw an application. Document the withdrawal in the client registration notes. For special procedures on Adult Protective Services, or APS home based care, see Chapter 2.
- If the withdrawal was done by letter, telephone call, or personal visit, a NOA shall be sent to acknowledge the withdrawal. Upload the withdrawal under the attachments link in the PP client registration.

- The individual should be told that he or she may reapply at any time.

3.27.3 Failure to follow through with services or disappearance

If an individual has submitted an application for *AS*, and then disappears or fails to follow through with the application and eligibility process after 45 days, the LDSS does not need to try to find the individual to ascertain their intent to proceed with the application, unless a valid APS report has been made. If there has been no valid APS report, a NOA terminating the application is sent 45 days after the application was received.

3.27.4 NOA for other case actions

- The NOA shall be mailed or given to the individual or his representative when an HBS or AFC case is approved, reduced, suspended, or terminated.

- Mail the NOA approximately **14 days before** the date the action is to become effective so that the individual has a 10-day notice. See Section 3.28.5 regarding early notification regarding HBS.

- Notices are not required for fluctuations in purchased service payments when the Purchase Order authorization remains the same.

3.27.5 Early notice due to reduction in funding for home based services

If the adult appeals the action within 10 days of the effective date of the NOA, services must continue. The LDSS is encouraged to provide notice earlier than the recommended 14 days before the action becomes effective, particularly when the action is due to lack of or reduction in funding to provide a particular service (e.g., companion services). Providing early notice of the intent to reduce or discontinue services due to funding constraints will provide sufficient time for services to continue during the appeal before funding is exhausted.

3.27.6 When notice of action not needed

The NOA is not issued for screening cases either at the conclusion of the screening or when the registration is closed in PeerPlace. The screening decision letter, issued by the screening team after the screening has been completed, serves as proper notice to the adult. The decision letter contains information about the screening results and appeal rights.

If the LDSS receives reliable information of an individual's death, the LDSS closes the registration. The NOA is not issued upon notification of an adult's death.

3.28 Appendix A: Forms

The following forms may be used for case management purposes. Unless otherwise indicated, these forms are located on the APS Division page on the DSS intranet.

Application for AS
This form should be used by an individual to apply for *AS* and *APS*. This form is also available in Spanish.

Adult Foster Care Agreement
This form is used as an agreement among the individual receiving AFC, the LDSS, and the AFC provider.

Adult Foster Care Interagency Agreement
This form is used when an LDSS is placing an adult in an AFC home in a neighboring jurisdiction.

Notice of Action-Adult Services & Adult Protective Services Programs
This form is used to notify an individual about certain actions that have been taken or will be taken on his or her case. This form is also available in Spanish.

Purchase of Services Order
This form is used to order services from vendors. This form is also used for unscheduled termination of, or change to, an existing POS Order.

Short-Form Attachment
This form is used when it is determined that an individual will only need residential level of care in an ALF setting. The attachment is used in conjunction with pages 1-4 of the UAI.

Uniform Assessment Instrument (UAI)
This form is used to assess an individual's need for services including assisted living, HBS, and Medicaid funded services.

3.29 Appendix B: Income eligibility determination

Income, not resources, is counted in determining if an individual meets the category of Eligibility Based on Income. All income, except items listed below, is to be counted.

Net income from self-employment, farm or non-farm, is to be counted. This is gross receipts minus expenses. The value of goods consumed by the client and his/her family is not to be counted.

The gross amount in wages or salary received is the figure to be used. However, if the wage earner voluntarily has additional amounts taken out for savings such as bonds, these amounts shall be counted as income.

Do count income from Social Security, but do not count income from Supplemental Security Income (SSI).

Income to be excluded

- Home produce utilized by the adult for his own consumption.
- The value of food benefits under the Supplemental Nutritional Assistance Program (SNAP).
- The value of supplemental food assistance under the Child Nutrition Act of 1966 (42 USC §§1771 through 1789). This includes all school meals programs; the Women, Infants, and Children program; and the Child Care Food Program.
- The value of foods donated under the U.S. Department of Agriculture Commodity Distribution Program, including those foods furnished through the school meals programs.
- Benefits received under Nutrition Program for the Elderly, Title VII of the Older Americans Act of 1965, as amended (42 USC §§3001 et seq,).
- Grants or loans to any undergraduate students for educational purposes made or insured under any program administered by the U.S. Secretary of Education;
- A scholarship or grant obtained and used under conditions that preclude its use for current living costs;
- Training allowance provided by the department for persons participating in rehabilitative services programs;

- Payment to VISTA volunteers.
- The Veterans Administration educational amount for the caretaker 18 years of age or older when used specifically for educational purposes. Any additional money included in the benefit amount for dependents is to be counted as income.
- Income tax refunds including earned income tax credit, advance payments, and refunds.
- Payments made under the Energy Assistance Program;
- All federal, state, and local government rent and housing subsidies and utility payments;
- Funds distributed to or held in trust for members of any Indian tribe under Public Laws 92-254, 93-134, 94-540, 97-458, 98-64, 98-123, 98-124. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income.
- All bona fide loans. The loan may be for any purpose and may be from a private individual as well as from a commercial institution. The amount disregarded is limited to the principal of the loan.
- Monetary gifts for special occasions such as the adult's birthday, holidays, or graduations.
- Withdrawals of bank deposits.
- Payment to vendors for services provided to the adult.
- Lump sum insurance payments.

3.30 Appendix C: Expenditures for services

3.30.1 Funding allocations

Each LDSS receives funding to purchase services needed by an adult to meet the goals of the adult's service plan. LDSS are encouraged to make maximum use of this funding in providing services to adults and shall be aware of the number of cases their allocations will support throughout the year. During ~~the course of~~ the fiscal year, if the LDSS realizes that it has been allocated more funds than are needed to serve adults, the LDSS shall return the funds in a timely manner to the state for reallocation to other LDSS.

3.30.2 LASER

LASER (Locality Automated System for Expenditure Reimbursement) is an automated system used to allocate funding.

3.30.3 Budget lines, cost codes descriptions

Budget lines and cost code descriptions including examples of reimbursable expenses are available on the VDSS intranet.

21704 GUARDIANSHIP PETITIONS

Provides for the costs of petitioning the court for appointment of a guardian for a Medicaid applicant who is unable to apply for himself or herself.

Note: VDSS does not provide a local budget allocation for this cost code, all expenditures entered in 21704 will be funded using 100% state General Funds.

LDSS should complete page two of the Response to Medicaid Referral form located on the VDSS intranet. Expenses shall be itemized, attached to the form, and retained by the LDSS as documentation for reimbursement.

Localities should submit a BRS to request funds to cover the expenditures. The request will be reviewed and acted on by the APSD Director.

Reimbursable examples
Expenses incurred during a guardianship proceeding for a Medicaid applicant who is unable to apply for himself or herself:

- Evaluation.
- Guardian ad litem legal fees.
- Attorney legal fees.

- Court filing fees.
- Other costs (itemized).

ADULT SERVICES (833)

83301 Adult Services – Home-Based Care -- Chore

Chore services are the performance of non-routine, heavy home maintenance for adults unable to perform such tasks themselves. Chore services are provided only to adults living in an independent situation who are responsible for maintenance of their own home or apartment and have no one available to provide this service without cost. Chore services include yard maintenance, painting, chopping wood, carrying wood and water, snow removal, and minor repair work in the home.

83303 Adult Services – Home-Based Care--Homemaker

Homemaker services are provided by an individual or agency provider who gives instruction in, or where appropriate, performs activities to maintain a household. The activities may include personal care, home management, household maintenance, nutrition, consumer education, and hygiene education.

83302 Adult Day Services

Program funds are used to purchase adult day services from ~~approved/~~licensed providers for a portion of a 24-hour day. Adult day services assess the needs of participants and offer services to meet those needs. Participants attend on a planned basis. Services include: personal supervision of the adult and activities that promote physical and emotional well-being through socialization.

83304 Adult Services- Home-Based Care--Companion

Companion services are performed by an individual or an agency provider who assists adults unable to care for themselves without assistance and where there is no one available to provide the needed services without cost. Services may include dressing, bathing, toileting, feeding, household and financial management, meal preparation, and shopping. Companion services shall only be provided to an eligible adult who lives in his or her own home.

83305 Guardianship Services

Provides for the purchase of guardianship services from a Virginia guardianship program for adults who have been adjudicated incapacitated by a court and no willing or suitable adult is available to serve as a guardian. Services promote the adult's independence; ensure the adult's physical, emotional, medical, and financial needs are met; and prevent destabilization of the adult's living situation. The need

must be documented in the case record service plan. Payments shall not be made to family members or friends of the adult who volunteer to become the adult's guardian.

83306 Prevention Services

Provides for the purchase of goods or services to prevent disruption of or to stabilize the adult's situation, provided that the need is documented in the case record. These services may include the purchase of short-term support until more permanent arrangements can be made. It may also include items such as clothing, food, utilities, or rent when no other resources are available and the lack of these goods and services become life threatening or may result in institutionalization. These services shall only be provided to adults who may need a temporary intervention to prevent an adult protective services response.

ADULT PROTECTIVE SERVICES (895)

89501 Adult Protective Services

This budget line is used to fund the APS program. This funding may be used for reimbursable expenses of providing protective services at the local level.

Protective services to adults consist of the receipt and thorough investigation of reports of abuse, neglect or exploitation of adults and of reports that adults are at risk of abuse, neglect or exploitation.

The purchase of goods or services is appropriate under the following circumstances:

- An APS report has been taken and the investigation has determined that an adult needs protective services and the service to be purchased is part of the service plan to protect the adult from ongoing abuse, neglect or exploitation; or

- An APS report has been taken and the protective services investigation has found an adult to be at risk of abuse, neglect or exploitation and the service to be purchased is part of the service plan to prevent abuse, neglect or exploitation from occurring.

Guardianship Fees

Section 64.2-2020 of the Code of Virginia requires a guardian to complete and submit an annual report, on the incapacitated adult for whom a guardian has been appointed, to the LDSS in the jurisdiction in which the adult resides. Section 64.2-2020 requires that the annual report, when filed, be accompanied by a filing fee of $5.00. The $5.00 filing fee that accompanies annual guardianship report shall be

used in the provision of services to protect vulnerable adults and prevent abuse, neglect or exploitation of vulnerable adults.

To record the receipt of guardianship fees, the LDSS should enter the amount collected as a credit, using Account Code 40895 Receipt of Guardianship Fees.

Admin Adult Protective Services

Administrative costs of operating the APS program are included in Services Staff and Operations or Services Staff and Operations pass-Thru (budget lines 855 and 857). Reimbursable examples include on-call coverage for staff who provide coverage for APS on nights, holidays, weekends, and other times outside of regular office hours; costs of staff travel for investigating, for ongoing service delivery, for training/education purposes, or other travel costs related to the APS program; office supplies and equipment dedicated to the operation of the APS program; and costs of community outreach to increase awareness of adult abuse.

At any point in the budget year, LDSS may request that 895 funding be transferred to BL 855. The two-part request must be entered into the LASER system and approved by the APS Division Director and a DSS budget analyst. **Note:** Though the $5.00 guardianship fees are entered into BL 895, these fees can't be transferred to 855. The filing fee is considered a credit to the LDSS and credits may not be transferred. The filing fee must remain in BL 895 to support victims of adult abuse, neglect, and exploitation.

REIMBURSEMENT THROUGH RANDOM MOMENT SAMPLING (RMS)

Screenings

Every individual who applies for or requests a *Medicaid LTSS screening shall be screened prior to receiving LTSS.* LDSS are reimbursed for screenings through the RMS process.

Assisted Living Facility (ALF) Assessments

LDSS assess *and reassess* individuals receiving AG in ALFs using the UAI to determine the level of care (residential or assisted living). LDSS are reimbursed for ALF assessments and reassessments via RMS.