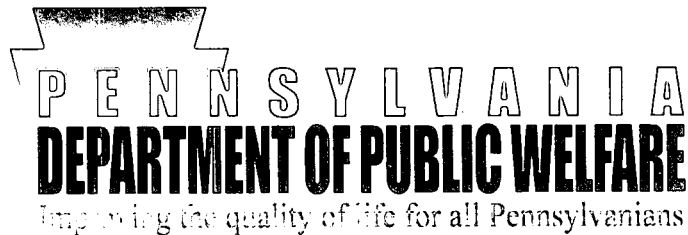


**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF SOCIAL PROGRAMS**

**ATTENDANT CARE PROGRAM
REQUIREMENTS**



MARK SCHWEIKER
Governor

FEATHER O. HOUSTOUN
Secretary

April 1, 2002

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE**

DATE: April 1, 2002

SUBJECT: Issuance of Revised Attendant
Care Program Requirements

TO: Attendant Care Contractors,
Providers and Consumers

FROM: Office of Social Programs (OSP)
Attendant Care Program

The Attendant Care Program Requirements represents the combined efforts of OSP staff, the Attendant Care Advisory Committee, contractors and providers. We appreciate the work and time that all persons involved have provided to ensure the success of this project. Thank you for a job well done!

The Attendant Care Program Requirements has been divided into chapters for ease in use. There is an initial Table of Contents, which covers all of the chapters, as well as a Table of Contents at the start of each chapter for that specific chapter.

The attached guide provides a highlight of major changes that are included in the requirements. Please review this guide and keep it handy for referral purposes.

Chapter I.2, Page I-2—This section discusses the history of the Attendant Care Program. It now indicates that a person who experiences any medically determinable physical impairment which can be expected to last for a continuous period of not less than 12 months or may result in death can be determined eligible for the Attendant Care Program. This will allow services to be provided to those individuals who meet all other requirements but whose life expectancy is not expected to be 12 months. This is also reiterated in the general eligibility section of III.1.

Chapter II.2, Page II-2—This section describes the minimum experience and training required for provider/contractor staff as well as consumer employed attendants. Standards have been added for both the service coordinator and the attendants providing services for the Act 150 Program.

Chapter II.2, Page II-4—This area provides a grand fathering clause for those attendants and service coordinators who are currently providing adequate services but do not meet the new minimum standards required.

Chapter III.1, Page III-2—This section provides under the general eligibility criteria that a person must be a citizen of the United States or an immigrant lawfully admitted for permanent residence in order to be eligible for services. A grand fathering clause has been included to continue services for those persons not meeting this criteria but who were receiving Attendant Care Services prior to the implementation date of these requirements.

Chapter III.3, Page III-3—The verification section provides a listing of what verifications are required and when they are required. It also provides guidance on how to handle situations if they are unable to obtain the required documentation.

Chapter III.9, Page III-8—This section describes those situations that can result in termination of services and what steps should be taken prior to termination of service. It includes a statement that the provider/contractor is responsible to help the consumer develop a plan of correction prior to termination depending upon the nature of the activity causing necessitating the termination.

Chapter IV.2, Page IV-2—The fee determination and redetermination section provides that the full amount of family monthly medical and disability expenses are deducted. It also provides that the children of the consumer or spouse, age 18 or older, who are dependent because of a mental or physical disability may be included as a family member at the option of the consumer if including them and their income will benefit the consumer.

Chapter IV.2, Page IV-3—This section provides that for the purpose of collecting weekly fees, the full fee or the cost of service, whichever is less, is due for the week if a consumer receives any portion of the approved service hours during the week. If a consumer receives no hours of service during a week no fee is due.

Chapter IV.7, Page IV-6—This section provides that earned income of a child under 14 years of age is excluded and earned income of a child under 18 years of age is excluded if the child is a full-time student. It also provides exclusion for employee reimbursements for travel or other expenses to the extent that the reimbursement does not exceed the expense.

Chapter IV.9, Page IV-7 through IV-10—This section provides an expanded listing of allowable medical and disability expense deductions.

Chapter V.4, Page V-4—This section provides that contractors and sub-contractors contact consumers with priority care situations within one hour of the notification by the consumer or other entity that a priority care situation exists.

Chapter V.5, Pages V-4 and V-5—This section describes the training and support activities for the consumer.

Chapter V.6, Pages V-5 and V-6—This section describes the training and support activities for the attendant, including provisions for training in health maintenance activities if certain conditions exist.

Chapter V.7, Pages V-6 and V-7—This section provides that a face-to-face monitoring visit may be conducted at a site other than the home for those consumers who are employed or who are attending school full-time.

Chapter VI.1, Page VI-2—Language was added to require that rights and responsibilities be provided to the consumer in writing at Intake and yearly thereafter during an in-home visit.

Chapter VII.1, Page VII-3—This section provides a definition for seasonal chores.

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CHAPTER 1
Purpose and Authority

ATTENDANT CARE PROGRAM

CHAPTER I

PURPOSE AND AUTHORITY

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I.1 Purpose of the Pennsylvania Attendant Care Program

The purpose of the Pennsylvania Attendant Care Service is to enable adults ages 18 through 59 who are mentally alert and have physical disabilities to perform activities of daily living (such as eating, personal hygiene, and transporting themselves). Using state and federal funding, in addition to the consumer's own resources, the Pennsylvania Attendant Care Program enables eligible individuals to obtain assistance from attendants in completing tasks in order to lead a more independent lifestyle.

The attendant care service is designed to support eligible adults in improving their quality of life by achieving one or more of the following goals:

1. Enabling consumers to live in the most integrated community setting as independently as possible;
2. Enabling consumers to remain in their homes and preventing unnecessary admission to nursing homes or other similar institutional settings; and
3. Enabling consumers to seek and/or maintain employment.

To meet these objectives, in-home attendant care services are provided to enable consumers to achieve maximum independence in their daily lives.

I.2 History of the Attendant Care Program

The Department of Public Welfare initiated a three-year Attendant Care Demonstration Program in October 1984. Deinstitutionalization and preventing institutionalization are major goals of the Attendant Care Program. A major innovation of the program is that consumers have the right to direct their own services i.e., screening, interviewing, hiring, training, managing, paying, and firing attendants.

The three-year demonstration program enabled the Department to define the Pennsylvania Model of Attendant Care Service based on policies that provide for a continuum of care. This service delivery model has received national recognition. These policies support the concept that, to the maximum extent possible, the assistance provided be directed by the person receiving the services and that the services be provided in a manner consistent with that consumer's capacity to manage it.

The Attendant Care Program exists pursuant to the Attendant Care Services Act (Act 1986-150, 62 P.S. § 3051 et seq.), also known as Act 150. Act 150 provides for basic and ancillary services that enable an eligible person to remain in his home and community rather than an institution and to carry out functions of daily living, self-care and mobility. An eligible person as defined under Act 150 is any individual with physical disabilities who is mentally alert and at least 18 years of age but less than 60 who, in addition to requiring attendant care services, experiences any medically determinable physical impairment which can be expected to last for a continuous period of not less than 12 months or may result in death. That person must also be capable of

selecting, supervising and, if needed, firing an attendant and be capable of managing his own financial and legal affairs.

Act 150 requires that attendant care services be provided statewide. Attendant care service shall be available only to the extent that it is funded through annual appropriation of state and federal funds. The Act took effect July 1, 1987. By December 1987, attendant care services were available in all 67 counties.

I.3 The Medicaid Waiver for Attendant Care Services

Since the inception of the Attendant Care Program, the program was funded through state appropriations and through the Social Services Block Grant (SSBG under Title XX of the Social Security Act). On August 7, 1995, the Commonwealth implemented the Medicaid Waiver for attendant care services, which accesses federal funds under Title XIX of the Social Security Act, to provide attendant care services to Medicaid eligible consumers who meet other eligibility requirements. Effective September 17, 1996, the Commonwealth limited participation in the Act 150 Program to persons who do not meet the eligibility requirements for the Medicaid Waiver.

Attendant care services under the Medicaid Waiver are identical to the services provided under the Act 150 Program. There are administrative differences between the programs to allow compliance with Title XIX requirements. Primary differences include financial and level of function requirements under Title XIX, and the Title XIX requirement to enroll all eligible and willing providers.

I.4 Federal Requirements

One source of funding for the Attendant Care Program is the SSBG of the Social Security Act. This federal funding stream provides states with financial resources to provide a broad range of social services. In Pennsylvania the Attendant Care Program is one of 15 social service programs funded by the SSBG.

Although the requirements of Title XIX of the Social Security Act are not identical to those of Title XX, the Medicaid Waiver incorporates the policies of the Act 150 Program, and therefore incorporates the Title XX requirements.

Included within the federal SSBG requirements are prohibitions against the use of SSBG funds for:

1. The purchase or improvement of land, or the purchase, construction, or permanent improvement of any building or facility;
2. The provision of payments to any client for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitations, room and board provided for a short-term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

3. Payment of the wages of any person as a social service (other than payment of the wages of welfare recipients employed in the provisions of Child Day Care Service);
4. The provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or a drug dependent person) unless it is an integral but subordinate part of an allowable social service;
5. Social services (except services to an alcoholic or a drug dependent person, or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any person living in such institutions;
6. The provision of any educational service which the state makes generally available to its residents without cost and without regard to their incomes;
7. Any Child Day Care Services unless such services meet applicable standards of state and local law; and
8. The provision of payments to clients as a service. (Note: This does not preclude payments to attendants made by the contractor through the consumer.)

I.5 Responsibility and Authority for Eligibility Determinations and Redeterminations

<u>Act 150</u>	<u>Medicaid Waiver</u>
The Department delegates to the Contractor providing services the authority to determine continuing eligibility for Act 150 participants.	The Department delegates to the Medicaid Waiver Provider of services the authority to determine continuing eligibility for Medicaid Waiver participants.

1. The Department delegates to Act 150 Contractors the authority to determine initial eligibility for both the Act 150 and Medicaid Waiver Programs.
2. Contractors and Medicaid Waiver Providers will be held fiscally liable by the Department for failure to determine and redetermine eligibility in accordance with the Program Requirements.
3. Contractors and Medicaid Waiver Providers shall provide attendant care services in compliance with the provisions of the Attendant Care Program Requirements.

I.6 Pennsylvania Model of Attendant Care Service

Contractors and Medicaid Waiver Providers shall offer consumers the full continuum of the Pennsylvania Model of Attendant Care Service, as set forth under this section.

1. A consumer has the right to make decisions about, direct the provision of, and control his or her attendant care services.
2. A consumer shall, to the highest degree possible, self-direct the recruiting, hiring, training, supervision, management and firing, if necessary, of an attendant.
3. Contractors and Providers shall provide a continuum of services which allow a consumer to choose the level of control of his or her services, ranging from complete agency model to complete consumer-employer model, and which allows the consumer to progressively attain higher levels of control over their attendant care services.
4. Contractors and Providers shall offer a consumer the option of performing all, some or none of the following tasks: recruiting, screening, managing, training, hiring, employing, and firing attendants. The Contractor or Provider is ultimately responsible for the completion of these tasks under the agency model and the consumer-employed model.

<u>Act 150</u>	<u>Medicaid Waiver</u>
<p>5. Contractors shall offer a consumer who has opted to be the employer under the consumer-employer model the option to perform either or both of the following tasks:</p> <ol style="list-style-type: none"> a. Receive program funds directly to complete payroll functions; and/or b. Complete related tax filings. <p>The Contractor is ultimately responsible for the completion of these tasks.</p>	<p>A Provider shall perform the fiscal agent tasks of payroll generation and related tax filings for a consumer employer, since Medicaid eligibility requirements will not allow a consumer to receive program funds directly. The consumer employer may elect to receive a payroll check to present to the attendant to whom it is written.</p>

6. Contractors or Providers and consumers shall record the consumer's choices regarding the tasks on the Consumer Designation of Primary Responsibility for Attendant Care Service Tasks/Activities (Appendix B). Both the Contractor and consumer shall sign the document.
7. Regardless of a consumer's designation of responsibilities for the continuum of tasks, the consumer shall be responsible for directing the activities of the attendant during the provision of services.
8. Contractors and Providers shall have an array of support activities available to assist and support consumers, at the request of the consumers.

9. Regularly assigned attendant(s) to the maximum extent possible shall perform personal care services.
10. Attendant care services must be available any day of the week or any hour of the day or night, depending upon the personal care needs of the consumer.
11. Contractors and Providers shall provide, to all consumers, basic and ancillary services when a regularly scheduled attendant will be unavailable for services for an extended period of time.
12. Contractors and Providers shall offer all applicants, who have been determined eligible for attendant care services, services until a regularly scheduled attendant can be found.
13. If service hours become difficult to fill, consumers and contractors or providers shall share in the responsibility for obtaining attendants regardless of the consumer's choice of service options.
14. The term Contractor is used generically to refer both to Contractors in the Act 150 Program and to Providers in the Medicaid Waiver in portions of the Attendant Care Program Requirements that are applicable to both programs.

I.7 Limitations on Provision of Service

1. Attendant care service shall be provided only to persons determined eligible by the contractor, provider or subcontractor.
2. Consumers shall exhaust other sources of service, including those provided under third party benefits, prior to receiving attendant care service.
3. A consumer may continue to receive services in the Medicaid Waiver only as long as the consumer meets eligibility criteria or who has been determined ineligible but whose services continue based on a timely appeal under the provisions of Chapter VII. If a consumer loses eligibility for the Medicaid Waiver due to improvement in function or due to increase in income or resources, the consumer may return to the Act 150 Program and will be subject to the provisions of the Act 150 Program. The right to return to the Act 150 Program upon loss of Medicaid Waiver eligibility does not apply to persons over 60 years of age who are served under the provisions of Appendix G.

Act 150 Program

Each Contractor's average hours of service to all Act 150 Program consumers shall not exceed 40 hours per seven-day week.

Medicaid Waiver Program

Average hours available under the Medicaid Waiver Program are adjusted periodically in order to maintain the budget neutrality requirements of the Medicaid Waiver for attendant care services and to operate within the budget requirements of the Commonwealth. The average hours of service available per Medicaid Waiver consumer is calculated by the Department and supplied to Medicaid Waiver providers.

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Administration

ATTENDANT CARE PROGRAM

CHAPTER II

ADMINISTRATION

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II.1 Program Monitoring and Quality Assurance

Contractors shall establish a quality assurance program that annually monitors and evaluates the quality of services provided to consumers. Contractors are responsible for monitoring their Attendant Care Program and subcontractors. Monitoring is to be accomplished using the Attendant Care Program Monitoring Instrument developed by the Department (see Appendix H). Attendant Care Program Contractors are also subject to monitoring and evaluation by Departmental staff.

II.2 Personnel Standards

Contractors shall employ adequate and competent personnel to ensure that the provisions of the Attendant Care Program Requirements are met. Contractors are encouraged to employ qualified persons with physical disabilities from within the program. The following additional staffing requirements shall apply.

Service Coordinators for the Medicaid Waiver Program. Service coordinators must meet one of the following provisions for minimum experience and training:

1. A Master's degree in human services (including sociology, social work, social welfare, psychology, special education, rehabilitation counseling, speech/language therapy, physical behavioral science); or
2. A Bachelor's degree in human services and at least one year of professional experience conducting psychosocial assessments, or at least six months of professional experience and at least six months as an attendant care program consumer; or
3. An Associate's degree in human services and at least two years of professional experience conducting psychosocial assessments, or at least one year of professional experience and at least one year as an attendant care program consumer; or
4. Successful completion of 12 credit hours of human services course work from an accredited college or university, and at least four years of professional experience conducting psychosocial assessments, or at least two years of professional experience and at least two years as an attendant care program consumer; or
5. A current registered nursing license, and at least two years of professional experience in nursing or conducting psychosocial assessments, or at least one year of professional experience and at least one year as an attendant care program consumer.

Service Coordinators for the Act 150 Attendant Care Program. Service Coordinators must meet one of the following provisions for minimum experience and training:

1. Meet the minimum experience and training provisions of Service Coordinators for the Attendant Care Waiver Program; or
2. A Master's degree in human services (including audiology, community counseling, occupational therapy, physical therapy, psychology, rehabilitation counseling, social work, social welfare, sociology, special education, speech/language therapy, or related behavioral science); or
3. A Bachelor's degree in human services and at least six months of experience in the human services field, or at least six months of professional experience with human service assessment and at least six months as a home and community service attendant or consumer; or
4. An Associate's degree in human services, and at least one year experience in the human services field, or at least one year of professional experience with human service assessment and at least one year as a home and community service attendant or consumer; or
5. A current licensed practical nurse with at least one year of experience in the human services field, or at least one year of professional experience with human service assessment and at least one year as a home and community service attendant or consumer; or
6. Successful completion of 12 credit hours of human services course work from an accredited college or university, and at least two years of experience in the human services field, or at least two years of professional experience and at least two years as a home and community service attendant or consumer; or
7. Four years as a home and community service attendant or consumer and a high school diploma.

Options Re-assessors. The minimum experience and training requirements for those persons completing reassessments for continued nursing home eligibility are identical to those for Service Coordinators.

Registered Nurse. The Medicaid Waiver provider must have registered nurse consulting services available, either as a staff member or through a contracted consulting arrangement, to provide support as needed to ensure the health, welfare, and safety of consumers. The responsibilities of a registered nurse consultant include the following:

1. Provide consultation services to consumers and to provider agency staff on issues related to supervision of attendant-assisted basic services and ancillary activities;

2. Provide training, as needed, to consumers, attendants, and provider agency staff, on issues related to health maintenance or other health, welfare, and safety issues;
3. Provide consultation, as needed, on service delivery problem solving related to the health, welfare, and safety of consumers.

Attendants. Attendants providing services to consumers in the Attendant Care Program must meet the following minimum standards:

1. Be 18 years of age or older;
2. Have the required skills to perform attendant care services as specified in the consumer's service plan;
3. Possess basic math, reading, and writing skills;
4. Possess a valid Social Security Number;
5. Be willing to submit to a criminal records check;
6. When required by the consumer, the attendant must be able to demonstrate the capability to perform health maintenance activities specified in the consumer's service plan or be willing to receive training to be able to provide the health maintenance activities specified in the consumer's service plan;
7. Contractors may not use Attendant Care Program funds to pay attendants who are family members of a consumer;
8. Attendants cannot be independent contractors.

The employer of an attendant shall have a description of the Contractor's and/or consumers-employer responsibilities including, but not limited to, the employment status of the attendant, payment of taxes, and benefits and insurances provided.

Grandfathering Provision for Service Coordinators and Attendants in the Act 150 Program

The minimum standards for service coordinators and attendants providing services to consumers in the Act 150 Program for attendant care services have changed. This provision is effective with implementation of these requirements. Service Coordinators or Attendants hired prior to the implementation date who do not meet the minimum standards shall be considered to be meeting the minimum standard as long as service being provided is satisfactory to the consumer.

II.3 Subcontractors and Consultants

1. Contractors may delegate to qualified subcontractors or consultants the responsibility to provide attendant care service, to determine and redetermine eligibility, or to perform other requirements of the Attendant Care Program.
2. Contractors are responsible for all services whether or not the services are provided directly or through subcontractors or consultants.
3. The Department will consider the Contractor or Provider to be the sole point of contact for Attendant Care Program matters.
4. Contractors shall ensure that subcontractors and consultants comply with the Attendant Care Program Requirements pertaining to the functions performed by them.
5. Contractors shall obtain written confirmation from subcontractors and consultants indicating their agreement to comply with the Attendant Care Program Requirements.
6. Contractors shall notify the Department of problems or noncompliance with subcontractors and consultants immediately upon discovery. Contractors shall provide the Department with a work plan that details a plan of correction and/or termination of the contract along with a contract termination transition plan prior to its implementation.
7. Contractors shall have executed written contracts with all subcontractors and consultants on file at the contractors' offices.
8. Contractors shall obtain advance Department approval of subcontractors and consultants.
9. Contractors shall supply a copy of the Attendant Care Program Requirements to each Attendant Care Program subcontractor or consultant.

II.4 Attendant Care Program Fiscal Manual

This manual, published under separate cover in March 1991 and updated in September 1992, contains the fiscal policies, procedures and requirements of the Act 150 Program.

II.5 Attendant Care Program Reports

Contractors shall submit reports of activities related to its service provision or contractual obligation in the form and frequency required by the Department. The reports include, but are not limited to:

1. Monthly Activity Reports. The monthly activity report, which will be used to collect programmatic information, is due in the Office of Social Programs by the 15th of the

month succeeding the month for which information is collected. The Department will provide the Monthly Activity Report format. The information requested may vary depending on the information and planning needs of the Department. The Monthly Activity Report must be accurate and timely.

2. Progress Reports. The contractor shall, at the Department's request, submit a progress report in a format provided by the Department. This report will contain information regarding the contractor or provider's activities.
3. Evaluation Reports. The contractor shall, at the Department's request, complete evaluation reports and participate in evaluation-collection activities by established due dates.

II.6 Consumer Files

1. For each consumer, Contractors shall establish and maintain a separate consumer service file which includes the following:
 - a) A description of the consumer's need for services, and the particular services to be provided, including the following:
 - i. Application for Attendant Care Services (SP 775).
 - ii. Attendant Care Service Notification of Eligibility Determination (PW 1299).
 - iii. Attendant Care Assessment Summary (SP 1538).
 - iv. Attendant Care Program Service Plan (SP 777), with Service Plan Addendum, signed by the contractor and the consumer.
 - v. Service Preference Form (SP 779).
 - vi. Consumer Selection of Attendant Care Control Option.
 - vii. Service Agreement Between Consumer and Provider Agency.
 - viii. Consumer Designation of Primary Responsibility for Attendant Care Service Tasks/Activities.
 - ix. Other pertinent service documentation recorded on the Attendant Care Program Service Notes (SP 778), including:
 - A. Documentation of problems or concerns raised by a consumer, attendant, or other third party, attempts to investigate the problem or concern, and disposition of the problem.

- B. Documentation of in-home monitoring visits and telephone contacts.
 - C. Signature and date of person entering information into the service notes.
 - D. The code that corresponds to the contact (i.e. VO, MV, or RV)
- x. For consumers who are the employers of attendants, a written agreement between the attendant and the consumer, recorded on the Agreement Between Consumer and Attendant.
- b) All documents must be complete, signed, and dated.

<p>Act 150</p> <p>Fee Redetermination Form (SP 776).</p> <p>Attendant Care Reassessment Summary (SP 1538 A).</p>	<p>Medicaid Waiver</p> <p>MA 51s, Options assessments and reassessments, Under 60 Attendant Care Program Clinical Nursing Facility Eligibility Determination Report, and related documents.</p> <p>PA 600P and PA 162 (Notice of Eligibility) if any, and related documents and proofs.</p>
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2. Contractors shall also maintain the following signed and dated documents in either the consumer file or in a separate fiscal file:
- a) For consumer employers, Criminal Record Check Policy (SP 780).
 - b) For consumer employers for whom the agency provides fiscal agent services, the following documents:
 - i. Consumer Employer Appointment of Agent.
 - ii. Federal and state tax forms.
3. Contractors shall maintain time sheets and related documents in the agency fiscal office.
4. Medicaid Waiver Providers shall maintain MA 319 invoices, remittance advices, and related documents in the agency fiscal office.
5. Contractors shall permanently maintain the following signed and dated documents in the active file:
- a) Application for Attendant Care Services.
 - b) Attendant Care Assessment Summary.

- c) The original Options Assessment.
7. Contractors shall retain other consumer file documents for the later of the following time periods:
- a) A period of four years from the end of the fiscal year in which the services were provided.
 - b) Until completion of an audit for compliance that began, but was not complete, within four years of the end of the fiscal year in which services were provided.
 - c) Until audit findings have been resolved for an audit for compliance that began within four years of the end of a fiscal year in which services were provided.
8. Contractors shall use forms designated or approved by the Department.

II.7 Consumer Signature on Attendant Care Program Documents

- 1. Contractors shall obtain a consumer's signature or an acceptable alternative on program documents. Both consumer and attendant must sign time sheets and the Agreement Between Consumer and Attendant.
- 2. Acceptable alternatives include the consumer's mark, or a signature stamp, for a consumer who is unable to sign.
- 3. If a consumer is unable to provide a signature, a mark or a stamp, the Contractor shall notate on the signature line that the consumer is unable to sign.
- 4. No other person may sign in the consumer's place, unless that person has power of attorney and a copy of the document so authorizing such authority is in the consumer's file.

II.8 Attendant Care Program Administrative Waivers

<p>Act 150</p> <p>1. The Department, at its discretion, may grant administrative waivers to certain requirements of the Attendant Care Program. Contractors may request an administrative waiver if it will assist in meeting the overall Attendant Care Program objectives and is not in conflict with Act 150, other federal and state laws and regulations, and the Pennsylvania model of attendant care service.</p>	<p>Medicaid Waiver</p> <p>Administrative waivers under the Medicaid Waiver Program are subject to the same provisions as Act 150, and additionally may not conflict with the Medicaid Waiver for attendant care services.</p>
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2. The Department will approve administrative waiver requests on a case-by-case basis.

3. At a minimum, the following circumstances require administrative waivers:

<p>Act 150</p> <p>a) Continuation of services for a consumer who leaves the Commonwealth for a period longer than 30 days, with or without the accompaniment of an attendant being compensated with program funds.</p> <p>b) Permission for a transferring contractor to fund a consumer being served by a second contractor in another region until the second contractor can assume the cost under its Act 150 contract.</p>	<p>Medicaid Waiver</p> <p>Continuation of services for a consumer who leaves the Commonwealth for a period longer than 30 days, with or without the accompaniment of an attendant being compensated with program funds.</p> <p>Exception: Medicaid Waiver funds can be automatically used to serve a consumer moving to a different region of the Commonwealth, without need for an administrative waiver.</p>
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4. To request an administrative waiver from an Attendant Care Program requirement, the contractor may submit, in writing, a reference to the requirement for which the waiver is requested, and documentation to justify the waiver.

5. Letters requesting administrative waivers to Attendant Care Program Requirements should be submitted to:

Deputy Secretary
Office of Social Programs
Room 533, Health and Welfare Building
Harrisburg, PA 17120

II.9 Attendant Care Advisory Committee

1. Consumers shall be included in the delivery and on-going monitoring of the Attendant Care Program.
2. Contractors shall establish an attendant care advisory committee that meets regularly and advises the Contractors on matters of policy, program operations, and community relations. The meetings should be held at each of the satellite offices managed by each Provider/Contractor in order to allow for additional consumers to join the meetings.
 - a) A contractor shall only serve as technical advisor to the committee.
 - b) Consumers and attendants must be represented on the committee. Representation from consumers and consumer organizations must constitute at least 51 percent of the membership.
 - c) Contractors must provide to all consumers written invitations to advisory committee meetings.
 - d) Contractors must provide to all consumers minutes of the advisory committee meetings.

CHAPTER III
General Eligibility

ATTENDANT CARE PROGRAM

CHAPTER III GENERAL ELIGIBILITY

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III.1 General Eligibility Criteria

To be eligible for attendant care services, a person must satisfy all of the following criteria:

1. Be at least 18 years of age but less than 60 years of age.

NOTE: Persons who are receiving services through the Attendant Care Medicaid Waiver Program may choose to continue to receive those services upon reaching the age of 60 through special agreement between the Department of Public Welfare and the Department of Aging.

2. Be mentally alert and capable of:
 - a. Selecting, supervising and, if needed, firing an attendant;
 - b. Managing one's own financial affairs;
 - c. Managing one's own legal affairs.
3. Experience any medically determinable physical impairment that can be expected to last for a continuous period of not less than 12 months or that may result in death.
4. Because of the physical impairment(s), the person requires assistance to complete functions of daily living, self-care and mobility, including, but not limited to, those functions included in the definition of attendant care services.
5. Be found in need of basic services on the basis of an assessment.
6. Be a citizen of the United States or an immigrant lawfully admitted for permanent residence.

NOTE: The requirement that an immigrant be admitted for permanent residence is effective with implementation of these requirements. Immigrants who were lawfully admitted but not for permanent residence and who were receiving attendant care services prior to implementation date shall continue to be eligible for those services for their current stay in the United States if they are considered to be a resident of Pennsylvania and they meet all other eligibility requirements.

7. Be a resident of Pennsylvania. A resident is a person who lives in Pennsylvania, intends to remain, and maintains a continuous physical presence in the state except for a temporary absence. For purposes of satisfying the general eligibility criteria, the following persons who are either United States citizens or immigrants lawfully admitted for permanent residence are considered Pennsylvania residents:
 - a. Persons who declare a place of permanent residence located within the Commonwealth.
 - b. Migrant workers who are seasonally employed or are seeking seasonal employment in the Commonwealth.

- c. Students who are attending school in Pennsylvania, if they meet all other eligibility criteria.
8. Participate in the eligibility process for the Medicaid Waiver for attendant care services.

III.2 Additional Eligibility Criteria for Participation in the Medicaid Waiver for Attendant Care Services

In addition to the requirements under Section III.1, a person must satisfy the following criteria to participate in the Medicaid Waiver for attendant care services:

1. The person requires nursing facility level of care for a period of twelve months or longer, as determined in an Options Assessment by the local Area Agency on Aging.
2. Possess income and resources within limits established in the Medicaid Waiver for attendant care services.

III.3 Verification

Contractors shall request verification of the following items at the time of application:

1. Alien status of an applicant if the applicant states that he or she is not a citizen of the United States.
2. Income (Waiver only).
3. Resources (Waiver only).
4. Medical expenses.
5. Information provided orally by the applicant that is inconsistent or conflicting with known information or information that is believed to be incorrect.

The Contractor will request verification at redetermination of only those items which are subject to change including:

1. Income (only if a change in income indicates a potential for Waiver eligibility);
2. Resources (only if a change in resources indicates a potential for Waiver eligibility);
3. Medical Expenses;
4. Information provided orally by the consumer that is inconsistent or conflicting with known information or information that is believed to be incorrect.

The applicant/consumer is the primary source of information in establishing eligibility. However, the contractor will assist the applicant/consumer, when necessary, in obtaining the required verification. Verification may include, but not be limited to the following:

1. Written evidence such as pay stubs, award letters, copies of checks, bank statements, receipts, etc;
2. Public records;
3. Collateral contacts, such as phone calls to employers;
4. Automated sources; and
5. Other means which will establish the truth of the applicant/consumer statement.

The applicant/consumer is expected, to the extent he or she is able, to attempt to secure verification from third party sources before the contractor assumes responsibility for making a collateral contact. If the applicant/consumer has cooperated but is still unable to provide acceptable evidence, the Contractor will make a collateral contact with a third party at the request of the applicant/consumer. If both the applicant/consumer and the Contractor fail to secure valid proof, the Contractor will make a reasonable judgment based on available evidence, credibility of the person, and validity of other supporting and conflicting evidence.

If the applicant/consumer fails to cooperate in providing verification, services can be denied or terminated with proper notice. If the applicant/consumer fails to cooperate in providing verification of medical expenses, eligibility will be determined without a deduction for the medical expense(s) in question.

NOTE: Contractors cannot deny eligibility for Waiver services if the Waiver applicant/consumer does not cooperate in providing the verifications listed above. The local county assistance office (CAO) is responsible for the determination of Waiver eligibility. However, services in the Act 150 program will be denied or terminated if the CAO denies eligibility for the Waiver program based on the non-cooperation of the applicant/consumer.

III.4 Request for Service

1. Contractors shall screen initial requests for service on the basis of broad eligibility criteria such as age, presence of a physical impairment, and the need for personal care services.
2. Contractors shall make referrals to appropriate agencies for persons who do not meet eligibility criteria on the basis of the intake screening.
3. Contractors shall notify an applicant of all available Medicaid Waiver Providers in a consumer's geographic area. An explanation of the right of choice of Providers shall be explained to the consumer in a manner that will be understood by the consumer. A cover

letter explaining choices will be sent with the PW 1299 to the consumer after waiver eligibility has been established.

4. Contractors shall terminate the eligibility determination process for persons found ineligible on the basis of the intake screening, unless an applicant requests a full eligibility determination despite the screening findings. It is the responsibility of the Contractor to notify the applicant of their right to a full eligibility determination.
5. Contractors shall maintain an up-to-date inquiry log of all persons requesting service, with at least the following entries:
 - a) Date of the inquiry.
 - b) Name of the potential applicant.
 - c) Address of the potential applicant.
 - d) Telephone number of the potential applicant.
 - e) Name of the caller and referring entity or person, if any.
 - f) Nature of the inquiry.
 - g) Name of the intake worker.
 - h) Date and reason for ineligibility, if applicable.
 - i) Referral made.
 - j) Disposition of the inquiry.

III.5 Initial Eligibility Determination

1. The Act 150 Contractor assigned to the geographic region in which an applicant is physically located at the time of request is responsible for the initial eligibility determination for applicants for both the Act 150 and the Medicaid Waiver Programs. Paperwork shall be promptly transferred to the Contractor/Provider in the receiving area when an applicant/consumer permanently changes his/her physical location.
2. Contractors shall conduct an in-person assessment within 15 working days following a request for services. An employee meeting the minimum qualifications as a service coordinator for the Medicaid Waiver Program will complete the assessment. The assessment will take place in the applicant's home, or in the hospital or nursing facility if services need to be in place prior to the individual's discharge from a facility.
3. Contractors and applicant shall complete and sign the Application for Attendant Care Services (SP 775) and Attendant Care Assessment Summary (SP 1538) to determine initial eligibility.
4. Contractors shall assess an applicant's capacity and willingness to select and direct attendants, establish the applicant's functional capacity, determine the absence or presence of a physical disability, and evaluate the nature of the home environment and the availability of family or friends willing to assist in providing care.

5. The Contractor and the consumer shall negotiate and sign a Service Plan (SP 777) based on the assessment of the applicant's needs.
6. Contractors and applicant shall complete and sign a Service Preference Form during the in-person assessment. (SP 779)
7. All Act 150 required forms must be completed and signed before beginning the waiver eligibility process.
8. When an applicant is found eligible for program services on the basis of the initial eligibility determination, the Contractor shall screen the applicant for potential Medicaid Waiver eligibility before placement in the Act 150 Program.
9. Contractors shall proceed with the Medicaid Waiver eligibility process when an applicant is potentially Medicaid Waiver eligible.
10. Contractors shall document, on the Temporary Exemption from Medicaid Waiver Participation form (Appendix A), the reason for an applicant's exemption from the Medicaid Waiver Eligibility process, and shall maintain the form in the applicant's file.
11. Contractors shall provide applicants with verbal and written notice of eligibility or ineligibility with a PW 1299.
12. Contractors shall determine an applicant ineligible if they are unwilling to cooperate in applying for Waiver eligibility.
13. Contractors shall obtain the applicant's signature on the Rights and Responsibilities form. A copy of the signed form will be given to the applicant. The original will be retained in the consumer's file.

III.6 Waiver Eligibility Process

In order for an applicant to be placed in the Medicaid Waiver for attendant care services, the following requirements must be met:

1. The Act 150 Contractor for the geographic area must have screened the applicant and found him or her eligible for Act 150 Services.
2. The applicant's physician must have completed an MA 51.
3. The local Area Agency on Aging must have completed an Options Assessment and found the applicant eligible for the nursing facility level of care for twelve months or longer, or which may result in death if less than twelve months.
4. The local county assistance office must have found the applicant financially eligible for Attendant Care Waiver participation.

5. The applicant's assessed service hours can be accommodated within the average number of service hours available in the Waiver Program relative to maintaining the budget neutrality requirements of the Medicaid Waiver of attendant care services.

III.7 Reassessments

<u>Act 150</u>	<u>Medicaid Waiver</u>
<p>At least once each year, and prior to the anniversary of each consumer's most recent full service reassessment, Contractors shall reassess the consumer's needs during an in-home visit. The consumer and the Contractor shall review the service plan for accuracy and sign the consumer's service plan if no changes are noted. If changes are noted, a new service plan shall be completed and signed.</p> <p>Contractors shall verify the consumer's continued back-up system during the reassessment.</p> <p>Reassessment verifications under the Act 150 Program are recorded on the Attendant Care Reassessment Summary (SP 1538 A).</p> <p>Contractors shall notify consumers of reassessment results under the provisions of section III.15.</p> <p>Contractors may conduct an annual service reassessment and a fee determination at the same visit.</p> <p>Contractors shall complete more frequent reassessments as needed or as reasonably requested by a consumer.</p>	<p>At least once each year, and prior to the one year anniversary of each consumer's most recent Options assessment or reassessment, Providers shall complete an Options reassessment with consumers during an in-home visit. Providers shall reassess the service plan with consumers, and both shall review the actual provision of attendant care services to the consumer. Providers shall verify the consumer's continued eligibility for services and the consumer's back-up system during the reassessment.</p> <p>Providers shall notify consumers of reassessment results under the provisions of section III.15.</p> <p>Providers shall notify consumers annually in writing at the time of reassessment of all available Medicaid Waiver Providers in a consumer's geographic area, and notate in the consumer's file that the notification has been made. Appendix A contains model language for the annual notification of available Medicaid Waiver providers.</p> <p>Upon request by the county assistance office, providers shall coordinate the submission of necessary documents for redetermination of a consumer's Medicaid Waiver Program fiscal eligibility.</p>

Contractors shall document the reassessment in the consumer's service notes.	<p>Providers shall complete more frequent reassessments as needed or as reasonably requested by a consumer.</p> <p>Providers shall document the reassessment in the consumer's service notes.</p>
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III.8 Change in the Provision or Level of Service by a Contractor or Provider

A Contractor or Provider may modify the provision of service to a consumer under the following conditions:

1. If, in the professional judgment of the Contractor, the consumer no longer requires the same service(s) or level of service(s), the Contractor may proceed to reduce or terminate service(s). The Contractor must document the facts supporting its determination and must provide the consumer with thirty (30) days advance written notice of the change. The notice must include an explanation of the proposed change in the scope or level of service(s), the facts supporting the change, the consumer's right to appeal the change, and the consumer's right to continue to receive service pending the outcome of his/her administrative appeal if his/her appeal is filed within ten (10) days of the postmark date of the Contractor's notice.
2. If, in the professional judgment of the Contractor, the consumer requires a level of service beyond that available under the Attendant Care Program, the Contractor may decline to provide such services. The Contractor must provide the consumer with written notice of the decision, the facts in support of the decision, and the right to appeal. The Contractor must also facilitate a referral to another appropriate service.

III.9 Termination of Service

1. If, in the case of a consumer receiving services, a Contractor reasonably determines that the consumer has engaged in any activities listed below, upon thirty (30) days advance written notice, a Contractor may terminate its services to the consumer:
 - a) The consumer engages in a course or pattern of uncooperative conduct including verbal and/or physical abuse of Contractor staff;
 - b) The consumer fails to comply with the terms of the service plan;
 - c) The consumer misuses services or uses services for other than the intended purpose in the service plan;
 - d) The consumer fails to maintain a safe and healthy environment in which the Contractor staff must work;

- e) The consumer submits false time sheets; or
 - f) The consumer fails to comply with the payment schedule agreed to by and between the Contractor and the consumer.
2. The Contractor is responsible to help the consumer develop a plan of correction for remedying the offending activity prior to termination, depending on the nature of the activity. This could include restricting a consumer from agency or consumer model for a period of time until the consumer has demonstrated correction of the offending activity.
 3. The Contractor must provide the consumer a termination notice, which explains the facts relied on for the decision, the consumer's right to appeal the provider's decision, the consumer's right to continued receipt of services pending the outcome of the appeal if the appeal is filed within ten (10) days from the postmark date of the notice, and the consumer's right to receive case referrals to another enrolled provider/contractor from the Contractor. The continuation of services under this condition presumes that the Contractor's employees are able to provide services to the consumer and that the continuation of services does not pose risk to the employees' health and safety. The Contractor will provide case referral to another enrolled contractor/provider.
 4. The requirement for thirty (30) days advance notice to the consumer is not applicable in situations where the health and safety of the contractor/provider's staff is at risk.

III.10 In State/Out-of-State Travel

1. A consumer may use attendant care services during business trips, vacations or other temporary travel, under the provisions of this section.
2. The roles and responsibilities of a consumer and attendant for attendant care services are the same during travel as at home.
3. The Attendant Care Program bears no responsibility for travel costs of either consumer or attendant.
4. A consumer is limited to authorized hours of service for vacations and other optional travel.
5. Subject to assessment of need and availability of funds, contractors may approve additional hours of service during necessary travel for the following purposes:
 - a) Employment. (Subject to approval by the Department)
 - b) Medical consultation.
 - c) Urgent personal business such as a family funeral.

6. A consumer is subject to all program requirements during the period of travel.
7. Payment for attendant care services for a consumer who is out-of-state for more than 30 days is subject to prior written approval by the Department, under the provisions of Chapter II (relating to administrative waivers.)
8. Contractors shall explain the travel policy to a consumer at the time of placement into the Attendant Care Program, and shall annually review the policy with the consumer.

III.11 Consumer Admission to a Hospital

This section applies to consumers admitted to a bed licensed as a hospital bed by the Pennsylvania Department of Health, including general, psychiatric and rehabilitation hospital beds, and beds in the rehabilitation or psychiatric units of general hospitals. It does not apply to admissions to the licensed nursing facility beds of general hospitals.

This policy must be explained to a consumer during the initial visit after acceptance into the Attendant Care Program, and/or a pamphlet may be given explaining this option. After the initial explanation, this option must be reviewed with consumers annually, preferably during reassessments.

Act 150

Consumers of attendant care service who are temporarily hospitalized may continue to receive limited ancillary services as long as they meet eligibility requirements and the services provided by the attendant do not duplicate or replace those services available through other third-party payers. Ancillary services provided during hospitalization are limited to minimal chores such as removing perishable foods from the home, mail pick-up, and shopping for perishable foods just prior to discharge from the hospital. Attendants may not provide personal care services, including assistance with bathing or eating, or health maintenance activities, to a hospitalized consumer.

Contractors shall conduct an assessment of need and adjust the service plan accordingly during the period of hospitalization. The contractor shall review such plans at least every two weeks. Continued payment for services beyond 30 days from the date of hospitalization shall be subject to approval by the Department upon the contractor's request for an administrative waiver.

Medicaid Waiver

The Waiver Program policy is identical to the Act 150 Program with the following exceptions:

1. The Department may, in its sole discretion, elect to transfer a consumer to the Act 150 Program due to a period of costly hospitalization. This policy is necessitated by the

federal requirement that Medicaid Waiver Services be budget neutral, that is, that the combined cost of Medicaid Waiver services and other health care costs under the Medical Assistance Program not exceed the cost of nursing facility care.

2. Under the Waiver Program, services involving maintenance and preparation of the home are not considered complete until verified by the consumer upon the consumer's discharge from the hospital. The related service hours are billed for the date of discharge, in the two-week period in which the date of discharge occurs.
3. Providers may bill for service coordination for a month in which the consumer is hospitalized for part of the month. They may not bill service coordination for any month in which the consumer is hospitalized for the full calendar month.

III.12 Temporary Admission to a Nursing Facility

1. Contractors shall reserve a consumer's placement in the Attendant Care Program when the consumer is admitted to a nursing facility for a period anticipated to be 90 days or less.
2. A contractor shall request an administrative waiver to reserve the consumer's placement in the Attendant Care Program for an additional 30 days, if discharge from the nursing facility is imminent at the end of the first 90-day period.
3. Contractors shall provide notice to the Attendant Care Program in the form of a Service Plan Addendum at the time of a consumer's admission to a nursing facility and at the time of discharge from the nursing facility back to Attendant Care Program.
4. In the case of a consumer's admission to a nursing facility for a period of more than 120 days, a contractor shall terminate the consumer from the Attendant Care Program.
5. This section applies to any admission to a licensed nursing facility bed including beds in a freestanding nursing facility and beds in the wing of a general hospital that are licensed as nursing facility beds.
6. Contractors shall provide no service including ancillary services during a nursing facility stay.

III.13 Transition of Services

1. Upon termination or expiration of a contract or provider agreement, the contractor shall participate in the transfer of Attendant Care Program responsibilities to another contractor in the manner defined by the Department, and shall supply to the receiving contractor the complete original consumer file. The transferring contractor shall maintain a copy of the consumer file until it has been verified that the receiving contractor has the original file in its possession.

2. Upon the transfer of an individual consumer to another contractor due to the consumer's relocation, the transferring contractor shall supply to the receiving contractor the complete original consumer file. The transferring contractor shall maintain a copy of the consumer file until it has been verified that the receiving contractor has the original file in its possession.

III.14 Transition of Services for Consumers Turning Age 60.

1. The local Area Agency on Aging (AAA) is responsible for the provision of Attendant Care services for an individual on the person's 60th birthday. The AAA is responsible for approving the service plan as developed by the attendant care service provider as specified in the Department of Aging Options Procedures Manual contained in Appendix F.

Note: Refer to Appendix G for special procedures that apply to Attendant Care Waiver Program transition.

2. Contractors shall give written advance notice to the AAA of consumers with impending 60th birthdays, including those of persons who will be served in the Medicaid Waiver under the provisions of Appendix F. Contractors shall notify the AAA at intervals of 18 months, 12 months, and four months prior to a consumer's 60th birthday, and provide copies of the notifications to the Department of Public Welfare, Office of Social Programs and the consumer.
3. Contractors shall coordinate with the appropriate AAA in accordance with the Department of Aging policy on the continued provision of attendant care services for consumers when they turn age 60. Coordination activities with the AAA must include, but not be limited to, meeting with the AAA to develop a process for the transition of consumers to AAA responsibility while continuing service through the attendant care provider. The consumer will be invited to attend this meeting and participate in the development of the process. A written summary of the meeting will be provided to the consumer whether or not he/she chooses to attend. A copy of the summary and the invitation will be maintained in the consumer's file.

III.15 Requirements for Notification of Applicants or Consumers

1. Contractors shall make written notification by use of the Notice of Eligibility Determination (PW 1299) in the following situations:
 - a) Initial eligibility determination or reassessment.
 - b) Fee determination or redetermination.
 - c) Permanent or temporary decrease of service hours.

- d) Permanent or temporary increase of service hours.
 - e) Termination from the program or the waiver eligibility process.
 - f) An applicant or consumer's voluntary withdrawal from the program.
 - g) A change or decision that has a substantive impact in a consumer's participation in the program, for example, limited to either agency or consumer-combination model due to difficulty in managing the chosen model of service.
2. Contractors shall issue a PW 1299 within ten working days after the eligibility interview to an applicant found ineligible for program services on the basis of the initial eligibility determination.
 3. Contractors shall both orally notify an eligible applicant and issue a PW 1299 within ten working days after the completion of, or temporary exemption from, the Medicaid Waiver eligibility process.
 4. Contractors shall orally notify a consumer and issue a PW 1299 within ten working days after an eligibility redetermination and/or fee redetermination interview.
 5. On each PW 1299 that is issued, the Contractor shall reference the Attendant Care Program requirement that references the reason for the notification to be sent.
 6. Contractors shall mail or hand-deliver the original copy of the PW 1299 to an applicant or consumer, so that notification is made within the specified time frames.
 7. Contractors shall include with the PW 1299 a notice of the contractor's local grievance process, including an explanation that the local grievance process can be filed simultaneously with a formal appeal, but that it is not required and does not change the time frames for formal appeal.
 8. Contractors shall include with the PW 1299 a notice that the applicant or consumer has the right to assistance in filing an appeal.
 9. Contractors shall retain a copy of the PW 1299 in the consumer's file or in a rejected application file, as appropriate.

ATTENDANT CARE PROGRAM

CHAPTER IV

FINANCIAL ELIGIBILITY

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IV.1 Financial Eligibility Criteria

1. Attendant care service is provided without regard to income. It is not necessary for applicants to meet any financial eligibility criteria.
2. Applicants whose family monthly gross income exceeds 300 percent of the Federal Benefit Rate, as published annually in the Federal Register, must pay a fee according to the sliding fee scale promulgated by the Department.
3. All applicants must exhaust all other available third-party benefits prior to receiving attendant care service.

NOTE: The Attendant Care Program is the payer of last resort. Contractors should review availability of third party resources on a case-by-case basis. If duplicate services are available at no cost to the consumer through another agency, the consumer must use those services. Attendant Care can be provided for any portion of eligible services that are not available through the other agency as long as there is no duplication of services. Individuals that receive lump sum benefits from agencies are not required to use the lump sum to purchase attendant services unless the award specifies that it be to be used for that purpose. If the award does not specify what the lump sum is to be used for it should be considered a resource as long as it is not a recurring benefit. Recurring benefits are considered income.

IV.2 Fee Determination and Redetermination

1. Contractors shall calculate weekly fees as follows, on the basis of family members in the household, income, and medical and disability expense:
 - a) Calculate the family monthly income.
 - b) Adjust the family monthly income by subtracting the amount of family monthly medical and disability expenses.
 - c) Apply the sliding fee scale under Appendix C, using the adjusted family monthly income and the number of family members identified to establish the weekly fee amount.
2. The following family members are included for the purpose of fee calculation if they reside in the consumer's household:
 - a) The consumer;
 - a) The consumer's spouse;
 - b) Dependent children who are under age 18;

- d) Children of the consumer or spouse, age 18 or older, who are dependent because of a mental or physical disability may be included at the option of the consumer if including them and their income will benefit the consumer; or
- e) Dependent children of the consumer or spouse who are under age 24 and who are full-time students at an accredited institution of higher learning, including a licensed trade or vocational school.

NOTE: Children placed in the household for foster care or group care, whether or not related to the consumer or spouse, are not counted for purposes of fee calculation.

- 3. Contractors shall use the sliding fee scale corresponding to the fiscal year during which the fee is calculated.
- 4. For the purpose of calculating weekly fees, if the cost of a consumer's approved weekly hours of service is less than the calculated fee, the weekly fee is limited to the cost of the approved weekly hours.
- 5. For the purpose of collecting weekly fees, the full fee or the cost of service, whichever is less, is due for the week if a consumer receives any portion of the approved service hours during the week. If a consumer receives no hours of service during a week, no fee is due.
- 6. In the case of a husband and wife who both receive services in the Act 150 Program, each shall be assigned one-half of a single fee so as not to double count the family income in establishing fees.
- 7. Contractors shall complete fee determinations at the following intervals:
 - a) Every 12 months for a consumer whose family monthly income is derived solely from a fixed income source; or
 - b) Every six months for all other consumers.
- 8. Contractors shall additionally complete fee redeterminations in the following situations.
 - a) When the Contractor learns of a change in circumstance that could affect fee calculation; or
 - b) When an installment expense will be satisfied before the next scheduled redetermination and the satisfaction of the expense will result in a change in the fee amount.

IV.3 Fee Exemption Criteria

A consumer who meets one or more of the following conditions is eligible for attendant care service at no cost to the consumer:

1. The consumer participates in the Medicaid Waiver for attendant care services;
2. The consumer has current Medical Assistance Program eligibility as verified yearly through the Eligibility Verification System;
3. The consumer receives SSI payments; or
4. The consumer's family monthly income, as adjusted under this Part, is less than or equal to 300 percent of the Federal Benefit Rate updated annually in the Federal Register by the U.S. Department of Health and Human Services.

IV.4 General Requirements

1. Contractors shall inform applicants orally and in writing of the fee policy during the initial assessment process. Contractors shall include in the notification the fact that attendant care services may be terminated if payment is not received according to payment schedule.
2. Contractors shall provide consumers with an annual reminder of the agency's payment schedule and the fee policy. A copy of the reminder shall be placed in the consumer's file.
3. Contractors shall notify consumers of the results of a fee redetermination, using the Attendant Care Service Notification of Eligibility Determination (PW 1299), whether or not there is a change in the fee.

IV.5 Delinquent Fees

Contractors shall use the following procedure when a consumer is delinquent in the payment of assessed fees:

1. Contractors shall write to a consumer who is two weeks late in the remittance of fees to remind the consumer of the obligation to remit the fees according to the prearranged schedule and to determine if a situation has developed that would temporarily prevent the consumer from paying the fee.
2. When a consumer is three weeks late in the remittance of fees and has not remitted fees after being contacted, the Contractor shall notify the consumer in writing that failure to make prompt payment within one week from the date of the letter can result in

termination of the consumer's attendant care services. The Contractor shall offer the consumer the opportunity to negotiate a payback schedule for past-due fees.

3. Contractors shall terminate the participation of a consumer who is four weeks late in the remittance of fees, and has not made arrangements for the remittance of late fees following issuance of the letter specified above.
4. Contractors shall place in the consumer's file copies of correspondence and forms generated in the collection of late fees. The Contractor shall record in the service notes reports of telephone calls related to late fees, including an agreed-upon payback schedule.

IV.6 Countable Income

Sources of family income include:

1. Money, wages or salary earned by family members 14 years of age or older before deductions for taxes, Social Security, bonds, pensions, union dues, health insurance, and similar purposes for work performed as an employee including commissions, tips, piece-rate payments, and cash bonuses.
2. Armed Forces pay which includes base pay plus cash housing and subsistence allowances but does not include the value of rent-free quarters.
3. Voluntary or court-ordered support received by a present or former spouse.
4. Voluntary or court-ordered child support.
5. Gross income from self-employment, farm or non-farm. Gross income is determined by deducting the verified costs of producing or continuing the income from the gross receipts.
6. Gross income from the rental of real property. Gross income is determined by deducting the verified costs of producing or continuing the income from the gross receipts.
7. Social Security pensions, survivors' benefits, children's Social Security benefits, permanent disability insurance payments, and special benefit payments made by the Social Security Administration before deductions of health insurance premiums.
8. SSI payments received by a minor or adult child identified as a dependent under V.2.
9. Railroad retirement, disability, and survivors' benefits payments made by the United States Government under the Railroad Retirement Act of 1974 (45 U.S.C.A. Sections 231-231v) before deductions of health insurance premiums.

10. Private pensions and annuities, including retirement benefits paid to a retired person or that persons' survivors by a former employer or by a union, either directly or through an insurance company, individual retirement accounts and Keoghs.
11. Government employee pension payments received from retirement pensions paid by federal, state, county, or other governmental agencies to former employees including members of the Armed Forces or their survivors.
12. Unemployment compensation received from governmental unemployment insurance agencies or private companies during periods of unemployment and strike benefits received from union funds.
13. Worker's compensation received from private or public insurance companies for injuries incurred at work. The cost of this insurance must have been paid by the employer and not by the worker.
14. Payments made by the Veterans Administration to veterans or their families.
15. Dividends, including dividends from stock holdings or membership in associations.
16. Interest on savings or checking accounts and bonds.
17. Income from estates, trust funds and settlements.

IV.7 Excluded Income

Sources of income excluded in determining family monthly income are:

1. Earned income of a child as follows:
 - a) Earned income of a child under 14 years of age.
 - b) Earned income of a child who is under 18 years of age and a full-time student.
2. Proceeds from the sale of property, such as a house or a car, unless the person was engaged in the business of selling such property, in which case the net proceeds would be counted as income from self-employment.
3. Borrowed money.
4. Tax refunds or rent rebates from any source.
5. Gifts.
6. The value of the coupon allotment under the Food Stamp Act of 1977 (7 U.S.C.A. Chapter 51, Section 2011-2026) in excess of the amount paid for the coupons.

7. The value of donated foods.
8. The value of supplemental food assistance under the Child Nutrition Act of 1966 (42 U.S.C.A. Sections 1711-1785) and the special food service programs for children under the National School Lunch Act (42 U.S.C.A. Chapter 13).
9. Loans and grants, such as scholarships, obtained and used under conditions that preclude their use for current living costs.
10. Grants or loans to an undergraduate student for educational purposes.
11. Payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (42 U.S.C.A. Sections 1415, 2473, 3307, 4601, 4602, 4621-4638, and 4651-4655; 49 U.S.C.A. Section 1605).
12. Home produce used for household consumption.
13. The value of rent-free quarters.
14. Foster care payments by a state agency.
15. Employee reimbursements for travel or other expenses to the extent that the reimbursement does not exceed the expense.

IV.8 Support Deduction

Contractors shall subtract from the family monthly income the amount of support paid by individuals included as family members as follows:

1. Voluntary or court-ordered support paid by the consumer, spouse or adult child to a present or former spouse not residing in the consumer's household; or
2. Voluntary or court-ordered support paid by the consumer, spouse or adult child for a child who is not residing in the consumer's household.

Consumers must provide verification of the expense in order to receive the deduction.

IV.9 Medical and Disability Expense Deductions

1. Contractors shall subtract from the family monthly income the amount of family monthly medical and disability expenses.
2. The following provisions apply in determining allowable deductions:

- a) The amount considered is the actual, anticipated, or obligated monthly amount.
- b) The expense is the responsibility of the family and is not paid or will not be paid by a third party.
- c) Anticipated monthly medical and disability expenses must be based upon previous or present medical obligations or cost.
- d) Expense deductions may be included in the calculation only if the Contractor places a copy of the bill or paid receipt in the consumer file. One month's receipts are required for recurring medical expenses.
- e) If installment payments are made, the amount considered is the actual amount paid per month.
- f) If installment payments are made, the Contractor shall document on the Application for Attendant Care Services (SP 775) or Fee Determination Form (SP 776) the beginning and ending dates of the payments and the initial amount of obligation.
- g) The consumer fee for attendant care services established under this part is not considered as an expense deduction.

3. The following expenses are considered in determining family medical and disability expense deductions:

- a) Doctor(s), including psychiatrists or psychologists.
- b) Providers of mental health treatment.
- c) Hospital care.
- c) Dental care.
- d) Eye care.
- f) Health care premiums.
- g) Prescription drugs and insulin.
- h) Prosthetic devices.
- i) Durable equipment (purchase, repair, maintenance or maintenance agreements).
- j) Vehicle and modification expenses that are unique to a disability.

- k) Home modifications that are unique to a disability.
- l) Clothing modifications that are unique to a disability.
- m) Medical supplies related to the care and treatment of a medical condition.
- n) Incontinence products related to a disability.
- o) Over the counter medications, supplies, supplements, cleansers, and other items, only when a copy of a physician's recommendation for the items is included in the file.
- p) Other reasonable medical or disability expenses that would not have been incurred in the absence of a disability.
- q) Medical transportation expenses not subject to reimbursement by a third party.

Medical transportation expenses may include the following:

- i) The actual cost of public transportation;
- ii) 12 cents per mile while driving their own vehicle, or
- iii) The actual amount charged if riding as a passenger in a vehicle owned by someone who does not meet the definition of a family member.

Items Not Allowable as Expense Deductions

Contractors may not consider the following items as family medical or disability expense deductions:

1. Cellular telephones.
2. Food Items.
3. Vehicle insurance, except the cost of insurance relating to vehicle modification expenses that are unique to a disability.
4. Vehicle expense not expressly related to a disability, such as tires or maintenance for an accessible van.
5. Expense for attendant care type services or companion services procured at consumer choice, over and above services authorized by the Attendant Care Program.
6. Supplemental hourly payments or bonuses made to an attendant over and above the payments authorized by the Attendant Care Program.

7. Luxury items such as swimming pools, home spas or home exercise rooms, even if recommended by a physician.

IV.10 Resource Eligibility for the Act 150 Program

Resources are excluded in determining eligibility for the Act 150 Program.

IV.11 Financial Eligibility for the Waiver Program

An applicant whose monthly gross income is less than or equal to 300 percent of the Federal Benefit Rate may be eligible for services through the Attendant Care Waiver Program. Potential eligibility for the Waiver Program should be determined using the income and resource guidelines in Appendix D.

ATTENDANT CARE PROGRAM

CHAPTER V

SERVICES

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V.1 Service Plans

Service plans are a negotiated contract between consumers and Contractors. Documentation is needed to show that a consumer participated in any changes to the service plan document.

1. Contractors and applicant/consumer shall fully complete and sign the service plan (SP 777).
2. Contractors shall record, in minutes, the length of time required to complete each basic and ancillary activity on a daily basis. Weekly minutes must total whole or half hour increments.
3. Contractors shall include the consumer's preferred method of signing program forms in the unique circumstances section of the SP 777.
4. Contractors shall identify in the comments section persons or organizations other than the consumer or attendant, who are responsible for activities that are itemized on the SP 777.
5. Contractors shall document in the service notes any conversation with consumers regarding requested changes.
6. Service plans are expected to reflect only the hours currently assessed. No cross outs, white-out or other deletions will be accepted.
7. Pages 2 and 3 of the service plan must be completed for every temporary increase in service hours that is expected to continue for more than 14 days.
8. A signature is not required for temporary service plans. The Contractor shall mail the new temporary service plan to the consumer with the PW 1299.
9. Service plans shall include a description of arrangements for response to health emergencies.

V.2 Health Maintenance Activities

1. Health maintenance activities are routine activities of daily living which are necessary for health and normal bodily functions, and which would be carried out by consumers if they were physically able. Health maintenance activities include assistance with activities of bodily function, which are not required by law to be performed by licensed health care personnel.
2. Contractors may approve service plan hours for attendant performance of health maintenance activities at a consumer's request, subject to the provisions of this section.

3. Disposable items and devices must be used and universal precautions followed as a precaution against the possible transmission of blood borne pathogens.
4. Contractors shall supply disposable gloves, as necessary.
5. Contractors shall evaluate the performance of health maintenance activities during routine monitoring visits and through consultation with consumers regarding their satisfaction with their attendant's performance of health maintenance activities.
6. Contractors shall consult with an appropriate health care professional if there is any indication that the health maintenance activities are not being carried out in a safe manner by an attendant or not being adequately supervised by a consumer.
7. If indicated, contractors shall intervene and require appropriate corrective measures as a condition of the consumer's continuing attendant care services.

V.3 Emergencies

1. An emergency is a situation in which a person's circumstances require immediate action, such as the need for police, fire or medical personnel.
2. Consumers shall have arrangements in place to respond to health emergencies, and shall describe the arrangements in the SP777. Either the consumer or the Contractor shall provide to the attendant details of the consumer's health emergency arrangements. If the attendant is providing services during a health emergency, the attendant shall follow the procedures outlined in the SP 777 or contact the emergency notification system for the local area.
3. The Attendant Care Program does not cover emergencies, and consumers should not call Attendant Care Contractor agencies or attendants for emergencies.
4. In an emergency situation, consumers should use the emergency notification system for the local area, such as dialing 911.
5. Contractors shall explain emergency policy to consumers at the time of placement into the Attendant Care Program and shall annually review the policy with consumers.

V.4 Back-Up Coverage and Priority Care

1. Priority care is care needed by consumers to ensure their health and safety.
 - a) Contractors or subcontractors shall have the capability to respond to priority care situations 24 hours per day, seven days per week.

- b) Contractors or subcontractors shall contact consumers concerning priority care situations within one hour of the notification by the consumer or other entity that a priority care situation exists.
 - c) Priority care may not be used to provide only ancillary services.
 - d) To facilitate scheduling of service hours in a priority care situation, Contractors may temporarily adjust a consumer's service schedule.
2. Back-up coverage is a substitute service source that can be available to provide attendant care service when the normally scheduled attendant is unavailable.
- a) Contractors shall encourage the use of family, friends, and neighbors as back-up coverage. Service notes shall include documentation of the efforts used to secure back-up coverage.
 - b) If a consumer has no back-up system in place or their back-up system fails, Contractors shall notify the consumer of what to do if they need assistance. This notification shall be documented in the consumer's file.
3. Consumers shall take primary responsibility for arranging back-up coverage and priority care. Contractors are ultimately responsible to ensure that priority care is provided to all consumers.
4. Consumers shall notify contractors promptly when a priority care situation arises or when the consumer's back-up system changes.

V.5 Training and Support Activities for the Consumer

1. Contractors are responsible for providing an array of training and support activities to assist consumers with the following activities:
- a) Managing the tasks delineated under Section A (relating to the Pennsylvania model of attendant care service).
 - b) Complying with program requirements.
 - c) Living independently.
2. Contractors shall provide consumers with a general orientation to the issues related to blood borne pathogens, including an overview of the Occupational Safety and Health Administration (OSHA) requirements.
3. The following training shall be made available to consumers on an on-going basis:

- a) Orientation to Attendant Care;
 - b) Recruiting and hiring attendants;
 - c) Training and supervising attendants;
 - d) Terminating services;
 - e) Back-up and Priority Care Systems.
4. At least annually, Contractors shall notify consumers of the training requirements for attendants.
5. If a Contractor documents a consumer's frequent inability to satisfactorily manage attendant care services and to comply with program requirements, the Contractor shall take the following progressive steps as a condition for the consumer to continue to receive attendant care services:
- a) Provide training;
 - b) Assist with the employer-related tasks defined in Chapter I.3 until the consumer is able to achieve independence in performing those tasks and complying with program requirements.
 - c) Perform the employer-related tasks defined in Chapter I.3 until the consumer is able to achieve independence in performing those tasks and comply with program requirements. (Refer to Chapter III.9, Termination of Services)

V.6 Training and Support Activities for the Attendant

1. Contractors shall provide mandatory annual training regarding blood borne pathogens to agency-employed and consumer-employed attendants.
- a) Contractors shall provide the training in conformance with regulations promulgated by OSHA of the U.S. Department of Labor.
 - b) The Contractor shall obtain a signed and dated statement from each attendant that the training was completed.
 - c) The Contractor shall make available a registered nurse to answer questions the attendant may have regarding blood borne pathogens.
2. Contractors shall offer training for all attendants in at least the following core areas:
- a) Orientation to attendant care;

- b) Working with persons with disabilities;
 - c) Social and communication skills;
 - d) Transfers, body mechanics, and equipment;
 - e) Personal care skills;
 - f) Home management skills;
 - g) Safety and emergency procedures.
3. Contractors shall offer hepatitis B vaccinations to agency-employed and consumer-employed attendants at no expense to the attendants, and shall obtain written consent or declination to receive the vaccinations.
4. Contractors shall provide training on the provisions of Act 28 (relating to neglect of a care-dependant person) and how it relates to job responsibilities to both consumer and agency-employed attendants. A copy of Act 28 is included in Appendix J.
5. Contractors shall provide or arrange for necessary health maintenance activities training for agency-employed and consumer-employed attendants at no expense to the attendant or consumer if one of the following conditions exists:
- a) The consumer requests that the training be provided; or
 - b) The attendant requests that the training be provided; or
 - c) It is the professional opinion of the Contractor that the training is necessary based on information received or observation during an in-home monitoring visit.

V.7 Consumer Service Monitoring

The following provisions shall apply to Consumer Service Monitoring:

- 1. Each Contractor must maintain a tickler system for all current consumers that will be used to ensure timely contacts, reassessments and monitoring visits with consumers.
- 2. Contractors may conduct a monitoring visit concurrently with a fee determination visit.
- 3. Contractors shall conduct monitoring visits at a time mutually agreed upon by the consumer and the Contractor.

4. A face-to-face monitoring visit may be conducted at a site other than the home for those consumers who are employed or who are attending school full-time.

Monitoring will take place using the following time frames:

In-Home Monitoring Visits

1. At least once each year, separated by a minimum of three months from the annual service reassessment visit, Contractors shall conduct an in-home monitoring visit to determine a consumer's satisfaction with the services that they receive.
 - a) The initial in-home monitoring visit by the Contractor shall occur on or before six months after initiation of service.
 - b) Contractors shall document the results of the monitoring visit, including the service coordinator's observations and any follow-up action or resolutions agreed to, in the service notes.
2. Contractors shall conduct in-home monitoring more frequently if determined necessary by the Contractor or the consumer. Circumstances that warrant more frequent monitoring may include, deteriorating function, terminal illness, complaints concerning the quality of service, and cases of suspected noncompliance with program requirements.

Telephone Monitoring Contacts

Contractors shall supplement annual reassessments and in-home monitoring visits with telephone contacts. Each contact (reassessment and monitoring) will be separated by three months. If a consumer is unable to communicate via telephone, the Contractor shall visit the consumer rather than make a monitoring telephone call.

Contractors shall document the results of monitoring telephone contacts in the service notes. Notes shall include questions by the consumer about the appropriateness, quality and adequacy of services. The service notes should clearly indicate that the contact was a telephone monitoring contact.

V.8 Coordination of Service with Other Sources of Service

1. Contractors shall coordinate with the Office of Vocational Rehabilitation, Department of Labor and Industry, county government offices and other sources of support services that are available to provide services according to the service plan to avoid duplication and to meet the consumer's need.

2. Contractors shall provide information, referral, and advocacy at a consumer's request in locating services such as transportation, income maintenance, housing, equipment, medical care and other essential services.

CHAPTER VI
Rights, Appeals & Grievances

ATTENDANT CARE PROGRAM

CHAPTER VI

RIGHTS, APPEALS, AND GRIEVANCES

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VI.1 Applicant and Consumer Rights and Responsibilities

The applicant/consumer rights and responsibilities form shall be signed and provided to the consumer at Intake and yearly thereafter during an in-home visit using the form in Appendix A. Contractors shall advise applicants and consumers of the following rights and responsibilities in a manner consistent with applicant/consumer's cognitive abilities.

1. The right to have an in-home eligibility interview within 15 working days after a request for attendant care services is made.
2. The right to oral and written notification (PW 1299), within ten working days after the eligibility interview regarding eligibility including the reason(s) for the decision and description of appeal rights in accordance with the Department's fair hearing procedures.
3. The right to oral and written notification (PW 1299) of the disposition of an eligibility interview if a determination or redetermination results in services or an increase in services, including the right to receive notification within ten working days after the interview, or if the consumer is not exempted from the Medicaid Waiver eligibility process, ten working days after the completion of the Medicaid Waiver eligibility process.
4. The right to an alternative accessible format including the use of interpreters or of taped copies of pertinent Attendant Care Program information, for those applicants and consumers who have vision or hearing impairments or who do not speak English.
5. The responsibility, under penalty of law, to report within 14 days after a change occurs, a change in circumstances that might affect eligibility, including address, income, resources, medical assistance eligibility status and functional status.
6. The responsibility to provide documentation of eligibility-related items, when requested, as a condition for receiving and continuing to remain eligible for attendant care service, including cooperation with the Medicaid Waiver eligibility process.
7. The legal responsibility, under penalty of law, for the truthfulness, accuracy and completeness of information provided to determine or redetermine eligibility, as attested to on Attendant Care Program forms.

VI.2 Nondiscrimination

Contractors shall not discriminate on the basis of race, color, religious creed, ancestry, national origin, age, sex, handicap or disability.

VI.3 Confidentiality

1. Contractors shall safeguard the use and disclosure of information regarding applicants and consumers.

2. Consumer information for the purpose of monitoring, review, evaluation or audit must be released to federal authorities, the Department, and their authorized representatives. Disclosure beyond this scope requires the consumer's informed and written consent.
3. Consumer or his/her authorized representative shall have access to the contents of the consumer's records.

VI.4 Right to Appeal

An applicant or consumer has the right to file an appeal and to obtain a hearing in accordance with procedures set forth under 55 Pa. Code, Chapter 275 (relating to appeal and fair hearing).

VI.5 Grounds for Appeals

Except as specified below, a consumer or someone acting on behalf of the consumer has the right to request a Departmental hearing of an appeal when the following occurs:

1. The denial of services.
2. The reduction, termination or suspension of services.
3. The computation of a fee amount.
4. The failure of the Contractor to act upon a request for services within the appropriate time-limits.
5. The failure of the Contractor to offer the Waiver consumer a choice of providers, where applicable.

Exception: An applicant or consumer does not have the right to appeal simply on the basis that:

A change in State or Federal law or regulation excludes the person from services or reduces the amount of services.

VI.6 Filing an Appeal – Consumer's Responsibility

1. A consumer or applicant retains the right to a Departmental fair hearing only if the hearing request is postmarked no later than 30 calendar days following the date the written notice is mailed or hand-delivered to the applicant or consumer.
2. To appeal an action, a consumer or applicant shall submit a written request for a Departmental fair hearing to the contractor in accordance with 55 Pa. Code, Chapter 275. The consumer shall specify the reason(s) for the appeal, current address and a telephone number where he or she can be reached during the day.

3. A consumer or applicant may elect to be represented at a hearing by anyone, including an attorney.

VI.7 Filing an Appeal – Contractor’s Responsibility

1. At a consumer’s request, contractors shall assist the consumer with filing an appeal with the Department of Public Welfare, Bureau of Hearings and Appeals.
2. Contractors shall forward a request for appeal and the envelope in which it was received to the Bureau of Hearings and Appeals within three working days from the date the appeal was received and date stamped by the contractor. The address for the Bureau of Hearings and Appeals is P.O. Box 2675, Harrisburg, Pennsylvania 17120.
3. For consumers already receiving attendant care services, contractors may not take a proposed adverse action until at least ten calendar days have elapsed. If the consumer appeals the proposed adverse action within the ten-day appeal period, services must continue as outlined in section VI.8.

VI.8 Service Continuation During an Appeal

If a consumer already receiving services files a timely appeal requesting a hearing, and that request is postmarked no later than the 10th calendar day following the date the PW 1299 is mailed or hand-delivered, services continue until the appeal is heard and a decision is rendered by the Bureau of Hearings and Appeals. This condition does not apply to situations in which services are being terminated or reduced due to one or more of the following reasons:

1. Unsafe conditions at the consumer’s place of residence, which jeopardize the safety or health of attendants and/or the contractor’s staff.
2. Unsafe activities at the consumer’s place of residence that jeopardize the safety or health of attendants and/or the contractor’s staff.
3. Unsanitary conditions at the consumer’s place of residence, which jeopardize the safety and health of attendants and/or the contractor’s staff.
4. Unsanitary activities at the consumer’s place of residence, which jeopardize the safety and health of attendants and/or the contractor’s staff.
5. Admission to a hospital or nursing facility.

VI.9 Notification to the Attendant Care Program

1. Contractors shall notify the Office of Social Programs orally and in writing of all appeals sent to the Department's Bureau of Hearings and Appeals.
2. Contractors shall send copies of all decisions received from the Bureau of Hearings and Appeals, including reconsideration decisions, to the Attendant Care Program Manager within three working days of receipt.

VI.10 Right to a Local Grievance Process

1. In addition to the formal appeals process under 55 Pa. Code, Chapter 275, Contractors shall establish a local grievance process that is subject to the approval of the Department.
2. Contractors shall inform consumers of the local grievance process upon their acceptance into the program. A copy of the local grievance process shall accompany every PW 1299.
3. Contractors shall make available the local grievance process concurrent with the formal appeals process. The local grievance process does not extend the time requirement for a formal appeal to the Department.
4. A Contractor shall respond to grievances as outlined in the contractor's local grievance process and notify an applicant or consumer in writing of the decision.
5. Services may not be terminated or reduced, nor fees imposed or adjusted, during the local grievance process if the grievance is initiated prior to the 10th calendar day following the date that the PW 1299 is mailed or hand-delivered to the consumer. This condition does not apply to situations in which services are being terminated or reduced due to one or more of the following reasons:
 - a) Unsafe conditions at the consumer's place of residence, which jeopardize the safety or health of attendants and/or the Contractor's staff.
 - b) Unsafe activities at the consumer's place of residence that jeopardize the safety or health of attendants and/or the Contractor's staff.
 - c) Unsanitary conditions at the consumer's place of residence, which jeopardize the safety or health of attendants and/or the Contractor's staff.
 - d) Unsanitary activities at the consumer's place of residence that jeopardize the safety or health of attendants and/or the Contractor's staff.
 - e) Admission to a hospital or nursing facility.

6. A local grievance process may not conflict with or circumvent the requirements set forth under 55 Pa. Code, Chapter 275.

CHAPTER VII
Glossary of Terms

ATTENDANT CARE PROGRAM

CHAPTER VII

GLOSSARY OF TERMS

VII.1 Definitions.....pg. VII-2

VII.1 Attendant Care Program Definitions

The following words and terms shall have the following meanings, unless the context clearly indicates otherwise:

Adult. A person who is over 18 years of age and under the age of 60;

Note: The Pennsylvania Department of Public Welfare has agreed with the Pennsylvania Department of Aging to serve a limited group of persons over the age of 60 in the Medicaid Waiver Attendant Care Program.

Applicant. A person who requests attendant care services for herself or himself.

Attendant. An individual, other than a family member, who provides attendant care to consumers.

Attendant Care Services. Those basic and ancillary services which enable an eligible individual to live in his or her home and community rather than in an institution and to carry out functions of daily living, self-care, and mobility.

Basic Services. Basic services shall include, but not be limited to:

1. Assisting a person to get in and out of a bed, wheelchair, and/or motor vehicle.
2. Assisting a person to perform activities of daily living including, but not limited to the following:
 - a) Health maintenance activities;
 - b) Bathing and personal hygiene;
 - c) Dressing and grooming; and
 - d) Feeding, including meal preparation and cleanup.

If an individual is assessed as needing one or more of the basic services, the following services may be provided if they are ancillary to the basic services.

1. Homemaker-type services including, but not limited to, shopping, laundry, cleaning and seasonal chores as defined in this section.
2. Companion-type services including, but not limited to, assistance with transportation, letter writing, reading mail, and escort.
3. Assistance with cognitive tasks including, but not limited to, managing finances, planning activities and making decisions. The consumer maintains the ability to direct and control these services.

CMS. Centers for Medicare and Medicaid Services; this is the federal administrative authority for the Medicaid Home and Community Based Waiver programs.

Consumer. A person who has been determined eligible for and is receiving attendant care services.

Contractor. An agency or an organization, which has been selected by the Department, through a request-for-proposal process, to provide attendant care services to eligible persons in the Act 150 program; the term contractor is used generically to refer both to contractors in the Act 150 Program and to providers in the Medicaid Waiver in portions of the Attendant Care Program Requirements that are applicable to both programs.

Department. The Pennsylvania Department of Public Welfare.

Family Composition. For purposes of determining family size and income for the Act 150 Program, the following persons, if they are living in the same household, are included:

1. The applicant or consumer and spouse, if any, including those in a common-law marriage.
2. Dependent children except for children placed in the household for foster care or group care.
Dependent children include:
 - a) Children under the age of 18;
 - b) Adult children who are dependent because of a mental or physical disability. These children may be included at the option of the consumer if including them and their income will benefit the consumer;
 - c) Children who are under 24 years of age who are full-time students at an accredited institution of higher learning, including a licensed trade or vocational school.

Family Member. Spouse, parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half-brother, or half-sister.

Provider. An agency or organization that has been enrolled by the Department to provide attendant care services to eligible persons through the Medicaid Waiver Program.

Seasonal Chores. Services that may be provided to consumers on a temporary basis. Seasonal chores may include shoveling snow to allow a consumer to safely leave their home, indoor spring-cleaning, and other tasks to assist a consumer to maintain a clean and safe environment. Due to the temporary nature of these services, the services shall not be included in service plans.

Spouse. A husband or wife whether married ceremonially or by common-law. A common-law marriage may exist if a man and woman living together are free to marry, declare that they have a common law marriage, and hold themselves out to the community as married.

Subcontractor. An agency or an organization that has subcontracted with a contractor or provider to provide attendant care service or to determine and redetermine the eligibility of persons for attendant care service.

Appendix A

APPENDIX A

**ATTENDANT CARE PROGRAM
PROGRAM FORMS**

OPTIONS ASSESSMENT FORM (DPW MEDICAID WAIVER FOR ATTENDANT CARE SERVICE)

Consumer Name: _____

Social Security Number: _____

Address: _____

Recipient Number: _____

Birthdate: _____

Telephone Number: _____

Referred by Agency Name: _____

Language Assistance Needed for Assess? Yes No

Contact Person: _____

Other Assists Needed for Assessment: _____

Telephone Number: _____

Emergency Contact Name: _____

Telephone Number: _____

MA-51 Attached Yes

Assessed by: _____

Date: _____

Location of Interview: _____

Present for Interview: Consumer Sig. Other ACP Agency Staff Other: _____

Names: _____

Class of Assessment Completed: Nursing Facility

<input type="checkbox"/> AC MED WAIVER
<input type="checkbox"/> MA-51
<input type="checkbox"/> Assessment Form

PA DEPARTMENT OF PUBLIC WELFARE
OFFICE OF SOCIAL PROGRAMS
ATTENDANT CARE PROGRAM

APPLICATION FOR ATTENDANT CARE SERVICES

CONSUMER INFORMATION				
NAME OF CONSUMER (LAST, FIRST, MIDDLE)			PROGRAM	DATE
ADDRESS STREET, ROAD, AVENUE - CITY OR TOWN, STATE			ZIP CODE	COUNTY
TELEPHONE NUMBER	BIRTH DATE	GENDER	SOCIAL SECURITY NUMBER	RECIPIENT NUMBER

DISABILITY(S)	DATE OF ONSET

ELIGIBILITY CRITERIA	
<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU EXPECT YOUR PHYSICAL DISABILITY(S) TO LAST FOR A CONTINUOUS PERIOD OF NOT LESS THAN 12 MONTHS?
<input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU CAPABLE OF SELECTING, SUPERVISING, AND IF NEEDED, FIRING AN ATTENDANT?
<input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU CAPABLE OF MANAGING OR DIRECTING OTHERS TO MANAGE YOUR OWN FINANCIAL AND LEGAL AFFAIRS?
<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU REQUIRE ASSISTANCE TO COMPLETE FUNCTIONS OF DAILY LIVING, SELF CARE, AND MOBILITY IN THE FOLLOWING: (If Yes Check All That Apply)
<input type="checkbox"/> DRESSING	<input type="checkbox"/> AMBULATION <input type="checkbox"/> BATHING <input type="checkbox"/> BOWEL, BLADDER OR OTHER BODILY FUNCTIONS
<input type="checkbox"/> GROOMING	<input type="checkbox"/> TRANSFERS <input type="checkbox"/> MEAL PREP <input type="checkbox"/> CONSUMPTION OF FOOD
<input type="checkbox"/> NONE OF THE ABOVE	<input type="checkbox"/> OTHER (Specify) _____

<input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU CURRENTLY RECEIVING ATTENDANT CARE OR OTHER IN-HOME SERVICES FROM ANOTHER AGENCY? (If Yes Specify)
--	---

EXPLAIN YOUR NEED AND REASON FOR APPLYING FOR ATTENDANT CARE SERVICES:

PROVIDER INFORMATION	
NAME OF PROVIDER	MA ID NUMBER
SIGNATURE OF PROVIDER REPRESENTATIVE COMPLETING THIS FORM	DATE

PA DEPARTMENT OF PUBLIC WELFARE
 OFFICE OF SOCIAL PROGRAMS
 ATTENDANT CARE PROGRAM
 SERVICE PLAN

CONSUMER INFORMATION					
NAME OF CONSUMER (LAST, FIRST, MIDDLE)			PROGRAM		DATE
ADDRESS (STREET, ROAD, AVENUE) (CITY OR TOWN) (STATE)				ZIP CODE	COUNTY
TELEPHONE NUMBER	BIRTH DATE	GENDER	SOCIAL SECURITY NUMBER		RECIPIENT NUMBER

I, the undersigned, have been adequately instructed by a health professional and am thereby qualified to instruct and supervise my attendant(s) in the performance of any needed health maintenance activities. Furthermore, either my physician, another health professional or myself will monitor the provision of any health maintenance activities that I receive and I understand that my attendant(s) may perform only those health maintenance activities specifically described in my service plan. I agree to provide disposable items or devices for use by my attendants, if I am the employer, when needed.

I also agree that it is my responsibility to notify the agency of any changes relating to any health maintenance activities or changes in my functional abilities that could necessitate a change in my Service Plan.

I understand that, if at any time, there is an indication that health maintenance activities are not being carried out according to established medical protocol by the attendant and/or not being properly supervised by me, the agency has the right and responsibility to intervene and provide the necessary training and /or corrective measures in order to insure my health and safety.

Listed below are my instructions to my attendant(s) in the event of an emergency:

Finally, I agree to abide by the policies/requirements stated in the Agency's Consumer Handbook and any applicable State or Federal requirements pertaining to the Attendant Care Program as a condition of participation in the program.

CONSUMER SIGNATURE

DATE

PA DEPARTMENT OF PUBLIC WELFARE
OFFICE OF SOCIAL PROGRAMS
ATTENDANT CARE PROGRAM

SERVICE PLAN ADDENDUM

CONSUMER INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX
SOCIAL SECURITY NUMBER	RECIPIENT NUMBER	BIRTH DATE	GENDER
ADDRESS (STREET, ROAD, AVENUE)			
CITY/TOWN		STATE	ZIP CODE
COUNTY		TELEPHONE NUMBER	
DATE SERVICE PLAN ADDENDUM COMPLETED		DATE OF PREVIOUS SERVICE PLAN	

<input type="checkbox"/> ACT 150 ATTENDANT CARE PROGRAM	<input type="checkbox"/> MODEL OF SERVICE	<input type="checkbox"/> AGENCY	<input type="checkbox"/> CONSUMER	<input type="checkbox"/> COMBINATION
<input type="checkbox"/> OVER 60 MEDICAID WAIVER				
<input type="checkbox"/> MEDICAID WAIVER	<input type="checkbox"/> MODEL OF SERVICE	<input type="checkbox"/> AGENCY	<input type="checkbox"/> CONSUMER	<input type="checkbox"/> COMBINATION

DATE PLACED IN ACT 150 _____

DATE PLACED IN WAIVER _____

PERMANENT BASIC SERVICE HOURS ASSESSED PER WEEK _____

PERMANENT ANCILLARY SERVICE HOURS ASSESSED PER WEEK _____

TOTAL PERMANENT HOURS ASSESSED PER WEEK _____

REASON FOR SUBMITTING SPA: _____

<input type="checkbox"/> PERMANENT INCREASE/DECREASE IN HOURS	<input type="checkbox"/> TEMPORARY INCREASE/DECREASE IN HOURS
EFFECTIVE DATE SUNDAY _____	DATE FROM: _____ TO: _____ HRS. FROM: _____ HRS. TO: _____

SOURCE OF FUNDING IF INCREASING HOURS: _____

PROVIDER INFORMATION

NAME OF PROVIDER	MA ID NUMBER
SIGNATURE OF PROVIDER REPRESENTATIVE COMPLETING THIS FORM	PRINTED NAME OF PERSON COMPLETING FORM

CONSUMER INFORMATION

NAME OF CONSUMER (LAST, FIRST, MIDDLE)				DATE	
ADDRESS (STREET, ROAD, AVENUE - CITY OR TOWN, STATE)			ZIP CODE	COUNTY	
TELEPHONE NUMBER	BIRTHDATE MM DD YY	SEX	SOCIAL SECURITY NUMBER		RECIPIENT NUMBER

CRIMINAL RECORD CHECK POLICY

Consumers who choose to be the employers of their attendants will determine whether or not to have criminal record checks performed on their attendant(s). Consumer employers will be fully informed about the responsibility they carry for their own health and safety, about the importance of having a criminal record check done on every attendant under their employ, and about the availability of the criminal record check at no cost to the consumer.

This informational process and payment for the criminal record check will be the responsibility of the agency which provides the service coordination for your attendant care service. If, after this informational process has been completed, you choose not to have criminal record checks done on your attendant(s), this decision must be documented (signed by you) and retained in your file at the agency.

I have read the above policy and it is my decision not to have criminal record checks performed on my attendant(s).

SIGNATURE OF CONSUMER

DATE

SIGNATURE OF AGENCY REPRESENTATIVE

DATE

If a consumer employer chooses to have a criminal record check completed and this check reveals that an attendant has a criminal record, it will be the consumer's decision whether or not to employ the person. The consumer's decision to employ an attendant with a criminal record and the consumer's acceptance of responsibility for any consequences must also be documented (signed by the consumer) and retained in the consumer's file.

I have read the above policy and it is my decision to have criminal record checks done on my attendant(s). It is also my decision to employ an attendant with a criminal record, if I so choose and I will accept full responsibility for this decision.

I choose to employ an attendant(s), on an interim basis, prior to receiving the results of the criminal record check and have discussed this interim employment arrangement with my attendant(s).

(CHECK ONE)

Yes No

SIGNATURE OF CONSUMER

DATE

SIGNATURE OF AGENCY REPRESENTATIVE

DATE

PA DEPARTMENT OF PUBLIC WELFARE
 OFFICE OF SOCIAL PROGRAMS
 ATTENDANT CARE PROGRAM

SERVICE PREFERENCE FORM

CONSUMER INFORMATION					
NAME OF CONSUMER (LAST, FIRST, MIDDLE)			PROGRAM	DATE	
ADDRESS (STREET, ROAD, AVENUE) (CITY OR TOWN) (STATE)			ZIP CODE	COUNTY	
TELEPHONE NUMBER	BIRTH DATE	GENDER	SOCIAL SECURITY NUMBER	RECIPIENT NUMBER	

This is to certify I have been informed and advised that I may be eligible for in-home attendant care Waiver services. If I am eligible for in-home attendant care Waiver services, I may choose between receiving these services, going to a nursing home, or receiving no services at all.

I have also been advised that the Act 150 Program is available only for individuals who are not eligible for Waiver services.

Based on the information I have received regarding the care options presented to me, I certify that I have been informed regarding my choices and that I have freely chosen my preference for receiving services, as indicated below

CONSUMER INITIALS:

I choose to receive attendant care service in the Medicaid Waiver, if found eligible. If I am ineligible for the Medicaid Waiver, I choose to receive attendant care service in the Act 150 program.

REASON:

I choose to live in a nursing home and decline in-home, community-based attendant care services that have been described to me.

REASON:

I refuse service of any kind.

REASON:

 CONSUMER SIGNATURE

 DATE

 PROVIDER REPRESENTATIVE SIGNATURE

 DATE

ATTENDANT CARE PROGRAM SERVICE NOTES

Consumer's Name	Social Security Number
-----------------	------------------------

Date	Notes

CODES: IA: Initial Assessment; RV: Reassessment Visit; RD: Redetermination Visit; MV: Monitoring Visit; VO: Visit Other; MTC: Monitoring Telephone Call; TCO: Call to Consumer; TCI: Call from Consumer TCS: Call from/to Other Sources; ON: Office Note

ATTENDANT CARE SERVICE NOTIFICATION OF ELIGIBILITY DETERMINATION

DATE THIS NOTICE IS

MAILED OR HAND-
DELIVERED TO YOU _____

INITIAL DETERMINATION

REDETERMINATION

CONSUMER INFORMATION

NAME OF CONSUMER (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER	RECIPIENT NUMBER
ADDRESS (STREET, ROAD, AVENUE) (CITY OR TOWN) (STATE)		ZIP CODE	COUNTY
ELIGIBILITY/SERVICE STATUS			
<input type="checkbox"/> Eligible	<input type="checkbox"/> Ineligible	<input type="checkbox"/> Reduction of Service Hours	<input type="checkbox"/> Increase in Service Hours
<input type="checkbox"/> Fee	<input type="checkbox"/> No Fee	<input type="checkbox"/> Termination of Service	
IF ELIGIBLE COMPLETE THE FOLLOWING:			
AUTHORIZED SERVICE HOURS PER WEEK			
<input style="width: 100px; height: 20px;" type="text"/> BASIC SERVICE HOURS	<input style="width: 100px; height: 20px;" type="text"/> ANCILLARY SERVICE HOURS	<input style="width: 100px; height: 20px;" type="text"/> TOTAL SERVICE HOURS PER WEEK	
DATE OF DETERMINATION	AMOUNT OF FEE	DATE SERVICES SCHEDULED TO BEGIN	

SECTION II

THIS IS TO NOTIFY YOU THAT THE ATTENDANT CARE SERVICE:

WILL NOT BEGIN AS YOU HAVE BEEN DETERMINED INELIGIBLE
 WILL BE REDUCED
 WILL REQUIRE FEE TO BE IMPOSED OR CHANGED
 WILL BE TERMINATED

FOR REASON(S) SHOWN:

THE REGULATORY CITATION UPON WHICH THIS DECISION IS BASED IS:

SECTION III - The effective date of this action is:

IMMEDIATELY FOR APPLICANTS FOUND INELIGIBLE UPON INITIAL DETERMINATION OF ELIGIBILITY, OR
 OTHER _____ (MO - DAY - YR.)

SECTION IV

If you disagree with the decision listed above, you have a right to appeal and request a hearing through the Department of Public Welfare's Office of Hearings and Appeals. However, you do not have the right to appeal a decision which is based on changes in Federal or State law or regulations simply because these changes now exclude you from service or reduce the amount of your service. You also do not have the right to appeal a decision because the service hours are reduced or eliminated by the provider agency due to the extent of funding provided through the appropriation for the Attendant Care Program

In order for your appeal to be heard, it must be postmarked on or before _____ (MO. - DAY - YR.)

which is 30 calendar days following the date this notice is mailed or hand-delivered to you. After this date, the Office of Hearings and Appeals reserves the right, by regulation, to dismiss the appeal without a hearing.

If you are currently receiving service, and your appeal is postmarked on or before _____ (MO. - DAY - YR.)

(the tenth calendar day following the date this notice is mailed or hand-delivered to you), you will continue to receive service pending the outcome of the hearing. If, however, your appeal is postmarked after this date, service will be discontinued or reduced on the effective date listed in Section III above.

If you wish to appeal and request a Fair Hearing, you must complete the reverse side of this form and return it to this agency at the address listed below. If you do not understand this decision or would like to meet with a representative of our agency please contact the agency representative who is named in section PROVIDER INFORMATION below.

PROVIDER INFORMATION

NAME OF PROVIDER	MA ID NUMBER
PROVIDER ADDRESS	TELEPHONE NUMBER
SIGNATURE OF PROVIDER REPRESENTATIVE COMPLETING THIS FORM	DATE

SECTION VI

RIGHT TO APPEAL AND FAIR HEARING

You have the right to file an appeal within the time limits specified on the other side of this form and request a fair hearing from the Department of Public Welfare.

In order to have a hearing, you **MUST DO THE FOLLOWING**.

1. state your reason(s) for the appeal in the space provided below otherwise the appeal request will be dismissed without a hearing; and
2. indicate your phone number including area code in the space provided below; and
3. indicate your exact address in the space provided below; and
4. mail or hand carry this form to the Provider/Contractor specified in SECTION V on the other side of this form.

If you have any questions, you may call the Provider/Contractor representative specified in SECTION V.

You have the right to be represented at the hearing by a lawyer or other person if you desire. You can ask the service provider agency to direct you to the local legal services office if you want information about obtaining a lawyer to represent you at a hearing.

Before the scheduled hearing takes place, you or your representative have the right to examine all information which the agency will introduce as evidence at the hearing.

During the hearing, a representative of the Department of Public Welfare who did not take part in the decision will talk with you. All facts will be studied, and a ruling will be made as to whether the decision of the provider agency is in accordance with the Department of Public Welfare's regulations.

I WANT A HEARING BECAUSE:

(PLEASE STATE YOUR REASON(S) FOR YOUR APPEAL)

YOU MUST INSERT YOUR MAILING ADDRESS AND TELEPHONE NUMBER HERE



IF SOMEONE WILL BE REPRESENTING YOU AT THE HEARING, PLEASE LIST THEIR NAME, ADDRESS AND TELEPHONE NUMBER HERE



I UNDERSTAND THAT I WILL RECEIVE NOTIFICATION OF THE HEARING ARRANGEMENTS.

SIGNATURE OF APPLICANT/CONSUMER

DATE

SIGNATURE OF PERSON ACTING ON BEHALF OF APPLICANT/CONSUMER

DATE

Mail or Hand-Deliver to the Provider/Contractor specified in SECTION V of this form

PA DEPARTMENT OF PUBLIC WELFARE
 OFFICE OF SOCIAL PROGRAMS
 ATTENDANT CARE PROGRAM

ATTENDANT CARE ASSESSMENT SUMMARY

CONSUMER INFORMATION						
NAME OF CONSUMER (LAST, FIRST, MIDDLE)			PROGRAM	DATE		
ADDRESS (STREET, ROAD, AVENUE) (CITY OR TOWN) STATE		ZIP CODE	AGE	COUNTY		
TELEPHONE NUMBER	BIRTH DATE	GENDER	SOCIAL SECURITY NUMBER	RECIPIENT NUMBER		
RACE <input type="checkbox"/>	ASIAN <input type="checkbox"/>	HISPANIC <input type="checkbox"/>	OTHER <input type="checkbox"/>	MARITAL STATUS <input type="checkbox"/>	MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
<input type="checkbox"/>	BLACK <input type="checkbox"/>	WHITE <input type="checkbox"/>	<input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	SEPARATED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>

EMERGENCY CONTACTS			
NAME	ADDRESS	RELATIONSHIP	TELEPHONE NUMBER

HOUSEHOLD COMPOSITION			
		<input type="checkbox"/> LIVES ALONE	<input type="checkbox"/> LIVES WITH OTHERS
NAME	AGE	RELATIONSHIP	ASSISTANCE PROVIDED, IF ANY

DISABILITY(S) / DIAGNOSIS	
PRIMARY	DATE OF ONSET
OTHER	DATE OF ONSET

PHYSICIANS		
NAME	ADDRESS	TELEPHONE NUMBER
PRIMARY		
OTHER		

PA DEPARTMENT OF PUBLIC WELFARE
OFFICE OF SOCIAL PROGRAMS
ATTENDANT CARE PROGRAM
ATTENDANT CARE ASSESSMENT SUMMARY

NAME OF CONSUMER (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER
--	------------------------

OTHER MEDICAL CONDITIONS	
	DATE OF ONSET

MEDICATIONS <input type="checkbox"/> YES <input type="checkbox"/> NO HEALTH MAINTENANCE ACTIVITIES <input type="checkbox"/> YES <input type="checkbox"/> NO
MOBILITY AIDS WHEELCHAIR WALKER CANE BRACES/PROSTHESES NONE OTHER (Specify):
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
COMMUNICATION AIDES:
SPECIAL DIET (Specify):

FUNCTIONAL STATUS (Enter Code)	
ACTIVITY	CODE
GET IN/OUT OF BED	
GET IN/OUT OF CHAIR	
TOILETING	
BATHING	
GROOMING	
DRINKING/EATING	
TAKE MEDICATIONS	
MOBILITY HOME	
PUT ON BRACES/PROSTHESES	
USE TELEPHONE	
PREPARE MEALS	
WASH DISHES	
DO LAUNDRY	
SHOP	
CLEAN HOUSE	
ADMIT VISITORS	
HANDLE MAIL/BILLS/BANKING	

<ol style="list-style-type: none"> 1. Independent 2. Independent with mechanical devices 3. With minimum assistance 4. With moderate assistance 5. Cannot accomplish N/A - Not Applicable
COMMENTS:

SERVICE/SUPPORT RESOURCES (Not Living in Household)			
PERSON / AGENCY NAME	TELEPHONE NO.	NATURE OF SERVICES / SUPPORTS	WHERE ARE SERVICES PROVIDED

PA DEPARTMENT OF PUBLIC WELFARE
OFFICE OF SOCIAL PROGRAMS
ATTENDANT CARE PROGRAM
ATTENDANT CARE ASSESSMENT SUMMARY

NAME OF CONSUMER (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER
--	------------------------

TRANSPORTATION

DRIVES: <input type="checkbox"/> YES <input type="checkbox"/> NO	PUBLIC TRANSPORTATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
--	--

HOUSING / PHYSICAL ENVIRONMENT

HOUSE APARTMENT MOBILE HOME OTHER (Specify) _____

	YES	NO	COMMENTS:
ACCESSIBILITY WITHIN HOME			
ACCESSIBILITY TO OUTDOORS			
KITCHEN / LAUNDRY APPLIANCES			
HEAT / HOT WATER			
SECURITY DOORS / WINDOWS			
HAZARDS			
IS CONSUMER SATISFIED WITH PRESENT HOUSING SITUATION			

EMPLOYMENT STATUS

EMPLOYED YES NO FULLTIME PART TIME

EMPLOYER: _____

ADDRESS: _____

EDUCATION STATUS

STUDENT YES NO FULLTIME PART TIME

SCHOOL: _____

ADDRESS: _____

OVR CLIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME AND PHONE NUMBER OF OVR COUNSELOR: _____
DOES CONSUMER HAVE EMPLOYMENT OR TRAINING GOALS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

ATTENDANT CARE SERVICE MANAGEMENT

	CONSUMER	PROVIDER	JOINT	COMMENTS:
RECRUITMENT / SCREENING				
INTERVIEWING / SELECTION				
ATTENDANT TRAINING				
ATTENDANT SUPERVISION/MANAGEMENT				
TERMINATION OF ATTENDANTS				
FINANCIAL MANAGEMENT OF SERVICES				

DOES THE CONSUMER HAVE ANY PREVIOUS EXPERIENCE MANAGING ATTENDANT SERVICES?
 IF YES, DESCRIBE: _____ YES NO

DOES THE CONSUMER HAVE ANY PROBLEMS WHICH MAY INTERFERE WITH MANAGEMENT OF SERVICE?
 IF YES, DESCRIBE: _____ YES NO

PA DEPARTMENT OF PUBLIC WELFARE
 OFFICE OF SOCIAL PROGRAMS
 ATTENDANT CARE PROGRAM
ATTENDANT CARE ASSESSMENT SUMMARY

NAME OF CONSUMER (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER
--	------------------------

CONSUMER RESPONSIBILITIES

DOES THE CONSUMER APPEAR TO UNDERSTAND THE PROGRAM REQUIREMENTS? YES NO

CONSUMER RESPONSIBILITIES? YES NO PROVIDER RESPONSIBILITIES? YES NO

IF NO, EXPLAIN:

IS THE CONSUMER AWARE OF THEIR RESPONSIBILITY TO HAVE A BACK - UP SYSTEM AVAILABLE? YES NO

CONSUMER TRAINING

DOES THE CONSUMER WISH TO PARTICIPATE IN CONSUMER TRAINING? YES NO

GROUP? INDIVIDUAL?

DOES THE PROVIDER FEEL THE CONSUMER NEEDS TRAINING? YES NO

COMMENTS:

SUMMARY OF NEEDS (Check all that apply)

<input type="checkbox"/> ATTENDANT CARE	<input type="checkbox"/> EQUIPMENT	<input type="checkbox"/> EMPLOYMENT
<input type="checkbox"/> A. C. MANAGEMENT SKILLS TRAINING	<input type="checkbox"/> COUNSELING	<input type="checkbox"/> ED. / VOC. TRAINING
<input type="checkbox"/> ATTENDANT BACK-UPS	<input type="checkbox"/> HOUSING	<input type="checkbox"/> LEGAL / ADVOCACY SERVICES
<input type="checkbox"/> MEDICAL CARE	<input type="checkbox"/> TRANSPORTATION	<input type="checkbox"/> IND. LIVING SKILLS TRAINING
<input type="checkbox"/> HOMEMAKER / CHORE	<input type="checkbox"/> FINANCIAL ASSISTANCE	
<input type="checkbox"/> OTHER _____		

SIGNATURE OF CONSUMER	DATE
SIGNATURE OF PERSON COMPLETING THIS FORM	DATE

FOR OFFICE USE ONLY

COMMENTS:

SIGNATURE	DATE SIGNED
-----------	-------------

PA DEPARTMENT OF PUBLIC WELFARE
OFFICE OF SOCIAL PROGRAMS
ATTENDANT CARE PROGRAM
ATTENDANT CARE REASSESSMENT SUMMARY

NAME OF CONSUMER (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER
DATE REASSESSMENT COMPLETED	DATE OF MOST RECENT SERVICE PLAN

PLEASE INDICATE ANY CHANGES FROM LAST REASSESSMENT					
6. ADDRESS:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	COMMENTS
7. TELEPHONE:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
11. EMERGENCY CONTACT:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
12. HOUSEHOLD COMPOSITION:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
15. PHYSICIAN:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
16. OTHER MEDICAL CONDITIONS:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
18. HEALTH MAINTENANCE ACTIVITIES:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
19. DIET:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
20. MOBILITY AIDS:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
22. THRU 39. FUNCTIONAL STATUS:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
40. SERVICE/SUPPORT RESOURCES:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
41. TRANSPORTATION:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
42. THRU 48. HOUSING/PHYSICAL ENVIRONMENT:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
49. EMPLOYMENT STATUS:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
50. SCHOOL STATUS:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
63. CONSUMER TRAINING:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
65. NEW NEEDS IDENTIFIED:	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
CHANGE IN FINANCIAL STATUS	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
NEED TO REDETERMINE FEE	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	
CHANGE IN BACK-UP SYSTEM	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	

CONSUMER SIGNATURE

DATE

PROVIDER REPRESENTATIVE SIGNATURE

DATE

18 MONTH NOTIFICATION

Transition from the DPW Under 60 Attendant Care Program to the Department of Aging

NAME OF AAA:

ADDRESS:

PHONE:

CONTACT PERSON(S):

This is to notify you that the consumer as noted below is turning 60 years of age in 18 months. This initial notice provides advance notification to your agency in order to facilitate transition planning.

CONSUMER'S NAME	
ADDRESS	
PHONE	
DATE OF BIRTH	
SOCIAL SECURITY NUMBER	
ATTENDANT CARE SERVICE MODEL (current)	
NUMBER OF HOURS PER WEEK TOTAL	
	BASIC
	ANCILLIARY
COST PER HOUR	

NAME OF DPW ATTENDANT CARE

CONTRACTOR/PROVIDER:

ADDRESS:

PHONE:

CONTACT PERSON:

Signature of agency personnel completing this form

Date

cc: Local AAA
DPW Attendant Care Program Manager
Consumer
Consumer File

12 MONTH NOTIFICATION

Transition from the DPW Attendant Care Program to the Department of Aging

NAME OF AAA:

ADDRESS:

PHONE:

CONTACT PERSON:

This is to notify you that the consumer noted below will be turning 60 years of age in one year. This notice provides advance notification to your agency in order to facilitate transition planning. The Department of Public Welfare's (DPW) Attendant Care Contractor/Provider listed below will contact your agency 4 months prior to the actual date of transition to set up a mutually convenient time for a visit with the consumer. This visit shall include representatives from both the Area Agency on Aging (AAA) and the DPW Attendant Care Contractor/Provider Agency.

CONSUMER'S NAME	
ADDRESS	
PHONE NUMBER	
DATE OF BIRTH	
SOCIAL SECURITY NUMBER	
ATTENDANT CARE SERVICE MODEL (current)	
NUMBER OF HOURS PER WEEK TOTAL	
	BASIC
	ANCILLIARY
COST PER HOUR	

NAME OF DPW ATTENDANT CARE

CONTRACTOR/PROVIDER:

ADDRESS:

PHONE:

CONTACT PERSON:

Signature of agency personnel completing this form

Date

cc: Local AAA
DPW Attendant Care Program Manager
Consumer
Consumer File

4 MONTH NOTIFICATION

Transition from the DPW Attendant Care Program to the Department of Aging

NAME OF AAA:

ADDRESS:

PHONE:

CONTACT PERSON:

This is to notify you that the consumer as listed below is turning 60 years of age in approximately 4 months. This notice provides advance notification to your agency of the required visit with the consumer to be held prior to the consumer's transition date. The Attendant Care Contractor/Provider listed below will call to set up a mutually convenient time for a visit with the consumer. The meeting shall include representatives from both the Area Agency on Aging (AAA) and the DPW Attendant Care Contractor/Provider Agency.

TRANSITIONING CONSUMER	
ADDRESS	
PHONE NUMBER	
DATE OF BIRTH	
SOCIAL SECURITY NUMBER	
ATTENDANT CARE SERVICE MODEL (current)	
NUMBER OF HOURS PER WEEK TOTAL	
	BASIC
	ANCILLIARY
COST PER HOUR	

**NAME OF DPW ATTENDANT CARE
CONTRACTOR/PROVIDER:**

ADDRESS:

PHONE:

CONTACT PERSON:

Signature of agency personnel completing this form

Date

cc: Local AAA
DPW Attendant Care Program Manager
Consumer
Consumer File

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF SOCIAL PROGRAMS**

TEMPORARY EXEMPTION FROM MEDICAID WAIVER PARTICIPATION

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

NUMBER OF SERVICE HOURS: _____

MONTHLY INCOME: _____

NURSING HOME ELIGIBLE?: (circle one) Yes No If yes, date _____

**NARRATIVE ON WHY THE CONSUMER SHOULD BE TEMPORARILY EXEMPTED
FROM THE WAIVER ELIGIBILITY PROCESS:**

Provider/Contractor Representative Completing Form

Date

- Model Letter to be used:**
- 1. For annual notification of choice of waiver providers.**
 - 2. When a new provider becomes available between annual notifications.**
 - 3. When a consumer enters the waiver from Act 150.**

(agency letterhead)

(Date)

Dear Attendant Care Waiver Consumer:

Medical assistance regulations require that you have the freedom to choose to receive your attendant care waiver services from any enrolled provider willing to serve your area. We are providing you with the names of other agencies available in your area, and enclosing brochures for those agencies. You may (**CONTINUE TO**) receive your attendant care service through our agency, _____, or you may choose to receive your services through the agency or agencies listed below.

* Agency: _____
Contact Person: _____
Telephone: _____

* Agency: _____
Contact Person: _____
Telephone: _____

Please call me at _____ if you have questions about this letter (**OR ABOUT THE SERVICES YOU CURRENTLY RECEIVE**).

Sincerely,

IMPORTANT INFORMATION

My Rights for Attendant Care Services

1. I have the right to have someone come to my home to talk to me about Attendant Care services. They will help me apply for these services. This must be done within 15 working days after I asked for services.
2. I have the right to have a letter telling me if I am eligible for service or not. This letter will be sent to me within 10 working days after my application. If I am not eligible, it will tell me why. The letter will also explain what I can do if I don't agree with the decision. Someone will also tell me if I am eligible.
3. I have the right to know what services I am eligible for. A letter will be sent to me telling me about the services within 10 working days after my application. A letter will also be sent to me when I am eligible for more services if a review of my services has been done. I will also be told about my services
4. I will be told if I am required to be part of the Medicaid Waiver program. I will be told how the process for this program works. A letter will be sent to me telling me what services I am eligible for. This will be sent within 10 days after the completion of the process to see if I am eligible.
5. I have the right to important attendant care information in an alternate format if I need it. I can get a taped copy or other special form of this information if I have special needs. I have the right to an interpreter if I don not speak English.

My Responsibilities

1. I have been told that the law says that I must report changes that affect my eligibility for services. I must report these within 14 days of the change. Some of the changes I must report are address, income, resources, Medicaid eligibility and my ability to function.
2. I have been told that I must sometimes show proof of information that I give. I will be told what proof I need. I have been told that if I choose not to show proof when I have been asked, my services could be stopped or denied.
3. I have been told that it is against the law to give false information to get services. I have been told that I must give correct and complete information to the best of my ability. I believe that I have done this on the forms completed for services.
4. I have been told that if I am eligible for services, I must maintain a safe place for my attendants to work.

Sign here _____ Date _____

1-800-757-5042

Please call this number if you have questions that have not been answered OR you have concerns about the services you receive.

APPENDIX B

**ATTENDANT CARE PROGRAM
FISCAL FORMS**

APPENDIX B

ATTENDANT CARE PROGRAM FISCAL AGENT FUNCTION

Because Federal law does not permit Title XIX eligibles to directly receive program funds, contractors function as fiscal agents for all consumer-employers participating in the Medicaid Waiver for attendant care services. Act 150 consumer-employers may also elect to have contractors function as their fiscal agents.

The primary responsibilities of a fiscal agent are payroll activities and the filing of tax forms with applicable governmental taxing agencies at all levels. Contractors under both Act 150 and the Waiver Program also must secure the completion of Attendant Care Program forms related to every consumer's choice of model of service.

Section I of Appendix B includes copies of fiscal agent and employment related forms that are exclusive to the Attendant Care Program and a chart clarifying the situations in which the forms are mandatory.

Section II lists forms that are required by governmental taxing agencies. Section II represents the Department's best information at the time of publication, and is provided as general guidance for contractor use in acting as a fiscal agent. The information in this appendix may not be exhaustive. Contractors are responsible to be aware of and to comply with any changes or additions to the reporting and filing requirements of taxing agencies. Contractors may use alternative tax forms to the extent that the forms are acceptable to the taxing agency.

I. Attendant Care Program Fiscal Agent and Employment Related Forms.

Form	Act 150	Waiver
Consumer Selection of Attendant Care Control Option	Mandatory	Mandatory
Service Agreement Between Consumer and Provider Agency	Mandatory	Mandatory
Consumer Designation of Primary Responsibility for Attendant Care Service Tasks/Activities	Mandatory	Mandatory
Consumer/Employer Appointment of Agent	Mandatory for consumer-employers	Mandatory
Application for Employment as an Attendant	Mandatory	Mandatory
Purpose of the Pennsylvania Attendant Care Program	Optional	Optional
Criminal Record Check Policy for Consumer-Employers	Mandatory for consumer-employers	Mandatory for consumer-employers
Agreement Between Consumer and Attendant	Mandatory for consumer-employers	Mandatory for consumer-employers
Time Sheets	Mandatory	Mandatory
Payroll Form	Optional	Optional
Attendant Status Form	Optional	Optional
Notice of Discontinued Employment	Mandatory	Mandatory

Consumer Selection of Attendant Care Control Option

I have selected Name of Contractor/Provider (hereafter referred to as "**Contractor/Provider**" as the approved provider to provide and coordinate my Attendant Care Service through the Pennsylvania Attendant Care Program. **Contractor/Provider** has informed me and given me options to choose regarding how much control I want over the attendants who will provide my Attendant Care Service. I understand that these options are offered to me by the Pennsylvania Attendant Care Program to allow me to exercise my right to choose to direct and control my Attendant Care Service in a manner that is consistent with my needs, capacity, and interest in directing my own Attendant Care Service.

I understand that I can choose to employ my own attendants (hereafter referred to as the "**Consumer/Employer Option**"), or I can choose to select attendants who are employed or subcontracted by **Contractor/Provider** (hereafter referred to as the "**Agency/Employer Option**").

Consumer/Employer Option

In choosing the Consumer/Employer Option, I understand that I choose to be the legal employer of the Attendants who will provide my Attendant Care Services. As their employer, I have the right and responsibility to hire and direct them in the provision of my Attendant Care Services and to perform and fulfill the duties of an employer, including recruiting, selecting, training, hiring, supervision, authorization and payment of wages, payment of taxes and insurance required, and dismissing attendants, as needed. In choosing the Consumer/Employer Option, I understand that I can also receive, at my request and as needed, assistance from Contractor/Provider and the Pennsylvania Attendant Care Program in performing these tasks. I also understand that I can choose to receive assistance from Contractor/Provider in fulfilling my payroll and fiscal duties and obligations as an employer by appointing Contractor/Provider as my payroll and fiscal agent, to act on my behalf, by signing Internal Revenue Service (IRS) Form 2678 (Employer Appointment of Agent") and the Pennsylvania Attendant Care Program "Consumer/Employer Appointment of Agent."

*I choose the **Consumer/Employer Option** and choose to employ the attendants who will provide my attendant care services.*

Agency/Employer Option

In choosing the Agency/Employer Option, I choose not to employ my attendant(s). In choosing the Agency/Employer Option, I understand that I retain the right and responsibility to select and dismiss my attendant(s) from among candidates provided by **Contractor/Provider** or its designee, to supervise and direct **Contractor/Provider**-employed attendants, and to authorize payment of attendants wages. In choosing the Agency/Employer Option, I understand that I can also receive, at my request and as needed, assistance from **Contractor/Provider** and the Pennsylvania Attendant Care Program in performing these tasks and in directing my Attendant Care Services.

*I choose the **Agency/Employer Option** and choose not to employ the attendants who will provide my Attendant Care Services. Instead, I want my attendants to be employed by **Contractor/Provider.***

My signature indicates that I have been informed of my choices with regard to the control I want to exercise over attendants who will provide my attendant care services and have freely chosen the control option I prefer.

Consumer Signature _____ Date _____

Contractor/Provider Signature _____ Date _____

Service Agreement Between Consumer and Contractor/Provider

This agreement is made between the Name of Contractor/Provider hereafter referred to as "Contractor/Provider", and Name of Consumer , hereafter referred to as "Consumer," for the purpose of establishing the relationship, roles, and responsibilities of the parties. Contractor/Provider is an attendant care service provider enrolled in and authorized to provide services through the Pennsylvania Attendant Care Program. Consumer is an individual who is eligible to receive the Attendant Care Service.

A. Consumer

1. By this agreement, the Consumer chooses the Contractor/Provider as the qualified provider of the Attendant Care Service that the Consumer is authorized to receive through the Pennsylvania Attendant Care Program. The Consumer understands that the services that the Contractor/Provider will provide are limited to those activities and tasks specified in the Consumer's approved Service Plan.
2. The Consumer agrees to follow the policies and procedures of the Contractor/Provider, of the Contractor/Provider's designees, and of the Pennsylvania Attendant Care Program including:
 - a) Reporting to the Contractor/Provider any changes that would affect the Consumer's eligibility or need for the Attendant Care Services;
 - b) Receiving training and assistance from the Contractor/Provider and participating in training for Attendants, as necessary, to ensure the Consumer's health and safety and the Consumer's continued participation in the Attendant Care Program;
 - c) Allowing the Contractor/Provider and/or representatives of the Pennsylvania Attendant Care Program into the Consumer's home at least once per year to monitor the Consumer's participation in the Attendant Care Program;
 - d) Making available for the Contractor/Provider's inspection and copying documents and records required for the Consumer's continued participation in the Pennsylvania Attendant Care Program;

The Consumer understands that failure to follow these policies and procedures may result in the Consumer's termination from the Pennsylvania Attendant Care Program.

3. The Consumer understands his/her right to select Attendants, make decisions about, direct the provision of, and control the Attendant Care Service to the maximum extent that the Consumer desires and is capable. The Consumer understands that he/she may request and receive assistance and support from the Contractor/Provider in coordinating and directing the Consumer's Attendant Care Service. The Consumer agrees to specify the degree of control and responsibility the Consumer wishes to exercise over the provision of the Attendant Care Service and the tasks that the Consumer wishes to perform by:
 - a) Selecting the attendant care control option by completing the attached form: "Consumer Selection of Attendant Care Control Option"
 - b) Specifying the Consumer's and the Contractor/Provider's primary responsibility for directing and managing the Attendant Care Service by completing the attached form: "Consumer Designation of Primary Responsibility for Attendant Care Service Tasks/Responsibilities."

- c) Appointing the Contractor/Provider as the Consumer's fiscal and payroll agent, if the Consumer chooses to employ the Attendants that will be providing the Consumer's Attendant Care Services.
- 4. The Consumer will assign weekly hours of work to their attendants within the limits established in the Consumer's attendant care service plan.
- 5. The Consumer understands that the Consumer has primary responsibility for making arrangements for back-up Attendants in the event an Attendant is unable to work on a regularly scheduled work day. The Consumer agrees to use family, friends, and neighbors as sources of back-up services where possible.
- 6. The Consumer is responsible for supervising the Attendant's recording of hours worked. The Consumer's and the Attendant's signatures on the time sheet attest that all times submitted for payment are actual and accurate. The Consumer understands that the Pennsylvania Attendant Care Program will only pay for Attendant hours consistent with the Consumer's Service Plan.
- 7. The Consumer is responsible for timely completion and delivery of Attendant time sheets according to the payroll schedule established by the Contractor/Provider. Consumer understands that late arrival of time sheets may result in delay in Attendants being paid.
- 8. The consumer agrees to pay the Attendant's wages in full on a regular schedule for the approved hours that the Attendants works. The Consumer agrees to comply with all applicable federal, state, and local laws and regulations regarding the employment of Attendants and the payment of required taxes levied on the Attendant's wages. The Consumer agrees to comply with the policies and procedures of the Pennsylvania Attendant Care Program and with the Pennsylvania Worker's Compensation Law regarding worker's compensation coverage of Attendants.
- 9. When an Attendant's employment ceases, the Consumer agrees to notify the Contractor/Provider of the date the employment ceased and of the reason. The Consumer agrees to notify the Contractor/Provider of changes in the status or addresses of their Attendant(s).

B. Contractor/Provider

- 1. As an authorized provider in the Pennsylvania Attendant Care Program and as the Attendant Care Service Contractor/Provider selected by the Consumer, the Contractor/Provider agrees to provide the Consumer with Attendant Care Services as specified in and authorized by the Consumer's approved Service Plan.
- 2. By agreement with the Consumer, the Contractor/Provider will assist the Consumer in directing and controlling the Attendant Care Service the consumer receives according to the Consumer's needs and capabilities. The Contractor/Provider will provide the following resources to the Consumer as requested and/or needed by the Consumers:
 - a) Training and skills development for the Consumer and for the Consumer's Attendants
 - b) Assistance in recruiting qualified Attendants
 - c) Paying for criminal record checks that the Consumer requests on Attendants the Consumer wishes to employ

- d) Services to perform the functions of a fiscal and payroll agent to assist the Consumer in performing the duties of an employer
- 3. The Contractor/Provider agrees to provide the Consumer's Attendant Care Services in a manner that ensures the Consumer's health, safety, welfare, and personal autonomy, including periodic monitoring of the provision of the Attendant Care Services. The Contractor/Provider agrees to correct problems that may be encountered to ensure the Consumer's health and welfare and to ensure that services provided to the Consumer are authorized and appropriate.
- 4. The Contractor/Provider agrees to maintain appropriate records and to provide the Consumer with information necessary for the Consumer's continued participation in the Pennsylvania Attendant Care Program.
- 5. The Contractor/Provider will assist the Consumer in acquiring worker's compensation coverage and reimburse the Consumer for the cost of coverage of Attendants that the Consumer employs to provide the Consumer's Attendant Care Service.
- 6. The fiscal agent agrees to pay the wages of Attendants that the Consumer selects to provide the Consumer's Attendant Care Services, based on the services specified in the Consumer's approved Service Plan.

C. Regulation

Any applicable federal, state, or local regulations pertaining to the provision and receipt of the Attendant Care Service are hereby incorporated by reference in this agreement.

D. Duration and Modification of Agreement

This agreement is the entire agreement and understanding between and among the Consumer and the Contractor/Provider. This agreement will be in effect as of the date the agreement is signed by the Consumer and the Contractor/Provider. The agreement can be modified by agreement of both parties. This agreement may be terminated immediately by either of the parties upon breach of any of its terms. This agreement may be terminated without cause upon ten (10) day written notice of one party to the other.

Consumers Signature _____ Date _____

Contractor/Provider Signature _____ Date _____

Consumer Designation of Primary Responsibility for Attendant Care Service Tasks/Activities

Attendant Care Service <i>Description of Task/Activity</i>	Primary Responsibility		
	Consumer	Contractor/Provider and Consumer	Contractor/ Provider
1. Advertising open attendant care service positions and recruiting new attendants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Obtaining required applications and related materials from prospective attendants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Screening, determining qualifications and eligibility, and interviewing attendant care applicants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Performing criminal records checks (✓ IF APPLICABLE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Checking applicant references, as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <i>Hiring the attendant as the attendant's legal employer.</i>	<input type="checkbox"/>	N/A	<input type="checkbox"/>
7. Selecting the attendant(s) that will provide the Consumer's Attendant Care Services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Preparing pay checks, paying required taxes and unemployment insurance, filing required forms, and performing other payroll duties required of the legal employer of domestic employees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Orienting and training attendants in <i>non-health maintenance attendant care service</i> activities authorized and required by Consumer's service plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Orienting and training attendants in <i>performing health maintenance activities</i> authorized and required by Consumer's service plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Firing, dismissing, or changing the Attendant(s) that provide the Consumer's Attendant Care Services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consumer Signature _____ Date _____

Contractor/Provider Signature _____ Date _____

Consumer/Employer Appointment of Agent

I, Name of Consumer (hereafter referred to as "**Consumer**"), have chosen to hire and employ the attendants who will provide **Consumer's** Attendant Care Services through the Pennsylvania Attendant Care Program. As a consumer/employer, **Consumer** elects to appoint Name of Contractor/Provider (hereafter referred to as "**Fiscal Agent**") to assist in fulfilling **Consumer's** responsibilities as an employer of Attendants. This appointment and authorization given to **Fiscal Agent** is limited to those employees that the **Consumer** employs as Attendant(s) through the Attendant Care Program of the Commonwealth of Pennsylvania. Contractor/Provider may provide Fiscal Agent services to the Consumer by itself or it may contract with another entity to provide some or all of these services to the Consumer.

In signing Internal Revenue Services (IRS) Form 2678, "**Employer Appointment of Agent**," **Consumer** appoints **Contractor/Provider** as **Consumer's** Fiscal agent, to assist **Consumer** in preparing payroll for **Consumer's** employee(s) and in fulfilling **Consumer's** federal tax obligations as an employer, pursuant to Section 3504 of the IRS Code. In signing the Pennsylvania Attendant Care Program "**Consumer/Employer Appointment of Agent**," **Consumer** elects and appoints **Contractor/Provider** as **Consumer's** fiscal agent, to assist **Consumer** in preparing payroll for **Consumer's** employee(s) and in fulfilling all of the **Consumer's** other state and local obligations to pay taxes, pay unemployment compensation insurance, file forms, and perform any of **Consumer's** other obligations as an employer.

In signing these forms, **Consumer** authorizes and directs **Fiscal Agent** to do all that is required and necessary on **Consumer's** behalf to comply with the provisions and requirements of federal, state, and local laws regarding **Consumer's** registration as an employer, including paying workers' compensation insurance premiums for **Consumer's** Attendant employees.

In making this appointment, **Consumer** authorizes **Fiscal Agent** to sign, on **Consumer's** behalf, all payroll tax forms and other forms for which **Consumer** is responsible as an employer. **Consumer** agrees to provide **Fiscal Agent** with all necessary information and documentation required for **Fiscal Agent** to meet **Consumer's** obligations in a timely manner in complying with all provisions of law and regulations which apply to employers. **Consumer** agrees to maintain all personnel records required by federal, state, and local laws in a permanent file for each Attendant that the Consumer employs. The Consumer agrees to make available for inspection all personnel records pertaining to the employment of Attendants and required for participation in the Pennsylvania Attendant Care Program.

This appointment is effective as of the date it is signed and accepted by both parties. The agreement may be terminated by either party with ten (10) days written notice to the other.

Our signatures indicate that the undersigned agree to the above.

Consumer Signature _____ Date _____

Contractor/Provider Signature _____ Date _____

List of Services Agreed to be Provided by Fiscal Agent

As the Consumer's appointed fiscal agency, the contractor/provider agrees to perform or assist the Consumer in performing the following employment and payroll-related tasks:

1. Registering the Consumer as an employer, including providing assistance to the Consumer in completing forms required to obtain employer identification numbers from federal agencies, state agencies, unemployment insurance agencies, and workers compensation insurance agencies.
2. Preparing and maintaining original and file copies of all forms needed to comply with federal, state, and local tax payment, payment of unemployment compensation insurance premiums, and all other reporting requirements of employers.
3. Acquiring workers' compensation insurance coverage for the Consumer's Attendants who are the Consumer's employees.
4. Upon receipt of the required completed forms from the Consumer, the Fiscal Agent will remit the required forms to the appropriate agency and maintain copies of the forms in the Consumer's file. The Fiscal Agent will return copies of all forms to the Consumer for the Consumer's permanent personnel records.
5. The Fiscal Agent will receive and process attendant care timesheets, process the payroll for the Consumer's attendant(s) upon receipt of the timesheets, and prepare the payroll for the Consumer's attendants, performing appropriate income tax, FICA, workers compensation, and other withholdings according to Federal and State regulations.
6. The Fiscal Agent will prepare payroll for the Consumer's Attendants according to approved timesheets and after making appropriate deductions.
7. The Fiscal Agent will distribute payroll checks to the Consumer's attendants according to the Consumer's regular check distribution policy in accordance with the policies and procedures established by the Attendant Care Program and the Department of Public Welfare.
8. The Fiscal Agent will make payments on behalf of the Consumer for federal withholding FICA (employer and employee shares), state withholding (optional), local taxes (optional), unemployment compensation taxes, workers' compensation insurance, and other payments required and as appropriate.
9. At the Consumer's request the Fiscal Agent will provide the Consumer with regular summaries of payroll and deductions made on the Consumer's behalf.
10. The Fiscal Agent will provide the Consumer with information, orientation, and training, as needed, concerning their fiscal and payroll responsibilities and obligations as employers of their attendant(s) during orientation provided by the Agency coordinating the Consumer's attendant care service. The Fiscal Agent will make orientation and training available to the Consumer on an ongoing basis to assist the Consumer with fulfillment of the duties of an employer.

Application for Employment as an Attendant

Name of Applicant (_____) _____
Area Code Telephone #

Apartment # Street Address City/Town State Zip Code

County

Because of the need to protect the health and welfare of the consumer, the Pennsylvania Attendant Care Program has established the following standards for the employment of Personal Care Attendants in the Program:

**Minimum Qualifications for Employment as a Personal Care Attendant
in the Pennsylvania Attendant Care Program**

1. Be 18 years of age or older;
2. Have the required skills to perform attendant care services as specified in the consumer's service plan;
3. Possess basic math, reading, and writing skills;
4. Possess a valid Social Security number;
5. Be willing to submit to a criminal records check; and,
6. Demonstrate the capability to perform health maintenance activities required by the consumer and/or specified in the consumer's service plan, or be willing to receive training in performance of the specified health maintenance activity.

Attached to this application for employment as a Personal Care Attendant is a summary of the following:

- The purpose of the Pennsylvania Attendant Care Program.
- Minimum qualifications for employment as a Personal Care Attendant.
- A summary of the tasks and activities a Personal Care Attendant may be asked to perform.

The applicant's signature on the line below acknowledges that you have been provided this information and have read the qualifications for employment as a Personal Care Attendant in the Pennsylvania Attendant Care Program.

I acknowledge that I have received and read the "Minimum Qualifications for Employment as a Personal Care Attendant in the Pennsylvania Attendant Care Program."

Applicant Signature _____ Date _____

Do you want to work: _____ Full time? _____ Part time?

Please indicate the hours each day that you can work in the **morning**, **afternoon**, or **evening** periods (for example, 8:00 a.m. – 12 noon on Mondays). Indicate for **all the days** you are available and willing to work:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Are you available to work in a back-up capacity (for example, filling in for a regular attendant)?

_____ Yes _____ No

Are you willing to work any holiday? _____ Yes _____ No

If YES, which holidays: _____

Were you 18 years of age or older on your last birthday? _____ Yes _____ No

Have you ever been convicted of a serious offense (other than a minor traffic violation) after your 18th birthday, or have you ever forfeited bond in a criminal proceeding? _____ Yes _____ No

If requested by the consumer/employer or the provider agency, are you willing to undergo a criminal records check as part of this application process?

_____ Yes _____ No

Reference (name): _____ Telephone # _____

Reference (name): _____ Telephone # _____

The answers given in this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. I understand that this application is not and is not a contract of employment.

Application Signature _____ Date _____

Applicants are considered for all positions without regard to race, color, religion, national origin, marital or veteran status, or the presence of a non-job-related medical condition or disability.

Purpose of the Pennsylvania Attendant Care Program

The purpose of the Pennsylvania Attendant Care Service is to enable eligible adults ages 18-59 who are mentally alert and physically disabled to perform activities or daily living (such as eating, personal hygiene, transporting themselves, and working) that they would ordinarily perform themselves were it not for their disability. Using state and federal funding, in addition to the consumer's own resources, the Pennsylvania Attendant Care Program enables disabled individuals to obtain assistance from Attendants in performing tasks that they would otherwise do themselves. The Attendant Care Service is designed to help disabled individuals to perform these activities and to live as independently as possible.

The Attendant Care Service is designed to support eligible adults in improving their quality of life by achieving one or more of the following goals:

- (1) Enabling consumers to live in the least restrictive environment as independently as possible:
- (2) Enabling consumers to remain in their homes and preventing unnecessary admission to nursing homes or other similar institutional settings; and,
- (3) Enabling consumers to seek and/or maintain employment.

To meet these objectives, in-home Attendant Care Services are provided to enable consumers to achieve maximum independence in their daily lives. The Attendant Care Service is in-home personal care and other approved support activities for consumers requiring assistance to accomplish daily living tasks.

The Attendant Care Service consists of BASIC, ANCILLARY, and HEALTH MAINTENANCE services provided by attendants in accordance with the consumer's approved service plan. The following are the types of Attendant Care Services that are provided by attendants:

BASIC SERVICES

1. Assistance in getting out of bed, wheelchair, and/or motor vehicle.
2. Assistance with routine bodily functions, including, but not limited to:
 - Bathing and personal hygiene
 - Dressing and grooming
 - Eating, including meal preparation and clean-up
 - Health Maintenance Activities (see below)

ANCILLARY SERVICES

If a person is assessed as needing one or more of the basic services above, the following services may be provided in conjunction with the basic services:

1. Homemaker-type services
2. Companion-type services
3. Assistance with cognitive tasks

ASSISTANCE WITH HEALTH MAINTENANCE ACTIVITIES

Attendants may be asked to provide Health Maintenance Activities if requested by the consumer and/or if required by the consumer's service plan. Health Maintenance Activities are those

activities that are necessary to maintain the health and normal bodily functions and would be carried out by the consumer/employer if the consumer were physically able. Health Maintenance Activities include, but are not limited to activities such as administration of medications, enemas, and suppositories; catheter irrigations; and wound care.

Attendants may perform Health Maintenance Activities under the following conditions:

1. The Provider has assessed the consumer as being capable of directing and supervising the attendant in the specified Health Maintenance Activities;
2. The attendant is trained and supervised in the prescribed activities by the consumer's physician and/or a qualified health professional;
3. The attendant's ability to carry out the activities safely has been documented by the provider agency;
4. The attendant's prior experience and work history do not indicate unsafe performance of such activities;
5. Disposable items or devices are used in performing the Health Maintenance Activity whenever they are available;
6. The provider has ensured that the consumer has in place appropriate referral arrangements with qualified health professionals to respond to health emergencies; and,
7. The Attendant providing the Health Maintenance Activities has read and understands the Consumer's service plan.

MINIMUM QUALIFICATIONS OF PERSONAL CARE ATTENDANTS

Because of the need to protect the health and welfare of the consumer, the Pennsylvania Attendant Care Program has established the following minimum standards for the employment of Personal Care Attendants in the Program:

Minimum Qualifications for Employment as a Personal Care Attendant in the Pennsylvania Attendant Care Program

1. Be 18 years of age or older;
2. Have the required skills to perform attendant care services as specified in the consumer's service plan;
3. Possess basic math, reading, and writing skills;
4. Possess a valid Social Security number;
5. Be willing to submit to a criminal records check; and,
6. Demonstrate the capability to perform health maintenance activities required by the consumer and/or specified in the consumer's service plan, or be willing to receive training in performance of the specified health maintenance activity

Criminal Record Check Policy for Consumer/Employers

Consumers who choose to be the employers of their attendants (hereafter referred to as "consumer/employers") must decide whether or not they want to have criminal record checks performed on the attendants that they hire through the assistance of the Pennsylvania Attendant Care Program. Consumer/Employers will be informed about their responsibilities as an employer and about their ultimate responsibility, as consumer/employers, for their own personal health and safety in their own homes. Consumer/employers will be informed about the importance of having criminal record checks performed on any and all attendants that intend to employ.

Criminal record checks will be performed at no cost to the consumer. Performance of the criminal record check and its cost will be the responsibility of the Contractor/Provider that provides the service coordination and support for the consumer/employer.

Consumers must choose whether or not they want to perform criminal record checks on Personal Care Attendants that they hire by completing the form below.

Responsibility for Employment of Attendants

If a consumer/employer chooses to have a criminal record check completed and this check reveals that an attendant has a criminal record, it will be the consumer/employer's decision whether or not to employ the person as an attendant. The consumer/employer's decision to employ an attendant with a criminal record and the consumer/employer's acceptance of responsibility for any consequences must also be documented by the signature of the consumer and retained in the consumer's file.

Consumer Selection of Criminal Record Check Option

- I have read the above policy and it is my decision **not to request criminal record checks on the attendants** on the attendants that I choose to employ through the assistance of the Pennsylvania Attendant Care Program.
- I have read the above policy and **I retain the right to request a criminal record check on attendants** that I choose to employ through the assistance of the Pennsylvania Attendant Care Program.
- I have read the above policy and **I request a criminal record check on all attendants** that I choose to employ through the assistance of the Pennsylvania Attendant Care Program.
- I choose to employ an attendant **on an interim basis pending completion of a criminal record check** and accept responsibility for my decision.

Consumer/Employer Acceptance of Responsibility for Employment

As a consumer/employer, I have the right to choose to hire and employ an attendant with a known criminal record. In doing so, I understand that this decision and the consequences thereof are my sole responsibility. In making any and all hiring decisions as a consumer/employer, I agree to hold harmless from any claims and responsibility the agency that I have chosen to provide me with the Attendant Care Service, the agent I have chosen as my Fiscal Agent, the Department of Public Welfare, and any and all of their employees and agents.

Consumer Signature _____ Date _____

Contractor/Provider Signature _____ Date _____

Agreement Between Consumer and Attendant

Parties to Agreement

This employment agreement is made between Name of consumer (hereafter referred to as "Consumer") and Name of attendant (hereafter referred to as "Attendant"). The purpose of this agreement is to establish the responsibilities of the parties to each other.

Duration of Agreement

This agreement will be effective when it is signed by both parties. The agreement will be in effect until it is terminated by either party with 5 calendar days of notice to the other which may be provided orally or in writing.

Attendant Qualifications

The Attendant attests that he/she meets minimum qualifications for employment in the Pennsylvania Attendant Care Program:

1. Attendant is 18 years of age or older;
 2. Attendant has the required skills to perform attendant care services as specified in the consumer's service plan;
 3. Attendant possesses basic math, reading, and writing skills;
 4. Attendant possesses a valid Social Security number;
 5. Attendant is willing to submit to a criminal record check;
- Consumer agrees to select or employ attendant on an interim basis pending completion of a criminal record check. Consumer has discussed with attendant and reserves the right to dismiss the attendant based on the results of the criminal record check.
6. Attendant can demonstrate the capability to perform health maintenance activities required by the consumer and/or specified in the consumer's service plan, or be willing to receive training in performance of the specified health maintenance activities.

Attendant Responsibilities

1. **Attendant understands that Attendant is employed by Consumer and not by the Contractor/Provider, the Consumer's agent (fiscal agent), or the Commonwealth of Pennsylvania.**
2. Attendant agrees to assist Consumer by providing the services and performing the activities specified in Consumer's service plan.
3. Attendant agrees to protect the health and welfare of Consumer by providing authorized services in accordance with the policies and standards of the Pennsylvania Attendant Care Program, including the Minimum Qualifications for Employment as a Personal Care Attendant.
4. Attendant agrees to provide Attendant Care Services as specified in the Consumer's service plan on a schedule mutually agreed upon between the Consumer and the Attendant. On an exception basis, occasional variations in the Attendant Care tasks and in the schedule will occur, based on mutual agreement of the parties.
5. In the event of illness, emergency, or incident preventing Attendant from providing scheduled service to Consumer, Attendant agrees to notify Consumer as soon as possible so that Consumer can obtain assistance from someone else.

6. Attendant agrees to participate in training in providing attendant care services, including training in performing any health maintenance activities, as required by Consumer and/or as specified in Consumer's service plan.
7. Attendant agrees to maintain Consumer's confidentiality and respect Consumer's privacy.
8. Attendant agrees to pay all required federal, state, and/or local wage and/or income taxes levied against Attendant's wages. Attendant agrees to cooperate with Consumer and Consumer's agent in providing information needed to comply with all income and unemployment taxation laws and regulations.
9. Attendant understands that this agreement does not guarantee employment.

Consumer Responsibilities

1. Consumer agrees to orient, train and direct Attendant in providing the attendant care services that are described and authorized by the Consumer's service plan or that are requested by the Consumer.
2. Consumer agrees to establish a mutually agreeable schedule for Attendant's services, either orally or in writing.
3. Consumer agrees to provide adequate notice of changes in Attendant's work schedule in the event of unforeseen circumstances or emergencies, but such notice cannot be guaranteed.
4. In consideration of Attendant's satisfactory job performance, Consumer agrees to authorize completed Attendant time sheets and to pay Attendant net wages on a regular and timely basis according to a predetermined payroll schedule. Net wages will include gross earnings calculated according to Attendant's pay rate minus payroll deductions for federal income taxes, employee's share of FICA, state income tax, and other deductions as appropriate. Consumer agrees to provide Attendant with a record of payments and deductions made from gross earnings.
5. Consumer agrees to pay all income and unemployment taxes and make regular payments of workers' compensation insurance premiums on behalf of Attendants.

Duration of Agreement

This agreement will be effective when it is signed by both parties. The agreement will be in effect until it is terminated by either party with 5 calendar days of notice to the other which may be provided orally or in writing.

Modification and Termination of Agreement

This agreement can be modified by agreement of both parties. This agreement can be terminated immediately by either of the parties for cause. This agreement may be terminated without cause with 5 (five) days notice of one party to the other orally or in writing.

Mutual Responsibilities

The parties agree to follow the policies and procedures of the Consumer's Agency, of the Agency's designees, and of the Pennsylvania Attendant Care Program. The Attendant and Consumer agree to hold harmless, release, and forever discharge the Agency, the Pennsylvania Department of Public Welfare, and their agents, from any claims and/or damages that might arise out of any action or omissions by the Attendant or the Consumer.

Consumer Signature _____ Date _____

Attendant Signature _____ Date _____

MAIL TO:

Contractor/Provider Name
Contractor/Provider Address
City, State, Zip Code
Name of Contact

THE ATTENTION OF:

TIME SHEET

Personal Care Attendant Name _____ Attendant Payroll ID # _____

Consumer/Employer Name _____ County _____ Fee \$ _____

WEEK 1

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Date							
IN:							
OUT:							
IN:							
OUT:							
Hours							

WEEK 2

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Date							
IN:							
OUT:							
IN:							
OUT:							
Hours							

WEEKDAY HOURS: Week 1 _____ Week 2 _____ TOTAL WEEKDAY HOURS _____ GROSS PAY \$ _____

WEEKEND HOURS: Week 1 _____ Week 2 _____ TOTAL WEEKEND HOURS _____ GROSS PAY \$ _____

GROSS PAY TOTAL \$ _____

My signature certifies that I received/provided a service or item on the date listed above. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material facts may be prosecuted under applicable Federal and State laws.

Consumer/Employer Signature: _____ Date _____

Attendant Signature: _____ Date _____

Office Approval _____

PAYROLL FORM

Payroll Deductions Taken From Attendant's Wages							
Unemployment Compensation	Federal Income Tax (Circular E)	State Income Tax	FICA Social Security	Local Tax	Other Deduction	Total Deductions	Net Pay= Gross Pay Minus Deductions
@_____	@_____	@_____	@_____	@_____			\$ _____
\$	\$	\$	\$	\$	\$	\$	-\$ _____
							= \$ _____

Employer Expenses						
FICA Social Security	Unemployment Compensation	FUTA Tax	Other Tax	Other Expenses	Gross Pay	Total Amount Paid to Consumer
\$	\$	\$	\$	\$	\$	\$

Consumer

Name of Consumer: _____

Consumer (Employer) Identification #: _____ Telephone # _____

Address of Consumer: _____

City/State/Zip Code: _____

Attendant

Name of Attendant: _____ Telephone # _____

Address of Attendant: _____

City/State/Zip Code: _____

Attendant Social Security Number: _____ - _____ - _____

MAIL TO:

Contractor/Provider Name
Contractor/Provider Address
City, State, Zip Code
Name of Contact

TO THE ATTENTION OF:

Personal Care Attendant Name _____ Attendant Payroll ID # _____

Consumer/Employer Name _____ County _____ Fee \$ _____

		Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.		Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	
	Date																
Morning	IN:																
	OUT:																
	Hours																
Afternoon	IN:																
	OUT:																
	Hours																
Evening	IN:																
	OUT:																
	Hours																
Daily Total	Hours																

WEEKDAY HOURS: 1ST Week _____ 2nd Week _____ TOTAL WEEKDAY HOURS _____ GROSS PAY \$ _____

WEEKEND HOURS: 1ST Week _____ 2nd Week _____ TOTAL WEEKEND HOURS _____ GROSS PAY \$ _____

My signature certifies that I received/provided a service or item on the date listed above. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material facts may be prosecuted under applicable Federal and State laws.

Consumer/Employer Signature: _____ Attendant Signature: _____ Date: _____

Office Approval: _____ Date: _____

Attendant Status Form (THIS FORM IS OPTIONAL)

Consumer's Name _____

Consumer Social Security # _____ - _____ - _____

Attendant Name _____

Attendant Social Security # _____ - _____ - _____

ACTION:

- Termination
- Change of Address/Other Change

Change in Status/Information

<u>OLD</u>	<u>NEW</u>
Name:	Name:
Street Address:	Street Address:
City/State/Zip Code:	City/State/Zip Code:
Phone:	Phone:
Hourly Pay Rate:	Hourly Pay Rate:

Effective Date: _____

Consumer's Signature: _____

Notice of Discontinued Employment

The purpose of this form is to provide notice of the end of an employment agreement between the Consumer and the Attendant. The form provides an opportunity for **either** or **both** parties to document the reason(s) for the termination of employment.

This form can be completed **individually** by the Consumer or the Attendant, or by **both parties** (the Consumer and the Attendant).

<u>Consumer/Employer</u>	<u>Attendant</u>
Name:	Name:
Address:	Address:
Phone:	Phone:

Date employment ended:

Briefly state below the reasons for ending the employment agreement between the two parties:

Consumer Signature _____ Date _____

Attendant Signature _____ Date _____

Please return this form to:

Attention of person's name
Contractor/Provider name
Address, city/town, state, zip code

II. Taxing Agency Forms.

A. Registration Forms.

1. Federal forms.

(a) Consumer completed.

- (1) SS-4 (Internal Revenue Service), Application for Employer Identification Number.
- (2) 2678 (Internal Revenue Service), Employer Appointment of Agent.

(b) Attendant completed.

- (1) W-4 (Internal Revenue Service), Employee's Withholding Allowance Certificate.
- (2) I-9 (Immigration and Naturalization Service), Employment and Eligibility Verification.

2. State forms.

(a) Consumer completed.

- (1) Employer's Initial Statement, Registration of Employer's Account for Pennsylvania Unemployment Compensation Taxes (UC 1) or Pennsylvania Combined Registration Form (PA 100).
- (2) Pennsylvania Unemployment Compensation Power of Attorney (UC 884).
- (3) Pennsylvania Combined Registration Form (PA 100).

(b) Attendant completed. There are none required.

3. Local forms. Contractor/Providers must check with local taxing agencies regarding the necessity for local forms.

B. Filing forms.

1. Federal forms.

- a. 941 (Internal Revenue Service), Employer's Quarterly Federal Tax Return.
- b. 940 (Internal Revenue Service), Employer's Annual Federal Unemployment (FUTA) Tax Return.

Note: In some instances it may be possible to file forms 1040-ES, and Schedule H as an attachment to a consumer employer's 1040 tax return, in lieu of the 941 and 940. Additional information regarding filing Federal forms is available in Internal Revenue Service Publications 15 and 926.

- c. W-2 (Internal Revenue Service), Wage and Tax Statement.
- d. W-3 (Internal Revenue Service), Transmittal of Wage and Tax Statements, when transmitting more than one W-2 per employer.

2. State forms.

- a. UC-2A, Employer's Quarterly Report of Wages Paid to Each Employee.
- b. Pennsylvania State Income Taxes.
- c. W-2 (Internal Revenue Service), Wage and Tax Statement.

3. Local forms. Contractors/Providers must check with local taxing agencies regarding the necessity for local forms.

APPENDIX C

SLIDING FEE SCALE FOR ACT 150 CONSUMERS

APPENDIX C

SLIDING FEE SCALE FOR CONSUMERS

Note: Appendix C is applicable to the determination of sliding fee scale amounts under the Act 150 Program. There is no sliding fee scale or patient pay amount associated with attendant care services provided under the Medicaid Waiver for attendant care services.

I. Financial Eligibility

- A. Individuals who are currently eligible for the Medical Assistance Program are automatically eligible for free attendant care service. Individuals who receive SSI payments are also automatically eligible for free attendant care service.
- B. For all other applicants of attendant care service, the fee is determined by family size and gross monthly income.
- C. In the case of a husband and wife who both receive services in the Act 150 Program, each shall be assigned one-half of a single fee so as not to double count the family income in establishing fees.
- D. The fee is based on the provision of services, not the number of service hours provided per week. However, if the weekly fee is more than the total cost of the service per week, the fee is limited to the cost of the service.

II. Using the Sliding Fee Scale

When the family gross income is between two dollar amounts on the scale, the flat weekly fee of the higher dollar amount should be charged. For example: a family consisting of three members with a monthly gross income of \$3,300. Since \$3,300 exceeds \$3,084 on the scale, the higher dollar figure of \$3,375 is used to determine the flat weekly fee. The flat weekly fee in this example is \$10. In this example, a husband and wife who both receive services in the Act 150 Program would each be assigned a weekly fee of \$5.00.

If the monthly income exceeds the income level on the scale, add \$5 to the flat weekly fee for each additional \$75 of income.

If there are more than eight people in the family, subtract \$200 for each additional person from the monthly income. After adjusting the monthly income for more than eight people, use column eight for a family size of eight. If the adjusted monthly income still exceeds the poverty figure on the fee scale, add \$5 to the flat weekly fee for each additional \$75 of income.

III. Annual Sliding Fee Scale Reissue

The Department will update and reissue the sliding fee scale annually, including years in which it does not update and reissue the Attendant Care Program Requirements.

2001-02 FY
Sliding Fee Scale
300% FBR

1	2	3	4	5	6	7	8	FEE
\$1,593	\$2,193	\$2,793	\$3,393	\$3,993	\$4,593	\$5,193	\$5,793	\$0
\$1,759	\$2,421	\$3,084	\$3,746	\$4,409	\$5,071	\$5,734	\$6,396	\$5
\$1,925	\$2,650	\$3,375	\$4,100	\$4,825	\$5,550	\$6,275	\$7,000	\$10
\$2,091	\$2,878	\$3,666	\$4,453	\$5,241	\$6,028	\$6,816	\$7,603	\$15
\$2,257	\$3,107	\$3,957	\$4,807	\$5,657	\$6,507	\$7,357	\$8,207	\$20
\$2,423	\$3,335	\$4,248	\$5,160	\$6,073	\$6,985	\$7,898	\$8,810	\$25
\$2,589	\$3,564	\$4,539	\$5,514	\$6,489	\$7,464	\$8,439	\$9,414	\$30
\$2,755	\$3,792	\$4,830	\$5,867	\$6,905	\$7,942	\$8,980	\$10,017	\$35
\$2,921	\$4,021	\$5,121	\$6,221	\$7,321	\$8,421	\$9,521	\$10,621	\$40
\$3,086	\$4,249	\$5,411	\$6,574	\$7,736	\$8,899	\$10,061	\$11,224	\$45
\$3,252	\$4,477	\$5,702	\$6,927	\$8,152	\$9,377	\$10,602	\$11,827	\$50
\$3,418	\$4,706	\$5,993	\$7,281	\$8,568	\$9,856	\$11,143	\$12,431	\$55
\$3,584	\$4,934	\$6,284	\$7,634	\$8,984	\$10,334	\$11,684	\$13,034	\$60
\$3,750	\$5,163	\$6,575	\$7,988	\$9,400	\$10,813	\$12,225	\$13,638	\$65
\$3,916	\$5,391	\$6,866	\$8,341	\$9,816	\$11,291	\$12,766	\$14,241	\$70
\$4,082	\$5,620	\$7,157	\$8,695	\$10,232	\$11,770	\$13,307	\$14,845	\$75
\$4,248	\$5,848	\$7,448	\$9,048	\$10,648	\$12,248	\$13,848	\$15,448	\$80
\$4,414	\$6,076	\$7,739	\$9,401	\$11,064	\$12,726	\$14,389	\$16,051	\$85
\$4,580	\$6,305	\$8,030	\$9,755	\$11,480	\$13,205	\$14,930	\$16,655	\$90
\$4,746	\$6,533	\$8,321	\$10,108	\$11,896	\$13,683	\$15,471	\$17,258	\$95
\$4,912	\$6,762	\$8,612	\$10,462	\$12,312	\$14,162	\$16,012	\$17,862	\$100
\$5,078	\$6,990	\$8,903	\$10,815	\$12,728	\$14,640	\$16,553	\$18,465	\$105
\$5,244	\$7,219	\$9,194	\$11,169	\$13,144	\$15,119	\$17,094	\$19,069	\$110
\$5,410	\$7,447	\$9,485	\$11,522	\$13,560	\$15,597	\$17,635	\$19,672	\$115
\$5,576	\$7,676	\$9,776	\$11,876	\$13,976	\$16,076	\$18,176	\$20,276	\$120
\$5,741	\$7,904	\$10,066	\$12,229	\$14,391	\$16,554	\$18,716	\$20,879	\$125
\$5,907	\$8,132	\$10,357	\$12,582	\$14,807	\$17,032	\$19,257	\$21,482	\$130
\$6,073	\$8,361	\$10,648	\$12,936	\$15,223	\$17,511	\$19,798	\$22,086	\$135
\$6,239	\$8,589	\$10,939	\$13,289	\$15,639	\$17,989	\$20,339	\$22,689	\$140

APPENDIX D

MEDICAL ASSISTANCE ELIGIBILITY HANDBOOK (EXCERPTS)

MEDICAID ELIGIBILITY HANDBOOK

WAIVER PROGRAMS

CITATION

389.1

GENERAL

The Federal government permits states to waive certain Medical Assistance (MA) program requirements in order to provide home and community based services to specific groups of clients. Home and community based services are an alternative to institutional or extended inpatient hospital care.

Waiver programs allow the Department to provide medical benefits to a person who may not otherwise qualify for MA. A waiver program may also provide services which are not normally covered by the MA Program. Waiver services are available as long as the estimated cost does not exceed the cost of institutional or inpatient care.

The following waiver programs are currently available:

- The MA 0192 Waiver for Persons with AIDS or Symptomatic HIV Disease - provides services to persons with Acquired Immune Deficiency Syndrome (AIDS) or Symptomatic HIV Disease.
- The Michael Dallas Model Waiver Program for Technology-Dependent Children - provides services to children who are dependent on a medical device to replace or compensate for a vital body function and to avert immediate threat to life.
- The Home and Community Based Services Waiver For Individuals Who Are Mentally Retarded - provides services in the community to persons who would otherwise need care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

- The Home and Community Based Waiver Program for Nursing Facility Residents with Other Related Conditions (OSP/OBRA Waiver) - provides services to inappropriately placed nursing facility and special rehabilitation facility residents with other related conditions who need specialized services.

 - The Home and Community Based Waiver Program for Attendant Care Services (OSP-AC Waiver) - provides attendant care to mentally alert adults 18 through 59 years of age with physical disabilities and who require a nursing facility level of care but who choose to remain in their own home or other community living arrangement.
-

MEDICAID ELIGIBILITY HANDBOOK

WAIVER PROGRAMS

CITATION

389.6 HOME AND COMMUNITY BASED SERVICES WAIVER FOR ATTENDANT CARE SERVICES - OSP/AC WAIVER

The Home and Community Based Services Waiver provides attendant care services in the community as an alternative to nursing facility care. The OSP/AC Waiver Program is for those persons who need attendant care services to remain independent in their own homes or in other community living arrangements.

The Office of Social Programs (OSP) has primary responsibility for the OSP/AC Waiver Program for attendant care services. At the county level, the Waiver Program is the responsibility of OSP's Attendant Care Provider and the County Assistance Office (CAO). The CAO will name a contact person and an alternate person to exchange information and resolve problems with OSP and the Attendant Care Provider. **See Appendix G** for a listing of the Attendant Care Providers.

A person is eligible for the OSP/AC Waiver Program if he:

- is 18 through 59 years of age;
- is a mentally alert person with a physical disability;
- requires nursing facility care as determined by a physician and approved by the Department;
- chooses to remain in his own home or other community setting;
- can safely be maintained in the community as determined by the Attendant Care Contractor;
- is financially eligible for the Medical Assistance (MA)

Program; and

- there is room in the Waiver for placement of the person.

NOTE: OSP will establish service hour thresholds for the purpose of maintaining controls on the cost-neutrality of the waiver services.

OSP and the Office of Medical Assistance Programs (OMAP) are under agreement with qualified providers to provide persons with the services they need to live in the community. Approved providers must be enrolled in the MA Program.

The OSP/AC Waiver provides those basic and ancillary services which enable eligible persons to live in their own homes and communities rather than in institutions and to carry out functions of daily living, self-care and mobility. Attendant Care Services provided under the OSP/AC Waiver Program are:

BASIC SERVICES

The basic services include, but are not limited to:

- Assisting a person to get in and out of a bed, wheelchair and/or motor vehicle;
- Assisting a person to perform routine bodily functions including, but not limited to:
 - health maintenance activities;
 - bathing and personal hygiene;
 - dressing and grooming; and
 - eating, including meal preparation and cleanup.

ANCILLARY SERVICES

Ancillary services may not be provided unless the person is receiving basic services. Ancillary services include the following:

- Homemaker-type services including but not limited to, shopping, laundry, cleaning and seasonal chores.
- Assistance with cognitive tasks, including but not limited to, managing finances, planning activities and making

decisions.

NOTE: A person who is receiving attendant care services under the OSP/AC Waiver Program is eligible to receive those services provided under the MA Program.

Waiver services are available to persons who receive cash assistance, SSI or MA if they meet the specific qualifications under the OSP/AC Waiver Program, and to medically eligible persons who are determined to be financially eligible for MA.

NOTE: The SSI recipient who is applying for the OSP/AC Waiver must meet the level of care requirements for Waiver participation.

The person applying for services under the OSP/AC Waiver who is not receiving SSI and who, based on the information available may qualify for SSI, is referred to the Social Security Administration (SSA).

REMINDER: The person and/or the person's representative is responsible for reporting any changes in the person's circumstances to the AC Contractor, the CAO and, if necessary, the SSA.

The AC Provider is responsible for determining the person's need for AC services.

The AAA has responsibility for determining the person's medical eligibility. This is accomplished by the review of the MA-51 and the OPTIONS Assessment.

NOTE: The AAA will complete the initial OPTIONS Assessment. All subsequent annual reassessments will be completed by the AC Contractor.

The CAO is responsible for determining if the person is financially eligible for the OSP/AC Waiver Program. Only the income and resources of the person eligible for the waiver services are considered.

NOTE: The CAO will not count the income or resources of an LRR. The Spousal Impoverishment Provisions and patient pay amounts toward cost of care do not apply to OSP/AC Waiver services. However, the person is responsible for co-pay amounts for other MA services (prescriptions,

doctor visits, etc.)

The person in the OSP/AC Waiver Program may also be eligible for food stamps. See the Food Stamp Handbook, Chapter 511.

389.61 INITIAL DETERMINATION FOR A PERSON APPLYING THE OSP/AC WAIVER PROGRAM

When considering the person's eligibility for the OSP/AC Waiver Program, the AC Provider, the local AAA and the CAO will cooperate in determining AC eligibility, medical eligibility and financial eligibility as follows:

THE ATTENDANT CARE PROVIDER WILL:

130. Identify the person who chooses to receive OSP/AC Waiver services.
131. Verify the person's current eligibility status in the SSI, cash assistance, MA or Food Stamp Programs with the CAO and, if not receiving MA, assist in the completion of the Application for Benefits.

NOTE: For current recipients, the AC Provider and the CAO will discuss the need for a partial or full redetermination and completion of the Benefits Review Form or the Alternate Redetermination Form.

The AC Provider will mark "AC Waiver" in the upper right hand corner of the Application of Benefits.

REMINDER: While a current SSI recipient is financially eligible for MA, the AC Provider must determine the need for AC services and medical eligibility for nursing facility care.

132. Provide person with the MA-51 for completion by the person's attending physician and return to the AC Provider.

NOTE: If completed MA-51 indicates eligibility for nursing facility care, the AC Provider attaches the OPTIONS Assessment cover sheet to the MA-51 and forwards to the AAA responsible for the

person's county of residence.

133. Review income for persons not receiving MA or SSI or those pending SSI approval by applying the special gross income test to the person's gross monthly income. Use the same exclusions and limits as listed in **389 Appendices A and B**.

- If the person's total gross income and countable resources are equal to or less than the limits in **389 Appendix B**, refer the person to the CAO for a determination of financial eligibility for the OSP/AC Waiver Program.
- If the person's total gross income and resources are more than the limits in **389 Appendix B**, advise the person of his potential ineligibility for Waiver services. Refer any person who wants to apply to the CAO for a determination of financial eligibility.

NOTE: A person whose income exceeds the gross income limit in 389 Appendix B may be eligible for AC Waiver Services in the MNO category only if he has high medical expenses and can spenddown.

THE AAA WILL:

134. Review MA-51 and OPTIONS Assessment cover sheet for appropriateness of the referral.

135. Schedule OPTIONS Assessment.

NOTE: The AAA will notify the person and the AC Provider regarding the scheduling of the appointment. The AC Provider assists the person through the assessment process and assists the AAA assessor with the person's special needs. The AC Provider staff person does not function as a co-assessor with input into the assessment during the interview or the subsequent clinical nursing facility eligibility decision.

136. Complete the OPTIONS Assessment.

REMINDER: AAA will not complete the OBRA-ID or OBRA-EV as these forms are not required

under the OSP/AC Waiver Program.

137. Prepare the yes/no recommendation for nursing facility care. **See 389, Appendix F.**
138. Forward the yes/no determination to the AC Contractor.

NOTE: The AAA will forward the original OPTIONS Assessment and the MA-51 to the AC Provider with the yes/no recommendation.

REMINDER: The AC Provider is responsible for all subsequent annual reassessments.

139. Assist in the completion of the Application for Benefits, if necessary.
140. Provide the AC Provider and person with the address of the CAO located in the person's county of residence, if requested.
141. Advise the person and the AC Provider that if an Application for Benefits is filed with the CAO, the CAO will issue a Notice of Eligibility to the person and the AC Provider.
142. Participate in the DPW Fair Hearing Appeal Process, when applicable.

THE CAO WILL:

143. Review the Application for Benefits, MA-51 and the OPTIONS yes/no nursing facility recommendation for completeness and medical eligibility.
144. If the person is currently receiving SSI benefits, the person is automatically financially eligible for the OSP/AC Waiver Program.

NOTE: The current MA or SSI recipient MUST be medically eligible for Waiver services; i.e., have a YES on the OPTIONS nursing facility recommendation.

145. If the person is not receiving SSI benefits, determine eligibility based on the information on the Application

for Benefits. Count only the income and resources of the person. Exclude the income and resources listed in **389 Appendix A**, and the SSI-related exclusions of **Chapter 340, Resources, and 350, Income**.

REMINDER: CAOs MUST apply the look-back periods and the transfer of assets (income and resources) requirements to assets disposed of for less than fair market value.

55 Pa. Code
178.104

- 146.** Compare the countable gross monthly income to the special income limit and countable resources to the resources limit in **389, Appendix B**.
- If the person's countable gross income and countable resources are more than the limits in **389, Appendix B**, deny MA eligibility for the OSP/AC Waiver Program.
 - If the CAO does not receive adequate information to make a determination, the CAO will notify the AC Provider and the person of the information needed and the date by which it must be received by the CAO.
- 147.** Determine the person eligible for the OSP/AC Waiver Program if he meets the level of care requirements and his income and resources do not exceed the limits in **389 Appendix B**.

NOTE: Under the OSP/AC Waiver Program, there is no patient pay amount for Attendant Care Waiver Services. However, these persons are expected to pay any co-pay amounts for MA services (e.g., prescriptions, doctor visits, etc.).

- 148.** Send the Notice of Eligibility for the OSP/AC Waiver Program. Send the Notice of Eligibility to:
- the OSP/AC Waiver person (send the original);
 - the AC/Provider; and
 - the Office of Social Programs.

NOTE: Refer to 389 Appendix G for the list of AC Providers.

149. The CAO will authorize OSP/AC Waiver Services as follows:

- for current Cash, MA or SSI recipients, update CIS by entering a 40 in the Facility Code field to indicate that the recipient is eligible for the additional services provided under the OSP/AC Waiver Program.
- for new applicants who qualify under the NMP or MNO requirements, authorize in the respective category and enter a 40 in the Facility Code field to indicate that the person is eligible for the additional services provided under the OSP/AC Waiver Program.
- for new applicants who qualify under the income and resource limits in **389, Appendix B**, authorize in the NMP category and enter a 41 in the Facility Code field to indicate that the person is eligible for the additional services provided under the OSP/AC Waiver Program.

150. Enter the information about any third party resources into the TPL file.

389.62 ANNUAL FINANCIAL REDETERMINATION

If the person is receiving SSI benefits, an annual financial review by the CAO is not required. The SSA completes the annual review. If SSA notified the CAO that an SSI recipient in the OSP/AC Waiver Program is ineligible for SSI, the CAO will:

- 151.** Immediately notify the AC Provider, in writing, that an application for the OSP/AC Waiver is needed. The AC Provider will complete the steps indicated in **Section 389.61, Initial Determination for a Person Applying for the OSP/AC Waiver Program.**
- 152.** Close the case and send a notice to all parties.
- 153.** Upon receipt of the completed Benefits Review Form, determine income and resources eligibility as indicated in **Section 389.61, Initial Determination for a Person Applying for the OSP/AC Waiver Program.**

NOTE: All information should be handled as quickly as possible to avoid any interruption in the person's eligibility for OSP/AC Waiver services.

154. Authorize in the respective category effective the day following the closure of the SSI budget, or, if later, the date the application is received and date-stamped or the earliest date the signature is obtained by the AC Provider.
155. Review the person's eligibility for food stamps if the person lives in a group living arrangement. See the Food Stamp Handbook, **Chapter 511**, Living Arrangements.

If the person is not receiving SSI, the CAO will:

156. Within 12 months of the initial OSP/AC Waiver services eligibility determination or the most recent financial redetermination, complete a financial determination based on the person's current income and resources.

NOTE: Send the notice of the interview date and time 14 days before the interview date. Send copies of the appointment notice to the person and the AC Provider. The AC Provider will assist the person in the completion of the Benefits Review Form or the Alternate Redetermination Form.

157. Upon receipt of the Application for Benefits, determine financial eligibility the same as for initial eligibility. See Section 389.61, Initial Determination for a Person Applying for the OSP/AC Waiver Program (for the CAO) steps 3 through 5.
 - Continue eligibility if the person remains financially eligible.
 - Close MA if person no longer meets financial requirements. Send the notice for closure effective the next semi-monthly issuance day following the 10-day period.
158. Review the person's eligibility for food stamp benefits. See Food Stamp Handbook, **Chapter 511**, Living Arrangements.

REMINDER: A person whose income exceeds the gross income limit in 389 Appendix B may be eligible

for AC Waiver Services in the MNO category only if he has high medical expenses and can spenddown.

389.63

ANNUAL REASSESSMENT FOR MEDICAL ELIGIBILITY

The person in the OSP/AC Waiver must continue to need AC services and meet the level of care required under the Waiver Program.

The AC Provider is responsible for the annual reassessment. The AC Provider will complete the reassessment based on the same criteria as the initial OPTIONS Assessment.

The annual reassessment for medical eligibility for the OSP/AC Waiver Program is completed as follows:

THE AC PROVIDER WILL:

- 159.** Arrange for the completion of the MA-51.
- 160.** Review the MA-51 for completeness and level of care.
- 161.** Complete the OPTIONS Reassessment.
- 162.** Assist in the completion of the Benefits Review Form or Alternate Redetermination Form, if necessary.
- 163.** Complete Sections 27, 28 and 29 of the MA-51, as appropriate, and sign in Section 30, as the reviewer.

NOTE: If the person remains eligible for Waiver services, indicate "Recertified for Attendant Care Waiver" in Section 29. On all annual or interim reassessments for the OSP/AC Waiver, the MA-51 replaces the clinical nursing facility yes or no recommendation.

If the AC Provider determines at any time that a person can no longer be maintained safely in the community, the AC Provider will arrange for an interim recertification review.

- 164.** Forward the completed MA-51, the person's Benefit Review Form or Alternate Redetermination Form and necessary documentation to the CAO.

THE CAO WILL:

165. Upon receipt of the annual or interim recertification form, review the information provided by the AC Provider.

- If the form states that the person is recertified for the OSP/AC Waiver, continue the OSP/AC Waiver Program if the person is financially eligible.

NOTE: On all annual or interim reassessments for the OSP/AC Waiver, the CAO will accept the MA-51 in lieu of the clinical nursing facility yes or no recommendation.

- If the person is not recertified for the OSP/AC Waiver, close MA for the Waiver Program. Send the notice of closure effective the next issuance day following the 10-day period. Send the notice to the person and the AC Provider. Determine eligibility for continued MA according to continuing NMP including Healthy Horizons, then MNO requirements.

166. If the AC Provider, the person and the person's physician determine that the person can no longer be safely maintained at home under the OSP/AC Waiver, close the OSP/AC Waiver Program case. If the person seeks nursing facility placement, the CAO will open the case as a continuing NMP-MA including Healthy Horizons or continuing MNO-MA case if the person is eligible. If the person enters a nursing facility in another county, transfer the case to the new CAO.

REMINDER: If the OSP/AC Waiver Program person enters a nursing facility, the OBRA-ID and, if necessary, the OBRA-EV forms must be completed.

389.64 CHANGES IN WAIVER ELIGIBILITY

The AC Contractor and the Waiver person are responsible for reporting all changes in the Waiver person's income, resources, and circumstances to the CAO.

If a change is reported for a person who is not an SSI recipient, the CAO will review the income and resources of the person. Employed persons, through the AC Provider, will provide

verification of gross earnings and impairment-related work expenses to the CAO each month.

NOTE: The CAO will establish a reporting plan with the AC Provider or its designee and the person.

If for any reason the person becomes ineligible for the OSP/AC Waiver Program, the CAO will send the person the appropriate notice advising the person of the date of ineligibility.

NOTE: The CAO will send copies of all notices to the person, the AC Provider and the OSP. Addresses for AC Contractors and OSP may be found in 389, Appendix G.

If the person reapplies for the OSP/AC Waiver Program following a period of ineligibility, the CAO will require a Recertification of Need for OSP/AC Waiver Program regardless of the length of time of person's enrollment in the Waiver Program has been closed.

REMINDER In these situations the AC Provider is responsible for the reassessment. The CAO will accept the MA-51 in lieu of the clinical nursing facility yes or no recommendation.

MEDICAID ELIGIBILITY HANDBOOK

WAIVER PROGRAMS

APPENDIX A

INCOME AND RESOURCES EXCLUDED FOR THE WAIVER PROGRAMS

Resources are excluded for SSI-related, AFDC-related and GA-related children under 21 years of age and SSI-related, AFDC-related and GA-related families with children under 21 years of age.

NOTE: Income of a child's parents is not counted when determining eligibility for a waiver program. Only the child's income is counted.

Exclude resources according to the SSI related provisions of **Chapter 340**, Resources. Exclude income according to the SSI related provisions of **Chapter 350**, Income.

Effective July 30, 1994, CAOs **MUST** apply the look-back periods and transfer of assets (income and resources) requirements, as changed by OBRA 93, to assets transferred for less than fair market value.

Exclude the following items as income or as a resource:

- Income and resources of the parent or spouse of the waiver client.
- Replacement of lost, damaged, or stolen excluded resources. Do not count cash, including any interest earned on the cash, or in-kind replacement received from any source for purposes of repairing or replacing an excluded resource. This exclusion applies if the cash, and the interest, is used to repair or replace the excluded resource within 9 months of the date the person received the cash. Any of the cash and interest that is not used to repair or replace the excluded resource will be counted as a resource beginning with the month after the 9-month period expires. The initial 9-month time period will be extended for up to an additional 9 months if the person had good cause for not replacing or repairing the resource. If the person changes his intent to repair or replace the excluded resource, funds previously held for replacement or repair will be counted effective with the date the person reports the change of intent.

- Income tax refunds. An amount refunded on income taxes.
- Payments by credit life or credit disability insurance policies. Payments made under a credit life or credit disability insurance policy are issued to, or on behalf of, borrowers who die or become disabled. The insurance covers the payment of loans or installment purchases which were the legal obligation of the deceased or disabled person. To qualify for the exclusion, the payments must be made directly to the loan company or mortgage company and cannot be available to the client for the purpose of meeting his basic needs.
- Repayment of a loan. Money received from another party in repayment of a loan. Interest received on the money loaned is counted as income.
- Bill paid for client or his spouse. A bill paid by a third party for an item other than food, clothing, or shelter.
- Replacement income. Income received as a replacement of income lost, stolen, or destroyed.
- Weatherization assistance.
- Medical assistance co-payments. A refund to the client authorized as a rebate for co-payments the client made in excess of the maximum charges allowed under the Department's co-payment program.
- Veteran's aid and attendance and housebound allowance. The aid and attendance and housebound portion of a veteran's benefit. See **Chapter 378, Verification, Appendix B**, to determine the amount to be excluded.
- Borrowed money.
- Medical care and services. Exclude if they are:
 - given free of charge or paid for directly to the provider by another person;
 - room and board received during a medical confinement;
 - assistance provided in cash or in-kind including food, clothing, or shelter under a federal, state, or local government program whose purpose is to provide medical care or services including vocational rehabilitation;
 - in-kind assistance except food, clothing, or shelter provided under a nongovernmental program whose purpose is to provide medical care or medical services;

- cash provided by any nongovernmental medical care or medical services program or under a health insurance policy; or

EXCEPTION: Do not exclude cash to cover food, clothing, or shelter if the cash is either repayment for a program approved service already paid for by the client or a payment restricted to the future purchase of a program approved service.

- direct payment of the client's medical insurance premiums by anyone on behalf of the client.

■ Social Services. Exclude if they are:

- cash or in-kind assistance provided under a federal, state, or local government program whose purpose is to provide social services including vocational rehabilitation;

NOTE: Do not exclude the cash or in-kind payment if the client receives it in return for services performed.

- in-kind assistance provided under a nongovernmental program whose purpose is to provide social services;

EXCEPTION: This does not apply to in-kind assistance in the form of food, clothing, or shelter.

- cash provided by a nongovernmental social services program, such as, but not limited to, cash provided by a private social services agency to a client for homemaker, attendant care, and/or chore services.

EXCEPTION: Do not exclude cash to cover food, clothing, or shelter if the cash is either repayment for program approved services already paid by the client or a payment restricted to the future purchase of a program approved service.

- Receipt of certain noncash items. Exclude noncash items other than food, clothing, or shelter if they are retained.

- Assistance for the homeless.
-

MEDICAID ELIGIBILITY HANDBOOK

WAIVER PROGRAMS

APPENDIX B

INCOME AND RESOURCE LIMITS FOR THE WAIVER PROGRAMS

EFFECTIVE 1/1/01

The CAO does not apply these limits or determine income or resource eligibility or a patient pay amount if the Waiver applicant or participant receives SSI.

EXCEPTION: The CAO will use these limits to determine if an applicant for the MA 0192 Waiver Program who is receiving MNO is eligible to receive NMP.

GROSS INCOME LIMIT:

One person \$1,593 per month

The person is eligible if his total gross countable income is equal to or less than the limit. This special MA income limit is based on 300% of the current Federal Benefit rate (current rate = \$531)

RESOURCE LIMIT:

One person \$2,000

The person is eligible if his total countable resources are equal to or less than the limit. See **Chapters 340**, Resources, and **389, Appendix A**, to determine countable resources for SSI related MA.

MEDICAID ELIGIBILITY HANDBOOK

INCOME

CITATION

350.6 EXCLUDED INCOME - TANF/GA AND SSI-RELATED

The CAO will exclude certain income when determining eligibility for MA.

The CAO will verify and record the reason for excluding the income. It may be necessary to verify the amount of the excluded income.

The following income is excluded for TANF-related/GA-related and SSI-related categories of MA:

1. INCOME TAX REFUNDS

55 Pa. Code
181.81(a)(2) SSI
178.4(g)
TANF/GA

A federal, state, or local tax refund is considered a resource and is treated as an unearned lump sum payment. See **Chapter 357**, Lump Sum.

A federal tax refund may include a year-end EIC payment. The EIC portion of the refund is excluded for TANF-related/GA-related categories, but is counted as an earned lump sum payment for SSI-related categories. See **Chapter 357**, Lump Sum.

2. EDUCATIONAL ASSISTANCE

Student financial assistance for educational expenses from scholarships, grants and loans received by a child under age 18 or under age 19 if a full-time student in secondary school or the equivalent level of vocational or technical training is excluded. Any

55 Pa. Code
181.81(a)(9) SSI
181.262
TANF/GA

portion of the financial assistance that is made available solely for basic living needs such as housing and food is not excluded.

NOTE: For a child age 19 to 21 receiving educational assistance. See Chapter 314, Students.

55 Pa. Code
181.81(a)(8) SSI
181.263(a)(2)
TANF/GA

3. MEDICAL ASSISTANCE CO-PAYMENT REFUNDS

The CAO will not count a refund from the Department because the client paid more for medical assistance services than the amount required as a co-payment.

4. JOB TRAINING PARTNERSHIP ACT (JTPA)

The CAO will not count money for the Job Training Partnership Act of 1982 for specific needs or supportive services such as child care, transportation, or meals.

55 Pa. Code
181.121(a)(8)
SSI
181.264(a)(8)
TANF/GA

5. RELOCATION ASSISTANCE AND REAL PROPERTY ACQUISITIONS

The CAO will not count money received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

55 Pa. Code
181.121(a)(7)
SSI
181.264(a)(7)
TANF/GA

6. SENIOR CITIZEN REBATE AND ASSISTANCE ACT

The CAO will not count money received under provisions of the Senior Citizen Rebate and Assistance Act originally enacted 3/11/71.

55 Pa. Code
181.123(a)(13)
SSI
181.264(a)(13)
TANF/GA

EXAMPLE: Property Tax/Rent Rebates.

7. FOSTER CARE AND ADOPTION SUBSIDY PAYMENTS

55 Pa. Code
181.123(a)9) SSI
181.264(a)14)

& 15)
TANF/GA

The CAO will not count money paid by a public or private placement or child care agency to the client for providing foster care for a child. Money received through Title IV-E of the Social Security Act or Article VII of the Public Welfare Code is restricted for the needs of the foster child.

The CAO will not count maintenance subsidies received under the Adoption Opportunity Act.

8. FOOD ASSISTANCE AND FREE SCHOOL LUNCHES

55 Pa. Code
181.121(a)(3)
SSI
181.264(a)(3)
TANF/GA

The CAO will not count the value of supplemental food assistance from Women's, Infants' and Children's (WIC) program and the National School Lunch Act.

9. FOOD STAMP PROGRAM BENEFITS

55 Pa. Code
181.121(a)(1)
SSI
181.264(a)(1)
TANF/GA

The CAO will not count the value of food stamps which a client receives.

10. USDA SURPLUS FOOD DONATION

55 Pa. Code
181.1219(a)(2)
SSI
181.264(a)(2)
TANF/GA

The CAO will not count the value of surplus commodities donated by the United States Department of Agriculture.

11. HOME PRODUCE

55 Pa. Code
181.123(a)(3)
SSI
181.263(a)(9)
TANF/GA

The CAO will not count the value of home produce, provided it is used by the applicant/recipient group for its consumption.

12. HOUSING SUBSIDIES

55 Pa. Code
181.121(a)(6)
SSI
181.264(a)(6)
TANF/GA

The CAO will not count Section 8 housing or utility subsidies, rehabilitation grants, or other Federal housing subsidies received under the US Housing Act of 1937, the National Housing Act, Section 101 of the Housing and Urban Development Act of 1965, Title V of the Housing Act of 1949, and the Housing and Community Development Act of 1974.

13. LIHEAP

55 Pa. Code
181.121(a)(6)
SSI
181.264(a)(4)
TANF/GA

The CAO will not count benefits for home energy assistance received under the Low Income Home Energy Assistance Program.

14. WEATHERIZATION

55 Pa. Code
181.81(a)(7) SSI
181.264(a)(17)
TANF/GA

The CAO will not count weatherization services or assistance payments.

15. HOME ENERGY ASSISTANCE BENEFITS

55 Pa. Code
181.123(a)(11)
SSI
181.264(a)(17)
TANF/GA

The CAO will not count home energy assistance (HEA) benefits. These benefits are furnished in-kind by a private, non-profit organization or furnished as cash or in-kind assistance by a certified supplier of home heating oil or gas, a certified entity providing home energy whose revenues are primarily derived

on a rate-of-return basis and regulated by the Pennsylvania Public Utility Commission or a certified municipal utility providing home energy. HEA benefits may include payments for heating or cooling, storm doors, weatherization services, blankets, and the like. HEA benefits do not include food or clothing.

NOTE: If the CAO is unable to determine if a vendor is certified or an organization is registered with the Department, it will contact the Area Manager. If the Area Manager advises that the vendor or organization is not registered, the CAO will count the HEA benefit as unearned income.

16. SUPPORT OR MAINTENANCE ASSISTANCE BENEFITS

55 Pa. Code
181.123(a)(11)
SSI
181.264(a)(18)
TANF/GA

The CAO will not count in-kind support or maintenance assistance (SMA) benefits provided by a private, non-profit organization. SMA benefits include in-kind provisions of food, clothing, temporary emergency shelter, furniture, appliances, and the like.

17. PAYMENTS MADE TO VOLUNTEERS

55 Pa. Code
181.121(a)(15)
SSI
181.264(a)(11)
TANF/GA

The CAO will not count payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and any other programs established under Subchapter I and II of the Domestic Volunteer Services Act of 1973, including VISTA, Service Learning Programs, and Special Volunteer Programs.

18. BORROWED MONEY

55 Pa. Code
181.81(a)(10)
SSI
181.263(a)(8)
TANF/GA

The CAO will not count money obtained by borrowing.

NOTE: Reverse mortgage payments, whether lump sum, monthly installment or combination of both, are considered loans in the month of receipt. There is no exclusion for the resource if the loan proceeds are retained beyond the month of receipt.

19. RECEIPTS FROM CONVERSION OF A RESOURCE

55 Pa. Code
181.81(a)(1) SSI
178.1(i)
TANF/GA

The CAO will not count income from the conversion of a resource, such as the sale, exchange, or replacement of a resource. This includes the cash or in-kind item that is provided to replace or repair an item that was lost, damaged, or stolen.

NOTE: Funds obtained from the conversion of a resource will be counted as a resource.

20. PAYMENTS FROM THE FAMILY CAREGIVER SUPPORT PROGRAM

55 Pa. Code
181.81(a)(12)
SSI
181.263(a)(6)
TANF/GA

The CAO will not count payments made under the Department of Aging's Family Caregiver Support Program. These payments are made as reimbursement for the following:

- Ongoing caregiver expenses.
- Assistance devices and home modifications.

21. JAPANESE-AMERICAN AND ALEUT RESTITUTION PAYMENTS

55 Pa. Code
181.121 SSI
181.264
TANF/GA

The CAO will not count payments made under Title I of the Civil Liberties Act of 1988 and Title II of the Aleutian and Pribilof Island Act enacted 8/10/88. This exclusion includes payments to the survivors of Japanese-Americans.

This exclusion continues as long as the payments are

kept separate and identifiable. If the payment is used to purchase real or personal property, the CAO will count the new resource unless excluded. Interest on the payment is counted unless otherwise excluded.

22. AGENT ORANGE SETTLEMENT PAYMENTS

55 Pa. Code
181.121(a)(19)
SSI
181.264(a)(20)
TANF/GA

The CAO will not count payments made from the Agent Orange Settlement Fund or any other fund established due to the settlement of the Agent Orange Product Liability litigation.

23. EARNED INCOME CREDIT (EIC)

55 Pa. Code
181.122(a)(19)
SSI
181.263(a)(11)
TANF/GA

The CAO will not count the advance monthly EIC payment and the year-end EIC payment refunded as part of federal income taxes. The CAO will exclude the payment in the month of receipt and the following month. Any portion remaining after the exclusion period is counted as a resource. EIC payments include the following:

- Supplemental Young Child Credit - This is available at the end of the year to a family with an infant who does not qualify for the dependent care credit. It is refunded in addition to the EIC payment. **and**
- Child Health Insurance Tax Credit - This is a refund of the amount paid by an employee for health insurance premiums if the coverage is for at least one child who is receiving TANF-related MA. It is refunded in addition to the EIC payment.

MEDICAID ELIGIBILITY HANDBOOK

INCOME

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350.7 EXCLUDED INCOME - TANF-RELATED

The following income is excluded for TANF related categories only:

1. FUNDS SUBJECT TO REIMBURSEMENT TO THE DEPARTMENT

The CAO will not count any money for which the client signs a Departmental reimbursement form.

55 Pa. Code
181.263(a)(1)

2. RETROACTIVE CASH ASSISTANCE PAYMENTS

The CAO will not count money authorized to correct underpayments to previous recipients as income in the month paid or the next month.

55 Pa. Code
181.263(a)(3)

NOTE: Any money remaining from the payment is considered a resource in subsequent months.

3. CORRECTIVE ASSISTANCE PAYMENTS

The CAO will not count any retroactive assistance payments received as a result of a prehearing conference, a fair hearing decision, or a court order.

55 Pa. Code
181.263(a)(4)

NOTE: A retroactive payment is excluded only for the month that is received and the following month. Any money left after the second month is added to the other resources. The client must provide verification of how and when the money was used.

4. REFUND OF ASSIGNED SUPPORT PAYMENTS

- an assigned court order; or
- a voluntary support payment being collected by the Commonwealth.

5. SUPPORT

The CAO will not count the first \$50 per applicant/recipient group of total current court ordered or voluntary support or alimony received each month. Payment on arrearages is not subject to the \$50 disregard.

55 Pa. Code
181.264(a)(16)

6. DONATIONS FROM PUBLIC OR PRIVATE AGENCIES

The CAO will not count money, goods, or services a client receives from a public or private agency or organization.

55 Pa. Code
181.263(a)(6)

7. DONATIONS FROM INDIVIDUALS

The CAO will not count in-kind goods or services provided by a person to an applicant/recipient group or third party payments made to a vendor on behalf of the applicant/recipient group.

55 Pa. Code
181.263(a)(7)

8. CONGREGATE MEALS

The CAO will not count benefits received under Part C of the Congregate Nutrition Service of the Older Americans Act of 1965.

55 Pa. Code
181.264(a)(12)

9. EARNED INCOME CREDIT (EIC)

The CAO will not count the advance monthly payment or year-end EIC amount.

55 Pa. Code
181.263(a)(11)

10. EXPERIMENTAL HOUSING ALLOWANCE PROGRAM

The CAO will not count payments from the Experimental Housing Allowance Program (EHAP) and made under annual contribution contracts entered into prior to January 1, 1975. The CAO will not count payments covered by the United States Housing Act of 1937.

55 Pa. Code
181.264(a)(5)

11. DAY CARE PAYMENTS

The CAO will not count money received from providing day care for children in an approved family day care home.

55 Pa. Code
181.263(a)(10)

NOTE: An approved family day care home is one in which child care is provided at any one time to four, five, or six children unrelated to the operator. The home must have a certificate of registration issued by DPW's regional office of child day care which specifies that the home is an approved day care home.

12. ALASKA NATIVE CLAIMS

The CAO will not count money received under the Alaska Native Claims Settlement Act.

55 Pa. Code
181.264(a)(9)

13. PAYMENTS TO INDIAN TRIBES

The CAO will not count the following payments to Indian tribes:

55 Pa. Code
181.264(a)(10)

- Funds distributed per capita to or held in trust for, members of any Indian tribe under the act of 3/18/72 (Pub.L. 92-254) and the act of 10/17/73 (Pub. L. 93-134).
- Receipts distributed to members of certain Indian tribes referred to in 25 U.S.C.A Section 459d (effective October 17, 1975).
- Interest and investment income accrued on Indian Judgement funds held in trust under the Per Capita Act effective January 12, 1983.

The CAO will not count a loan, such as, but not limited to, a car loan or a personal loan from non-LRR sources. Occasional nonrecurring small amounts of money given as a gift is not counted, regardless of whether the giver is or is not an LRR, if the amount of the gift does not exceed \$50 per person in a calendar quarter.

55 Pa. Code
181.263(a)(8)

NOTE: A gift received by a member in the applicant/recipient group may be divided among all the members in the applicant/recipient group if the

gift is intended for the entire applicant/recipient group.

NOTE: If the gifts exceed \$50 per person per calendar quarter, only the amount of the gifts over \$50 per person is treated as a resource in the month received.

MEDICAID ELIGIBILITY HANDBOOK

INCOME

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350.8 EXCLUDED INCOME - SSI-RELATED

The following income is excluded for SSI-related categories only:

1. PAYMENTS TO ALASKAN NATIVES

The CAO will not count tax exempt payments received under Section 21(a) of the Alaska Native Claims Settlement Act. 55 Pa. Code
181.121(a)(11)

The CAO will not count money received under a program established prior to July 1, 1973 which provides payments based solely on length of residence in Alaska and attaining age 65. The Alaska Longevity Bonus is excluded under Section 1612(b)(2)(B) of the Social Security Act. 55 Pa. Code
181.121(a)(12)

2. PAYMENTS TO INDIAN TRIBES

The CAO will not count the following payments to Indian tribes: 55 Pa. Code
181.121(a)(13)

- The Blackfeet and Gros Ventre Tribes under the act of 3/19/72 (Pub. L. 92-254).
- The Grand River Band of Ottawa Indians under the act of 10/18/76 (Pub. L. 94-540).
- The Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation under Section 2 of the act of 10/10/78 (Pub. L. 95-433).
- Those tribes or groups under Section 7 of the act of 10/9/73 (Pub. L. 93-134).

3. OLDER AMERICANS ACT BENEFITS

The CAO will not count any money, other than wages, received under the Older Americans Act of 1965.

55 Pa. Code
181.121(a)(16)

4. RETROACTIVE SSI AND RSDI PAYMENTS

The CAO will not count retroactive SSI or RSDI payments for six calendar months after the month in which the retroactive payment is received.

55 Pa. Code
181.121(a)(17)

NOTE: If a portion of the payment remains after the end of the six month period, it is counted as a resource.

5. EARNED INCOME LESS THAN \$10

The CAO will not count earned income which is less than \$10 monthly, from a single source, received once in a quarter, and received too infrequently or irregularly to be reasonably anticipated.

55 Pa. Code
181.22

EXAMPLE: Mrs. Nguyen does housecleaning on a regular basis and earns \$80/wk. On 11/20, a customer pays her \$10 for some additional cleaning. On 12/22, the same customer again requests additional cleaning and pays \$10.

The CAO excludes the \$10 received 11/20, but counts the \$10 received 12/22 since she received the earned income more than once in a quarter.

6. DISASTER RELIEF ASSISTANCE

The CAO will not count, for 18 months, money received as a result of a catastrophe declared as a major disaster by the President under the Disaster Relief Act of 1974 or another federal law. However, all of the following conditions must be met:

55 Pa. Code
181.123(a)(4)

- The person was living in his own home at the time of the disaster but was forced to leave because of the catastrophe.
- The person began to receive the disaster assistance within 30 days after the last day of the catastrophe. **and**

- The person received the disaster assistance while living in any residential facility, including a private household maintained by another person.

The income exclusion begins on the date the disaster assistance is received and ends on the last day of the 18th full month following the month it was received.

The CAO will:

- verify the amount of the money and the date of receipt;
- exclude any money received for a period of 18 full calendar months beginning the month the first payment was received;
- create an alert for the 17th month to review the applicant/recipient group's circumstances;
- if any unused cash remains after the 19th month, count the cash as a resource.

EXAMPLE: As a result of a flood on 9/10 which was declared a disaster by the President, Mr. Burke receives unemployment compensation paid under the Disaster Relief Act of 1974. He receives \$60/wk. beginning 10/1.

The CAO excludes the income beginning 10/1/90 and ending 3/31/92.

7. INTEREST ON DISASTER RELIEF ASSISTANCE

The CAO will not count interest earned on disaster relief assistance for a period beginning the date the assistance was received and ending on the last day of the ninth full month following the month it was received.

181.123(a)(5)

The CAO will extend this period to 18 full months if the client shows good cause for not repairing or replacing the property for which the disaster relief was given. Good cause is established when circumstances beyond the client's control prevent the replacement of a home or other kinds of property within the nine month period.

NOTE: The client must provide verification from at least two contractors to indicate that he has made a reasonable effort to have the damaged property repaired or replaced within the initial period. If the disaster has resulted in a large volume of work needed in the area, the CAO may contact area contractors to determine the minimum time needed to complete the work. An extension is granted only if the client indicates that he still intends to make the repairs or replacement. The CAO will retain written verification or record any information obtained by verbal contact.

The CAO will:

- extend the period an additional nine calendar months if good cause is established;
- create an alert for the 17th month to review the applicant/recipient group's circumstances;
- if the client changes his intent to make the repairs or replacement during the extended period, count any money still held for repairs, replacement, or contracting as income in the month the client reports the change in intent; **and**
- if any unused funds, including interest, remain after the 19th month, count the cash as a resource.

8. GERMAN REPARATION PAYMENTS

The CAO will not count payments made to survivors of the Holocaust under the Republic of Germany's Federal Law for Compensation of National Socialist Persecution, also known as the German Restitution Act. These payments may be made periodically or as a lump sum.

55 Pa. Code
181.123(a)(6)

9. UNEARNED INCOME LESS THAN \$20

The CAO will not count unearned income which is less than \$20 monthly and which is received too infrequently or irregularly to be reasonably anticipated. If the amount exceeds \$20 or is received more than once in a calendar quarter, the full amount is counted as income.

55 Pa. Code
181.123(a)(7)

10. PAYMENTS BY A STATE BASED SOLELY ON RESIDENCE

The CAO will not count periodic payments made by a state based solely on length of residence and attainment of age 65, under a program established before July 1, 1973.

55 Pa. Code
181.123(a)(8)

11. INTEREST ON BURIAL FUNDS

The CAO will not count interest earned on a burial fund which has been excluded as a resource, if the interest accumulates as part of the burial fund. See **Chapter 340, Resources**.

55 Pa. Code
181.123(a)(10)

NOTE: If this interest income is withdrawn, the CAO will count it as income.

12. REDUCED UNEARNED INCOME TO RECOVER AN OVERPAYMENT

If unearned income is reduced to recover an overpayment, the CAO will count the net income *if* the overpaid amount was counted in determining eligibility for cash or MA during the time the overpayment occurred.

55 Pa. Code
181.123(a)(14)

The CAO will:

- verify the monthly amount of the overpayment and the dates it occurred;
- verify the amount being deducted as repayment from the current benefit;
- determine the total amount of the overpayment for the months the client was receiving cash or MA when the overpayment occurred;
- divide the amount of the overpayment previously counted by the current amount of the reduction in benefits to determine the number of months it can be excluded; and
- create an alert to count the full benefit, including the reduction, when the total overpayment which was previously counted is excluded.

13. ADVANCE PAYMENTS AGAINST EXPENSES OF OBTAINING INCOME

The CAO will not count a lump sum advance payment made to cover the expenses to obtain income.

55 Pa. Code
181.123(a)(15)

14. WAGES, ALLOWANCES, OR TRANSPORTATION REIMBURSEMENT UNDER TITLE VI OF THE REHABILITATION ACT

The CAO will not count money received by an eligible handicapped person for wages, allowances, or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis. The person must be employed in a project under Title VI of the Rehabilitation Act of 1973.

55 Pa. Code
181.121(a)(10)

15. PAYMENTS BY CREDIT LIFE OR DISABILITY INSURANCE POLICIES

The CAO will not count payments made under a credit life or disability insurance policy issued to, or on behalf of, borrowers to cover payments on loans or installment purchases in the event of death or disability of the client. These payments are made directly to the loan or mortgage company and are not available to the client.

55 Pa. Code
181.81(a)(3)

16. REPAYMENT OF A LOAN

The CAO will not count money received from another individual in repayment of a loan.

55 Pa. Code
181.81(a)(4)

NOTE: Any interest received on the money loaned is counted as income.

17. BILL PAID BY A THIRD PARTY

The CAO will not count the payment on a bill for a client by a third party.

55 Pa. Code
181.81(a)(5)

18. REPLACEMENT INCOME

The CAO will not count money received to replace income that was lost, stolen, or destroyed.

55 Pa. Code
181.81(a)(6)

EXAMPLE: A client's paycheck is stolen before he

is able to cash it and his employer issues a replacement check. The CAO counts the original paycheck as earned income in the month of receipt and excludes the replacement check.

19. VA AID AND ATTENDANCE AND HOUSEBOUND ALLOWANCE

The CAO will not count the portion of the VA benefit which is specified as the Aid and Attendance or Housebound allowance. For procedures to verify Aid and Attendance, see **Chapter 378, Verification, Appendix B.**

55 Pa. Code
181.81(a)(9)

NOTE: Any portion of the Aid and Attendance benefit remaining after the month of receipt is counted as a resource.

20. SOCIAL SERVICES

The CAO will not count money obtained from any of the following social services:

55 Pa. Code
181.81(a)(12)

- Cash or in-kind income given to a client under a federal, state, or local government program whose purpose is to provide social services including vocational rehabilitation.
- In-kind assistance provided under a nongovernmental program whose purpose is to provide social services.
- Money provided by a nongovernmental social services program to be used to repay program approved services already paid by the client or to be used to pay for such services in the future. Examples of these services include, but are not limited to, homemaker services, attendant care, and chore services.

21. ASSISTANCE FOR THE HOMELESS

The CAO will not count money given as assistance to a homeless client.

55 Pa. Code
181.81(a)(14)

22. ASSISTANCE TO PREVENT FUEL CUTOFFS

The CAO will not count money received under the Energy Emergency Crisis Assistance Program or the Emergency Energy Conservation Services program under Section 222(a)5) of the Economic Opportunity Act of 1964.

55 Pa. Code
181.121(a)(4)

23. PROPERTY TAX REFUND

The CAO will not count money received from a public agency as a refund of taxes paid on property.

55 Pa. Code
181.123(a)(1)

24. MEDICAL CARE AND SERVICES

The CAO will not count medical care and services if they are:

55 Pa. Code
181.81(a)(11)

- free or paid directly to the provider by another person;
- room and board received during a period of confinement;
- provided as cash or in-kind income (including food, clothing, and shelter) under a federal, state, or local program, whose purpose is to provide medical care or services including vocational rehabilitation;
- cash provided by a nongovernmental medical care or medical service program under a health insurance policy if it is a repayment for program approved services already paid for by the client or the repayment is restricted to the future purchase of a program approved service;

EXAMPLE: The CAO will not count money paid to a client from his insurance company to reimburse him for payments for prescription drugs.

- direct payment of medical insurance premiums by anyone on behalf of the client;
- reimbursement from a health insurance policy for medical expenses previously paid by a client; and

- in-kind assistance provided by a nongovernmental program whose purpose is to provide medical care or medical services.

25. RECEIPT OF CERTAIN NONCASH ITEMS

55 Pa. Code
181.82(a)(13)

The CAO will not count noncash items which are excluded as an MA resource.

26. GUARDIAN FEES

The CAO will not count the amount spent by the client on court-ordered guardian fees if having a guardian is a condition of receiving the income.

55 Pa. Code
181.134

27. INTEREST FROM CERTAIN BURIAL SPACE ARRANGEMENTS

The CAO will not count interest earned on agreements representing the purchase of excluded burial spaces if the interest is left to accumulate. Interest not left to accumulate is counted as interest income.

55 Pa. Code
140.271(a)(20)

28. SSA AUTHORIZED REPRESENTATIVE PAYEE FEE

The CAO will not count the monthly fee paid to a qualified organization authorized by the Social Security Administration to receive the client's monthly RSDI or SSI benefit or Federally administered state supplementary payment. The fee is the lesser of 10% of the monthly benefit or \$25 per month.

55 Pa. Code
140.271(a)(21)

NOTE: If the client is institutionalized, a fee may not be withheld from benefits which must be set aside for the client's personal needs.

29. RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENT

55 Pa. Code
140.271(a)(22)

The CAO will not count the one-time lump sum payment to a person exposed to doses of radiation and determined to have contracted certain diseases after the exposure. Payment is made by the Federal Department of Justice to the person or the person's survivors. Interest earned on the unspent payment is counted as income.

30. VICTIMS COMPENSATION PAYMENTS

55 Pa. Code
140.273(a)(16)

The CAO will not count effective May 1, 1991 payments received from a state-administered victims compensation fund to cover expenses incurred or losses suffered as the result of a crime.

NOTE: Any portion of the payment remaining after the calendar month of receipt is also excluded as a resource for nine calendar months following the calendar month of receipt.

31. STATE AND LOCAL RELOCATION ASSISTANCE

55 Pa. Code
140.273(a)(17)

The CAO will not count a relocation assistance payment made by a state or local government in the month of receipt. Any portion of the payment remaining is also excluded as a resource for the nine months following the month of receipt.

32. AUSTRIAN REPARATION PAYMENTS

55 Pa. Code
140.273(a)(18)

The CAO will not count payments made based on wage credits under Paragraphs 500-506 of the Austrian General Social Insurance Act. These payments are made to persons who suffered imprisonment or unemployment or were forced to flee Austria during the period March 1933 to May 1945 for political, religious or ethnic reasons. The CAO will count the interest earned on payments retained as income.

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Issued: May 1, 2001

MEDICAID ELIGIBILITY HANDBOOK

RESOURCES

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340.8 RESOURCE EXCLUSIONS

The CAO will exclude certain resources when determining eligibility for MA.

55 Pa. Code
178.1(b)

340.81 EXCLUDED RESOURCES - GA AND SSI-RELATED

The following resources are excluded for both GA and SSI related categories:

1. FOOD STAMP BENEFITS

The CAO will not count the value of food stamps which a client receives.

55 Pa. Code
178.61(d) SSI
178.161(a)4) GA

2. LIHEAP

The CAO will not count benefits for home energy assistance received under the Low Income Home Energy Assistance Program.

55 Pa. Code
178.80 SSI
178.161(a)8) GA

3. PENNSYLVANIA UNIFORM GIFTS TO MINORS ACT (PUGMA)

The CAO will not count a gift made to a person under age 21 under PUGMA until the person reaches age 21. The gift may be made under the following conditions:

55 Pa. Code
178.78 SSI
178.161(a)13)
GA

- The donor must be at least age 18.

- The gift must be in an irrevocable form.
- The gift and any earnings from the gift must be under the control of a custodian. **and**
- The control cannot be transferred to the minor until he reaches age 21.

The CAO will count any disbursements by the custodian to the beneficiary as income in the month disbursed. If any of the disbursed funds remain in the next month, the CAO will count the remaining amount as a resource unless the person is under age 21.

When a person reaches age 21, any funds remaining from a gift made previously under PUGMA are counted as a resource.

4. HOUSEHOLD GOODS AND PERSONAL EFFECTS

The CAO will not count the value of household goods and personal effects such as the following:

55 Pa. Code
178.66 SSI
178.161(a)1 GA

- Household furnishings, major appliances, items used to provide, equip, and maintain a household.
- Personal items of limited value including clothing, jewelry, children's toys, family heirlooms, items of personal care, musical instruments, and hobby items.
- Any items required because of a person's physical condition, such as, but not limited to, prosthetic devices, dialysis machines, motorized wheelchairs, hospital beds, and similar items.
- Farm animals for domestic use, pets, and farm equipment and farm animals needed for employment.
- Equipment needed for employment, rehabilitation or self-care.

55 Pa. Code
178.66 SSI
178.161(a)1 GA

5. HOME ENERGY ASSISTANCE BENEFITS

The CAO will not count home energy assistance (HEA) benefits. HEA benefits include, but are not limited to, payments for heating and cooling, storm doors, weatherization service, and blankets.

55 Pa. Code
178.79 SSI
178.161(a)6) GA

6. SUPPORT OR MAINTENANCE ASSISTANCE BENEFITS

The CAO will not count in-kind support or maintenance assistance (SMA) benefits provided by a private, nonprofit organization. SMA benefits include in-kind provisions of food, clothing, temporary emergency shelter, furniture, appliances, and the like.

55 Pa. Code
178.79 SSI
178.161(a)7) GA

7. MOTOR VEHICLE

The CAO will not count one motor vehicle. See Section 340.5, Motor Vehicles.

55 Pa. Code
178.67 SSI
178.161(a)2) GA

8. BURIAL SPACE

The CAO will not count certain burial spaces. See Section 340.71, Burial Spaces.

55 Pa. Code
SSI
178.161(a)9) GA

9. REVOCABLE BURIAL RESERVE

The CAO will not count a revocable burial reserve up to \$1,500 in value. See Section 340.722, Revocable Burial Reserves.

55 Pa. Code
SSI
178.161(a)10)
GA

10. IRREVOCABLE BURIAL RESERVE

The CAO will not count an irrevocable burial reserve.

55 Pa. Code
178.72
SSI
178.161(a)11)
GA

11. LIFE INSURANCE

The CAO will not count term insurance or other life insurance which does not accumulate a cash value. See Section 340.4, Life Insurance.

55 Pa. Code
178.70 SSI
178.161(a)12)
GA

The CAO will not count life insurance up to a maximum face value of \$1,500 for each insured person. See Section 340.4, Life Insurance.

55 Pa. Code
178.69 SSI
178.161(a)14)
GA

12. REAL PROPERTY USED AS A PRINCIPAL PLACE OF RESIDENCE

The CAO will not count resident property owned by an applicant/recipient. See Section 340.62, Resident Property.

55 Pa. Code
178.62 SSI
178.162 GA

13. JAPANESE-AMERICAN AND ALEUT RESTITUTION PAYMENTS

The CAO will not count payments made under P.L. 100-383, Title I - Civil Liberties Act of 1988 and Title II - The Aleutian and Pribilof Island Act enacted 8/10/88. This exclusion includes payments to the survivors of Japanese Americans.

55 Pa. Code
178.61 SSI
178.161 GA

The exclusion continues as long as the payments are kept separate and identifiable. If the payment is used to purchase real or personal property, the CAO will count the new resource unless it can be excluded. Interest on the payment is counted unless otherwise excluded.

14. AGENT ORANGE SETTLEMENT PAYMENTS

The CAO will not count payments made from the Agent Orange Settlement Fund or any other fund established due to the settlement of the Agent Orange Product Liability litigation.

55 Pa. Code
178.83 SSI
178.161(a)16)
GA

15. EARNED INCOME TAX CREDIT

The CAO will not count the advance monthly EITC payment and the year-end EITC payment refunded as part of Federal income taxes. The CAO will exclude the payment in the month of receipt and the following month. Any portion remaining after the exclusion period is counted as a resource. EITC payments include the following:

OBRA 1990
(Public Law
101-508)

- Supplemental Young Child Credit - This is available at the end of the year to a family with an infant who does not qualify for the dependent

care credit. It is refunded in addition to the EITC payment. **and**

- Child Health Insurance Tax Credit - This is a refund of the amount paid by an employe for health insurance premiums if the coverage is for at least one child who is receiving TANF-related MA. It is refunded in addition to the EITC payment.

340.82 EXCLUDED RESOURCES - GA-RELATED

The following resources are excluded for GA-related categories only:

1. RETROACTIVE ASSISTANCE PAYMENTS

The CAO will not count any retroactive assistance payments received as a result of a prehearing conference, a fair hearing decision, or a court order.

55 Pa. Code
178.161(a)3)

NOTE: A retroactive payment is excluded only for the month that it is received and the following month. Any money left after the second month is added to the other resources. The client must provide verification of how and when the money was used.

2. PERSONAL PROPERTY OF AN SSI OR SBP RECIPIENT

The CAO will not count the personal property of an SSI or an SBP recipient even if the SSI or SBP recipient is an LRR to a member of the applicant/recipient group.

55 Pa. Code
178.161(a)5)

3. REAL PROPERTY OWNED BY AN SSI OR SBP RECIPIENT

The CAO will not count real property owned by an SSI or an SBP recipient even if the SSI or SBP recipient is an LRR to a member of the applicant/recipient group.

55 Pa. Code
178.162

4. EDUCATIONAL SAVINGS ACCOUNTS

An educational savings account at a bank or other

62 P.S. 408.2

financial institution is exempt. This educational savings account must be in an interest bearing account. Any tuition account or college savings bonds purchased under the Tuition Account Program and college savings bonds are also exempt.

- This account must be established only to pay for tuition, books and any incidental expenses at an approved postsecondary or vocational school, community college, college or university, must be in a separate account and must be clearly identified "for educational purposes" to allow for monitoring of deposits and withdrawals.
- Any funds deposited in the account and any interest earned by the account is exempt for as long as the funds remain in the account.
- Any funds deposited in the account must be from earned income only.
- Any amount including interest withdrawn from the account and used for educational expenses is exempt from consideration.
- The amount and dates of deposits and withdrawals must be verified through bank or financial institution statements and through documents from the educational institution to determine that the funds are being saved and spent on educational activities.
- Any funds that are withdrawn and spent for things other than education are considered a resource in the month(s) withdrawn and used.

Overpayments, if they are determined to have occurred, should be submitted to OFAIR.

340.83 EXCLUDED RESOURCES - SSI RELATED

The following resources are excluded for SSI related categories only:

1. RECREATIONAL EQUIPMENT

The CAO will not count any equipment used for recreation, such as an all-terrain vehicle, dune buggy, boat, snowmobile, or motorcycle.

55 Pa. code
178.66

2. USDA SURPLUS FOOD DONATION

The CAO will not count the value of surplus commodities donated by the United States Department of Agriculture.

55 Pa. Code
178.61(j)

3. HOUSING ASSISTANCE

The CAO will not count Section 8 housing or utility subsidies, rehabilitation grants, or other federal housing subsidies paid under the United States Housing Act of 1937, the National Housing Act, Section 101 of the Housing and Urban Development Act of 1965, or Title V of the Housing Act of 1949, as provided by Section 2(h) of the Housing Authorization Act of 1976.

55 Pa. Code
178.61(k)

4. PAYMENTS TO VOLUNTEERS

The CAO will not count payments from VISTA, Service Learning Programs, and Special Volunteer Programs. These payments to volunteers are made under Section 404(g) of the Domestic Volunteer Services Act of 1973.

55 Pa. Code
178.61(h)

5. RETROACTIVE PAYMENT UNDER SSI AND TITLE II OF THE SOCIAL SECURITY ACT

The CAO will not count retroactive SSI and SSA benefits for six calendar months after the month in which the retroactive payment is received. The funds do not need to be in a separate account.

55 Pa. Code
178.76

NOTE: The money, if co-mingled with other funds, must be identifiable using items such as personal records or institutional accounts.

EXAMPLE: Joan Fuller received a retroactive SSI payment on 1/16/90. The payment is excluded for six months, beginning on 2/1/90.

The CAO will not exclude under this provision a resource purchased with the money unless that resource is excluded.

If a portion of the payment remains after the end of the six month period, it is counted as a resource.

6. REPLACEMENT ASSISTANCE

The CAO will not count an in-kind replacement assistance received for the purpose of repairing or replacing an excluded resource.

55 Pa. Code
178.75

The CAO will not count assistance to replace an excluded resource that is lost, damaged, or stolen.

The CAO will not count the cash and interest earned on the cash received for repair or replacement for the nine calendar months after the date the cash was received. The initial nine month period may be extended for up to an additional nine months if the client has good cause for not replacing or repairing the resource.

NOTE: The CAO will count as a resource any remaining cash and interest beginning with the month following the end of the nine month period. If the initial nine month period is extended, the CAO will count any remaining cash and interest beginning with the month following the end of the good cause extension period.

If the good cause period is extended and the client changes his intent to repair or replace the excluded resource, the CAO will count the funds as a resource, beginning the month in which he reports.

7. DISASTER RELIEF ASSISTANCE

The CAO will not count, for nine months, money and interest, if any, received as a result of a catastrophe declared as a major disaster by the President under the Disaster Relief Act of 1974 or another Federal law. The nine month period begins on the date the disaster assistance is received and ends on the last day of the ninth full month following the month the cash was received. The CAO will verify the date the money was received and the amount.

55 Pa. Code
178.74

This initial nine month period may be extended to 18 full months if the client shows good cause for not repairing or replacing the property for which the disaster relief was given. Good cause is established when

circumstances beyond the client's control prevent the repair or replacement within the nine month period.

NOTE: The client must present verification from at least two contractors to indicate that he made a reasonable effort to have the damaged property repaired or replaced within the initial period. If the disaster has resulted in a large volume of work needed in the area, the CAO may contact area contractors to determine the minimum time needed to complete the work. An extension is granted only if the client indicates that he still intends to make the repairs.

The CAO will retain the documentation in the record, or note any verbal evidence obtained through personal contact. Establish an alert for a review of the situation before the end of the period.

55 Pa. Code
178.74

The CAO will count as a resource any remaining cash and interest not used to repair or replace destroyed property beginning with the month following the expiration of the nine month or 18 month period.

If the money is spent for something other than the intended purpose, the CAO will determine if there is an overpayment due to excess resources.

8. FOOD ASSISTANCE

The CAO will not count the value of supplemental food assistance from the Women's, Infants', and Children's (WIC) program or the National School Lunch Act.

55 Pa. Code
178.61(e) & (f)

9. FEDERAL LOANS AND GRANTS TO UNDERGRADUATE STUDENTS

The CAO will not count a grant or loan to an undergraduate student made or insured under a program administered by the Commissioners of Education under Section 507 of the Higher Education Amendments of 1968.

55 Pa. Code
178.61(g)

10. UNIFORM RELOCATION ASSISTANCE AND REAL PROPERTY ACQUISITIONS

The CAO will not count money received under Title II of the Uniform Relocation Assistance and Real Property

55 Pa. Code
178.61(a)

Acquisition Policies Act of 1970.

11. PAYMENTS TO INDIAN TRIBES

The CAO will not count the following payments to Indian tribes:

- Judgment payments under the act of March 18, 1972 and the act of October 18, 1976. 55 Pa. Code 178.61(b)
- Funds distributed per capita to, or held in trust for, members of any Indian tribe under the act of October 19, 1973. 55 Pa. Code 178.61(c)
- Receipts distributed to members of certain Indian tribes referred to in Section 5 of the act of October 17, 1975. 55 Pa. Code 178.61(l)

12. PAYMENTS UNDER THE ALASKA NATIVE CLAIMS SETTLEMENT ACT

The CAO will not count tax exempt portions of payments received under Section 21(a) of the Alaska Native Claims Settlement Act. 55 Pa. Code 178.61(i)

13. GERMAN REPARATIONS PAYMENTS

The CAO will not count payments made to survivors of the Holocaust under the Republic of Germany's Federal Law for Compensation of National Socialist Persecution, also known as the "German Restitution Act". The payments may be made periodically or in a lump sum. 55 Pa. Code 178.81

14. PROCEEDS FROM THE SALE OF AN EXCLUDED RESIDENT HOME

The CAO will not count proceeds which are used or obligated to buy another excluded home. The purchase of the new excluded home must be made within three months. 55 Pa. Code 178.77

If a recipient of Medicaid sells his excluded resident home, the CAO will:

- verify the amount of the proceeds and the date received;

NOTE: Proceeds are the net payments received after all encumbrances, moving costs, and sales expenses are deducted.

- determine if the client intends to use or obligate the proceeds to purchase another excluded resident home within three months. The three month replacement period starts on the date MA eligibility begins for an applicant or on the date the proceeds are received for a recipient;
- count the interest earned on the proceeds as income;
- if the client purchases a new resident home, count as a resource the amount left after subtracting from the net proceeds the purchase price and costs of moving to the new excluded home;
- not exclude mortgage payments made on the new home for any period after occupancy; and
- if the applicant/recipient does not purchase another excluded resident home within the three-month replacement period, count as a resource the total amount of the proceeds from the sale of the original property.

15. NONBUSINESS PROPERTY ESSENTIAL TO SELF-SUPPORT

The CAO will not count tools, equipment, uniforms, and similar items required by an employer.

55 Pa. Code
178.65

The CAO will not count non-business property needed for self-support. See Section 340.632.

16. INCOME PRODUCING PROPERTY

The CAO will not count real or personal property used in a trade or business which is essential to self-support. See Section 340.633, Exclusion of Income Producing Property.

17. VICTIMS COMPENSATION PAYMENTS

The CAO will not count effective May 1, 1991 payments received from a state-administered victims compensation fund to cover expenses incurred or losses suffered as the result of a crime.

55 Pa. Code
178.61(m)

NOTE: Any portion of the payment remaining after the calendar month of receipt is also excluded as a resource for nine months following the calendar month of receipt.

18. STATE AND LOCAL RELOCATION ASSISTANCE

The CAO will not count a relocation assistance payment made by a state or local government in the month of receipt. Any portion of the payment remaining is excluded as a resource for the nine months following the month of receipt.

55 Pa. Code
178.61(n)

19. AUSTRIAN REPARATION PAYMENTS

The CAO will not count payments made based on wage credits under Paragraphs 500-506 of the Austrian General Social Insurance Act. These payments are made to persons who suffered imprisonment or unemployment or were forced to flee Austria during the period March 1933 to May 1945 for political, religious, or ethnic reasons. The CAO will count the interest earned on payments retained as income.

55 Pa. Code
178.6(p)

20. RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENT

The CAO will not count the one-time lump sum payment to a person exposed to doses of radiation and determined to have contracted certain diseases after the exposure. Payment is made by the Federal Department of Justice to the person or the person's survivors. Interest earned on the unspent payment is counted as income.

55 Pa. Code
178.61(q)

MEDICAID ELIGIBILITY HANDBOOK

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340.9 DISPOSITION OF RESOURCES

The disposal of a resource, whether excluded or countable, may affect eligibility. This includes, but is not limited to, resources disposed of in the following ways:

55 Pa. Code
178.101 SSI
178.171 GA

- Spending liquid or converting nonliquid resources to pay medical expenses.
- Selling real or personal property.
- Exchanging for other property.
- Decreasing the value by putting an encumbrance on it.
- Increasing the value by adding another person's name to the title, deed, or account.
- Establishing a burial reserve.

When a client converts or sells a resource, whether excluded or countable, the CAO will count the newly acquired cash or item as a resource and add it to other countable resources to determine resource eligibility.

55 Pa. Code
178.1(i)

EXAMPLE: Mr. L sold his car for \$4,200 and is now looking for a newer car. Until he purchases another car or otherwise spends the money he received to reduce the amount of his resource, the \$4,200 will be added to other countable resources and compared to the resource limit to determine eligibility.

The client must report the disposition of excluded or countable

property, including the property of an LRR.

If resources are disposed of, the CAO will determine if there was fair consideration only if the person is applying for or receiving payment for nursing facility care.

55 Pa. Code
178.1(i)

See the Nursing Care Handbook for requirements on the look-back period for transfer of assets and transfer of assets used to establish a trust for determining whether fair consideration was received.

APPENDIX E

OPTIONS REASSESSMENT FORM

OPTIONS REASSESSMENT FORM

Name _____ Social Security # _____
 Address _____ Telephone # _____
 Assessed by _____ Date _____
 Type of Reassessment _____ Date of Last (Re) Assessment _____
 Location of Reassessment _____
 Primary Care Physician _____ Telephone # _____
 Date last seen by PCP _____
 Emergency Contact _____ Telephone # _____

PHYSICAL HEALTH			<input type="checkbox"/> No change
Have any new illnesses or diagnosis been identified since last re-assessment?	Currently being treated		NARRATIVE: Describe severity, treatments, problems
Illnesses/Diagnosis	No	Yes	

MEDICATIONS			<input type="checkbox"/> No change
List any new or changes in medications (OTC or prescription) consumer is taking since last (re)assessment	Dose/Freq Route	NARRATIVE: Describe problems	

RELATED CATEGORIES	CHANGES		Describe changes and corresponding needs since last (re)assessment
	NO	YES	
NUTRITION			
SOCIAL PARTICIPATION			
COGNITIVE FUNCTIONING			
EMOTIONAL STATUS & BEHAVIOR			
INFORMAL SUPPORTS			
FORMAL SERVICES			
PHYSICAL ENVIRONMENT			
FINANCIAL RESOURCES			

OPTIONS REASSESSMENT FORM

ACTIVITIES OF DAILY LIVING No change

CODES for level of ADL functioning	Codes for bowel and bladder management
1. Independent. Performs safely without assistance 2. Uses assistive device, takes long time, or does with great difficulty 3. Does with some help 3A. Does with supervision, set up, cueing or coaxing only 3B. Does with hands-on help 4. Does with maximum help or does not at all. Helper does more than half of all the activity	1. Independent. No accidents 2. Self-care of devices or ostomy/no accidents 3. Does with help 3A. Does with supervision, set-up, cueing or coaxing assist with equipment/infrequent accidents 3B. Does with hands-on help and/or accidents less than daily 4. Does with maximum help and/or daily accidents

ACTIVITIES OF DAILY LIVING	Code level of functioning		Describe improvements, deterioration, and corresponding needs
	Old	New	
Bathing			
Dressing/Undressing			
Grooming			
Eating			
Transferring In/Out of Bed/Chair			
Toileting			
Bladder Management			
Bowel Management			

MOBILITY No change

Codes for level of mobility functioning
1. Independent. Performs safely without assistance 2. Uses assistive device, takes long time, or does with great difficulty 3. Does with some help 3A. Does with supervision, set-up, cueing, or coaxing only 3B. Does with hands-on help 4. Does with maximum help or does not do at all. Helper does more than half of all of the activity

Is consumer bed bound? No Yes

MOBILITY	Code level of functioning		Describe improvements, deterioration, and corresponding needs
	Old	New	
Walk indoors			
Walk outdoors			
Climb stairs			
Wheel in chair			

Is consumer at risk of falling? No Yes
 If yes, Describe

Has the consumer fallen since the last (re)assessment? No Yes
 If Yes, Describe

OPTIONS REASSESSMENT FORM

INSTRUMENTAL ACTIVITIES OF DAILY LIVING	<input type="checkbox"/> No change
--	------------------------------------

CODES for IADLs 1. Independent 2. Independent but with great difficulty or with mechanical help 3. With assistance of a helper 4. Unable/helper does

INDEPENDENT ACTIVITIES OF DAILY LIVING	Code level of functioning		Describe improvements, deterioration, new unmet needs
	Old	New	
Preparing meals			
Doing housework			
Doing Laundry			
Shopping			
Using Transportation			
Managing Money			
Using Telephone			
Doing Home Maintenance (chores and repairs)			

CARE PLAN REVIEW WITH THE CONSUMER				
Services/Placement Adequate	No	<input type="checkbox"/>	Yes	<input type="checkbox"/> Describe
Services/Placement Appropriate	No	<input type="checkbox"/>	Yes	<input type="checkbox"/> Describe
Services Other Than In Care Plan	No	<input type="checkbox"/>	Yes	<input type="checkbox"/> Describe
Satisfied With Quality of Services Received	No	<input type="checkbox"/>	Yes	<input type="checkbox"/> Describe
Priority Care Back Up System Reviewed			Yes	<input type="checkbox"/> Describe
Review Choice of Waiver Providers in Region	N/A	<input type="checkbox"/>	Yes	<input type="checkbox"/> Describe

COMMENTS:

Consumer Signature

Date

Provider Representative Signature

Date

APPENDIX F

OPTIONS PROCEDURE MANUAL (EXCERPTS)

OPTIONS PROCEDURES MANUAL

BOOK I

A. OPTIONS ASSESSMENT

The OPTIONS assessment is conducted for consumers seeking long term care services. The assessment is done to determine consumer needs and the most appropriate and effective means of meeting those needs. The assessment is accomplished using the **Comprehensive OPTIONS Assessment Form (COAF)**, the **Nursing Facility OPTIONS Assessment Form (NF OAF)** or the **Nursing Facility (NF) Express Screen** and following the INSTRUCTIONS for their use.

The "Comprehensive OPTIONS Assessment Form" (COAF), which is the full OAF used previously for all assessments, is to be continued to be used when conducting Home and Community Based Services (HCBS), lottery funded or PDA Waiver, Family Caregiver Support Program, and initial PCH/Dom Care assessments. There is nothing to prohibit an AAA from continuing to use the COAF for all assessments, including NF and OBRA, if that is the preference. The COAF can be found in Appendix A.

An abbreviated version of the OPTIONS Assessment Form (OAF) can be used when conducting an assessment for applicants seeking and desiring Nursing Facility (NF) placement and who require a more extensive assessment than the NF Express Screen to determine eligibility for NF placement. This version of the OAF contains only those pages of the full Comprehensive OAF which are needed in order to determine NF clinical eligibility. This version of the OAF is titled "Nursing Facility OPTIONS Assessment Form" (NF OAF) and can also be found in Appendix A. **NOTE:** If the applicant is targeted on the PASRR-ID and does not meet criteria for a screening exception through the ID, the PASARR-EV must determine the applicant to be a screening exception because of a medical condition in order to proceed with the abbreviated NF OAF. (If a PASARR-EV is needed, this NF application must be sent to a specific DPW Program Office for final processing.)

The NF OAF can also be used when conducting assessments for NF residents who were admitted as private pay and after "spending down" are now applying for MA coverage and for enrollees in the DPW Health Choices HMO (Physical Health Managed Care Organization PH-MCO) needing assessment for NF clinical eligibility (this assessment must occur prior to the enrollees admission to a NF and PH-MCO must contact the AAA to initiate the OPTIONS assessment). The NF OAF should be used for all DPW Attendant Care and OSP/ Independence Waiver applicants as this is the instrument of choice for these DPW programs.

The "Nursing Facility (NF) Express Screen" is to be used only for those NF applicants who clearly meet the "Screen" criteria found in Book I, A., Section 12, and Appendix D, "Instructions For Completion of the NF Express Screen." The Recertification Form (Appendix G) is to be used for annual recertification of PCH and Dom Care residents.

NOTE: Before the NF OAF is used, the **Decision Screen for Potential Use of the NF OAF for Consumer Requesting Nursing Facility Placement** form must be completed. This form can be found in Appendix S. The consumer requesting NF placement must be made aware that he/she could possibly be served with home and community based services (HCBS) (Lottery funded or PDA Waiver).

I.2

1. Home and Community Based Services (HCBS) Application Process

Effective in fiscal year 1998-99, the PDA Waiver will be implemented statewide. At such time as a waiver slot becomes available in a service delivery area, the following HCBS Application process takes place. For counties that are already administering the PDA Waiver, these procedural standards will become effective on date of final issuance. All care plans implemented prior to the promulgation of these procedural standards are exempt, as are new applicants for the Family Caregiver Support Program (FCSP) who are not interested in obtaining other services in conjunction with the FCSP. If, however, the carereceiver is interested in obtaining supplemental home and community based services (HCBS), is age 60 or older and has been assessed and found nursing facility clinically eligible, then the HCBS Application Process applies.

When reading the following information, please refer to the flowchart titled Home and Community Based Services Application Process contained in Appendix "T."

Any individual age 60 or older applying to an AAA for HCBS, who is assessed and found nursing facility clinically eligible (NFCE) and financially eligible as determined by the County Assistance Office, must be served under the PDA Waiver with full waiver services (this assumes that a waiver slot is available and there is not a waiting list for waiver services). If a consumer chooses not to apply for waiver services or chooses not to enroll in the waiver services program after having been determined eligible, at its discretion the AAA may develop a care plan providing limited services. Expenditures on behalf of this consumer will be limited to no more than \$200 per month for services including home delivered meals, but not including care management. A "one time" \$2,000 expenditure for home improvements/modifications may also be provided at the discretion of the AAA. Care management is excluded to make the task of projecting costs of services in care planning more straightforward, and to make it consistent with FCSP. Consumers receiving limited lottery funded HCBS must receive the FNM and should be placed on the OPTIONS waiting list, if applicable according to the FNM score. These procedural standards will be monitored through case reviews conducted by Department staff.

Presumptive Eligibility

Consumers initially applying for HCBS will be clinically assessed by the OPTIONS team. If a consumer is assessed and found NFCE, then he/she will be screened by the OPTIONS team to determine the likelihood of financial eligibility, using the Financial Eligibility Screen Form found in Appendix "U" to determine Presumptive Financial Eligibility.

Providing Services While Waiting for a Financial Determination

The AAA may choose to arrange for services for individuals who are likely to be eligible while waiting for a confirmed financial determination from the County Assistance Office. This determination may take up to a maximum of 90 days. If the individual is indeed determined to be financially eligible, then the provider(s) of service(s) will be instructed to back-bill MA for the period that the consumer was presumed eligible. If the consumer is found to be financially ineligible, then the AAA will be responsible for any costs that have already been incurred using Lottery funding.

Waiting List

If all the waiver slots are full, then an eligible consumer who desires HCBS must be placed on the chronological waiver waiting list.

While a consumer is on a waiver waiting list, he/she may temporarily be served with 100% Lottery funded services should such services be immediately available. When a waiver slot becomes available at that person's position on the waiver waiting list, he/she must be transferred to the PDA Waiver.

If HCBS are not immediately available through either the waiver or 100% Lottery funded services, the consumer may be placed on both the waiver waiting list and the standard AAA waiting list which is governed by the Functional Needs Measurement (FNM). If services first become available to the consumer via the standard AAA waiting list, he or she may be temporarily served through 100% Lottery funding, but must remain on the waiver waiting list and be transferred to the waiver as soon as one becomes available. If services first become available under the waiver, he/she would receive that slot and must be removed from the standard AAA waiting list.

2. Program Requirements:

Whenever possible, the assessments must be conducted face-to-face and occur in consumer's present living environment (except for the NF Express Screen).

Every effort must be made to complete assessments within the following time frames from the time of receipt of the referral:

Hospitals - three (3) working days

Nursing Facilities - five (5) working days

Community (Pre-Admission Assessments {PAA} requiring an MA-51) - five (5) working days

Community (OPTIONS HCBS Assessments not requiring an MA-51) - ten (10) working days

NOTE: Date of referral:

- For PAA, it is the date of receipt of the completed MA-51.
- For persons applying for OPTIONS (lottery-funded) HCBS, where the MA-51 is not required, it is the date of phone call or first contact for referral for services.
- If during the assessment process for OPTIONS HCBS, it is determined that the person will be accessing one of the programs requiring an MA-51, then the date of referral is the date of receipt of the completed MA-51.

The AAA retains overall responsibility for ensuring that assessments are competently provided in accordance with PDA standards. This responsibility includes ensuring that all workers performing assessments have been properly trained using the OPTIONS SELF-STUDY MANUAL under the direction of an OPTIONS supervisor using the OPTIONS SUPERVISOR'S SELF-STUDY GUIDE and attending all future OPTIONS training deemed mandatory by PDA.

1.4

Assessments for Medical Assistance Waiver services must be performed in-house by the AAA rather than contracted to another provider.

If AAAs choose not to conduct assessments in-house for non-MA Waiver services, they may sub-contract to a PDA approved agency, and not more than one agency for provision of these assessments. The sub-contracted assessment agency must be a public or private non-profit agency and willing to establish and maintain the OPTIONS assessment functional capacity which meets requirements set forth in the cooperative agreement between the AAA and PDA and in this OPTIONS Procedures Manual (OPM), and must be approved as such by PDA.

The AAA and its non-MA Waiver assessment sub-contractor may not have an administrative or financial interest in, nor do intake for, a nursing facility, hospital, personal care home, home health agency or personal care agency. This rule does not apply to AAAs that are part of County government as long as they are administratively separate from their respective County Homes, and adequate measures are in place to prevent conflict of interest.

AAAs may not directly provide home and/or community based services other than assessment and care management. All of these services must be sub-contracted in a manner compliant with the standards contained in the two paragraphs immediately above.

(The requirements in the four foregoing paragraphs apply to assessment only and do not include care management. See Book II., Section B. for details of requirements for provision of care management.)

The Department is aware that existing multi-year contracts may be affected by these policies. Therefore, compliance with these policies will become mandatory for new contract executions or discretionary extensions which take place on or after July 1, 1999. The exception is for Medicaid Waiver services, for which the policy will take effect on the date of promulgation of the policies. AAAs which believe that compliance with these policies will have deleterious effect on their local service delivery system will have an opportunity to request a waiver from the Secretary of Aging. Such waiver requests will be carefully reviewed using criteria which have yet to be developed, and only approved when the Secretary agrees that there is clear and convincing evidence that the waiver is necessary to accommodate unique local circumstances.

At a minimum, individuals completing assessments must perform each of the following:

- ◆ Receive the assessment referral.
- ◆ Conduct the assessment as required by PDA and collect additional information as necessary from collateral sources.
- ◆ Arrange/ensure thorough, adequate completion of MA-51 and PASRR-ID, if appropriate.
- ◆ Obtain and complete PASRR-EV and other OBRA documents, if appropriate.

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- ◆ Consult with RN/MD consultants as needed for evaluation/interpretation of medical information.
- ◆ Make a determination regarding NF clinical eligibility, level of care and/or service needs as appropriate.
- ◆ Make appropriate referrals for care management, placement, etc. to include the provision of all relevant information to assist in placement and/or care plan development.
- ◆ Complete administrative reviews, NF express screens and annual recertifications as required by PDA.
- ◆ Complete Functional Needs Measurement (FNM) as appropriate.
- ◆ Assign to Waiver waiting list as appropriate "chronological" – first come, first served. (FNM is not needed)

3. Population to be Assessed:

- ◆ Consumers age 60 and over applying for home and community based services (HCBS) which require care management (adult day care, family caregiver support, counseling, personal assistance services, home health care, personal care, domiciliary care, overnight shelter).

NOTE: For any consumer requesting home delivered meals (HDM) only and/or any service that does not require care management, a full COAF assessment is not required. However, based on professional judgment, appropriate steps must be taken to assure that resources are being used to meet consumers needs (e.g. locally developed abbreviated assessment).

- ◆ Consumers age 18-59 applying for HCBS - See Section 16, Book I.
- ◆ Consumers determined to be in need of protective services (substantiated cases). See APD #97-24-01.
- ◆ Consumers applying for family caregiver support services.
- ◆ Consumers applying for Special State Supplement for placement/or who are already residing in an approved/licensed PCH or DC care home.
- ◆ Consumers applying for the PDA Waiver.
- ◆ Consumers applying for the DPW Attendant Care (AC) Waiver program.
- ◆ Consumers applying for the DPW OSP/Independence Waiver program.
- ◆ Consumers seeking enrollment into the DPW Long Term Care Capitated Assistance program (LTCCAP).

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- ◆ Consumers applying for Medical Assistance (MA) for nursing facility (NF) services - to determine NF clinical eligibility and appropriate level of care (LOC) along with functional and service needs.
 - ◆ Current MA eligible persons who apply for placement in a NF.
 - ◆ Persons who apply for NF and would become eligible for some MA reimbursement immediately upon entering the NF.
 - ◆ NF residents who were admitted as private pay and after "spending down", are now applying for MA coverage (these consumers should be assessed no later than 45 days prior to the expiration of private pay coverage to allow for safe and orderly discharge should the NF resident be found to be NF clinically ineligible).
 - ◆ Enrollees in a DPW Health Choices - Physical Health Managed Care Organization (PH-MCO) who need to be assessed for NF clinical eligibility (this assessment must occur prior to the enrollees admission to a NF and the PH-MCO must contact the AAA to initiate the OPTIONS assessment).
 - ◆ NF residents who may be discharged. (This applies only to consumers seeking SSI or Community Services)

If an OPTIONS assessment is requested to assist with discharge planning, for those consumers requesting SSI (PCH or Dom Care) or Community Services, a copy of the MA-51 and a copy of a NF written discharge notice must be provided to the AAA before the assessment is conducted. The notice demonstrates that the resident and, if known, a family member or legal representative of the resident has received written advance notice (either 30 days or, as soon as practicable, depending on the reason for discharge) and the written notice must include the following:

- ◆ The reason for transfer or discharge;
 - ◆ The effective date of transfer or discharge;
 - ◆ The location to which the resident is transferred or discharged;
 - ◆ A statement that the resident has the right to appeal the action to the State;
- ◆ The name, address and telephone number of the State long term care ombudsman;
- ◆ For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act.
- ◆ For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

The above conditions are excerpts from existing NF regulations and as such should be found on the resident's NF record and do not impose additional requirements on NFs. Receipt of this information will ensure that residents have been informed of their rights and options and are in agreement with the discharge planning assessment to determine community services or other residential placement.

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The AAA should not conduct the requested assessment unless and until they receive a copy of a discharge notice; if an appeal has been filed and is pending, the AAA is to delay doing the assessment or take no action until the results of the appeal are known.

- ◆ All OBRA targeted individuals - includes all ages and "private pay" consumers entering an MA certified NF.
- ◆ Any consumer who has reason for considering NF placement who requests an OPTIONS assessment.

NOTE: A full NF OAF assessment is not required for certain NF applicants who meet the criteria as in Book I, Section A, #12, Nursing Facility Express Screen.

NOTE: All NF assessments must include the OBRA ID screen (and EV if appropriate). OBRA process requirements are found in Book I, Section C and the forms in Appendix E.

4. Assessment Outcomes:

Following referral and screen for appropriateness of referral, the OPTIONS assessment takes place. Following the assessment, the most appropriate care option will be issued, with consideration given to consumer's condition, choice and to availability and feasibility of using more economical alternative facilities and services when making a NF level of care decision. Decisions are made with the following possible outcomes:

- ◆ The Long Term Care Capitated Assistance Program (LTCCAP) which is available to NFCE and financially eligible consumers residing in an area where LTCCAP is available, with the goal of enabling consumers to remain in their own home as long as possible through services provided under the program.
- ◆ PDA Waiver services and care management provided to NF clinically eligible (NFCE) and financially eligible consumer.
- ◆ Any other DPW Waiver programs, i.e. Attendant Care, etc.
- ◆ At the discretion of the AAA, limited Lottery funded services of \$200 a month (including home delivered meals) and a "one time" \$2,000 for home improvements/modifications provided to consumers who have either chosen not to apply for or, having been found eligible, chosen not to be enrolled to receive PDA Waiver services.
- ◆ Lottery funded home and community based services (HCBS) (after being determined ineligible for PDA waiver or having chosen not to be enrolled to receive PDA waiver services), protective services and/or family caregiver support services with care management provided to all consumers receiving any of these services.
- ◆ NF placement (if the consumer requests and prefers facility placement); NFCE consumer is directed to and, if necessary, assisted in obtaining NF placement.

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NOTE: A NF clinically eligible (NFCE) consumer is an individual who is assessed and determined to be clinically eligible for Nursing Facility care. This determination is made based on the OPTIONS assessment which finds the consumer to have a medical diagnosis(es)/illness or condition which creates medical needs that require medical care and services which are:

- ◆ ordered by, or provided under the direction of a physician,
- ◆ needed to be given on a regular basis and provided by or under the supervision of a skilled medical professional, or
- ◆ because of a mental or physical disability, the individual requires nursing and related health and medical services in the context of a planned program of health care and management.

A NF clinically eligible consumer can be placed and served in a Nursing Facility or can be kept and served at home with HCBS, through PDA waiver or lottery funded services.

Consumers must be found NFCE in order to access PDA and DPW Community Waiver services (including the LTCCAP-Long Term Care Capitated Assistance Program). It is not required that consumers be found NFCE in order to access lottery funded HCBS, but they can be.

- ◆ A consumer who is a person with a target diagnosis of mental illness, mental retardation or other related condition and needs specialized services can not be served with lottery funded/Aging block grant community services. (This does not apply to PDA Waiver services.) See Appendix EE for description MH, MR and ORC Specialized Services.
- ◆ OBRA consumer outcome care recommendation is made for OBRA targeted consumer; this is forwarded to appropriate DPW program office for final determination for care.
- ◆ PCH placement; eligible consumer is directed to and, if necessary, assisted in obtaining PCH placement.
- ◆ DC placement; eligible DC consumer is referred to the Area Agency on Aging (AAA) Dom Care Program.
- ◆ DPW AC Waiver consumer is referred back to DPW ACP contractor who is responsible for services/care.
- ◆ OSP/Independence Waiver consumer is referred back to DPW CSPPPD contractor who is responsible for services/ care.
- ◆ NF clinically eligible consumer age 18 to 59 is served with full or supplemental AAA CS as outlined in Book I, Section 16.
- ◆ No services needed.

5. PDA Waiver Outcome Requirements

- ◆ For PDA Waiver, the following must be completed:
- ◆ MA-51 (Appendix C)
 - ◆ COAF
 - ◆ Financial Status Screening Form (Appendix U)
 - ◆ Determination Report
 - ◆ Care Plan

Eligibility for the PDA Waiver is based upon the MA-51 and completion of the COAF. In order to be eligible for the waiver a consumer must meet the following criteria:

- ◆ be aged 60 or older;
- ◆ be nursing facility clinically eligible (NFCE);
- ◆ can be cared for in the community without exceeding the 80% of Medicaid payment for NF;
- ◆ consumer must choose home and community based services (HCBS) rather than NF services;
- ◆ meet Medicaid financial requirements.
- ◆ Please see Appendix N for CAO requirements.

***NOTE:** A MA-51 must be completed at time of initial assessment and annually at the time of reassessment for PDA waiver. The initial MA-51, along with the consumer determination report, is sent to the CAO and a copy retained in the consumer's record. The MA-51 obtained at reassessment is not sent to the CAO (unless the consumer's current condition has changed since the initial MA-51 was done), it is retained in the consumer's record. See Book V for additional information on the PDA Waiver.

- ◆ Residents of Domiciliary Care Homes are eligible to receive PDA Waiver services as appropriate to their plans of care. All requests to serve residents must be submitted in writing to the Secretary of Aging. Your Aging Program Consultant should be involved in the process as they will be exercising professional judgment to make a recommendation to the Secretary concerning the appropriateness of the placement. Requests should include how the individual fits the criteria for clinical eligibility into the PDA Waiver and why the individual's needs can best be met in the Domiciliary Care locus.

NOTE: In the event that there is a conflict between the procedures described in any of the books of this Bulletin and the regulations as specified in Chapter 21 – Domiciliary Care Services for Adults, the STRICTER of the two standards will apply.

6. Lottery Funded Home and Community Based Services (HCBS) Outcome Requirements:

- ◆ If the consumer requests, prefers and is determined to need and be appropriate for HCBS following the completion of the COAF, a care plan must be completed (with consumer input and consent). This consumer first must have been found to be ineligible for PDA waiver in order to receive full Lottery funded HCBS. If a person chooses not to apply for or, after having been found eligible, chooses not to enroll

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in the PDA Waiver Services Program, the AAA may provide limited Lottery funded services. (See Book I, Section A.)

- ◆ For lottery funded HCBS, the following must be completed:
- ◆ COAF
 - ◆ FNM
 - ◆ Care Plan
 - ◆ Financial Status Screening Form (If NFCE)
- ◆ If the consumer has requested HCBS, but, following the completion of the COAF, has been found eligible for placement in a NF, Dom Care or PC Home, and wishes to pursue such placement, then a MA-51 must be obtained.

7. Nursing Facility (NF) Outcome Requirements:

- ◆ For NF, the following must be completed:
- ◆ MA-51 (Appendix C)
- ◆ PASRR-ID (Appendix E)
- ◆ NF OAF or COAF (Appendix A) or NF Express Screen (Appendix D)
- ◆ Determination Report (for non-OBRA only) (Appendix B)
- ◆ PASARR-EV (for targeted OBRA only) (Appendix E)
- ◆ MA Program Office Transmittal (for targeted OBRA only)
- ◆ The MA-51 and PASRR-ID must be obtained prior to completion of an OAF; if the request/referral is specifically for NF placement.
- ◆ The MA-51 is a medical evaluation that must be completed and signed by a licensed physician; the individual to be assessed or designated representative is responsible for providing the completed MA-51. If the MA-51 provided is incomplete and/or does not provide sufficient information, it is to be returned either to the individual (or designated representative) or directly to the physician responsible for completing the form.
- ◆ OPTIONS workers do not write on the MA-51 except for items #21.A, #21.B, and #22 (Signature). Instructions for completion of the MA-51 are found in Appendix C.
- ◆ For OBRA NF applicant see the OBRA section in Book I, Section C for instructions on required OBRA forms and their completion and routing and special instructions regarding the MA-51.
- ◆ Following the assessment process, if the consumer is a regular (not OBRA) NF applicant, the original MA-51 is forwarded to the CAO; the original Determination Report is sent to the consumer or designated representative, and a copy to the CAO; a copy of each of these forms is to be retained in the consumer's OPTIONS record.
- ◆ If the consumer is an OBRA NF applicant, all forms are sent to the specific appropriate MA Program Office (see OBRA section Book I, Section C) with copies retained in the consumer's OPTIONS record.

8. Personal Care/Domiciliary Care Homes (PCH/DC) Outcome Requirements:

- ◆ For PCH/DC the following must be completed:
- ◆ MA-51
- ◆ COAF
- ◆ Determination Report
 - * PA-761 or PA 1-D
 - * SSA 1610

The eligibility requirements for the Special State Supplement for PCH/Dom Care are found in the Medical Assistance Handbook for Chapter 391 issued by the Department of Public Welfare and found in Appendix M. This section of the OPM provides additional instructions and interpretation relating to OPTIONS program procedures.

The responsibility for determining financial eligibility has been assumed by Social Security Administration. The OPTIONS sites are no longer required to submit financial verification (PA 1628 Certification of Income and Resources) to the County Assistance Office.

An applicant for the Special State Supplement must complete the appropriate sections and sign either PA-761 Application for Personal Care Supplement or PA 1-D Application for Domiciliary Care Supplement. The OPTIONS site must date stamp these forms with the date the signed application was received. Form 761 is date stamped on the bottom of page one in the appropriate area (#4). Form PA 1-D should be date stamped on the bottom of page two in the blank area.

AAA's are permitted to accept and date stamp a FAXed PA-761. However, both the FAXed and original PA-761 must be submitted to the CAO along with the MA-51 and Consumer Determination Reporting following the assessment.

In conjunction with the completion of the PA-761 or PA 1-D, the OPTIONS site may request that the applicant complete form SSA 1610 Public Assistance Information Request. The form should be completed as outlined in MA Eligibility Handbook. In addition, the request for benefits and consumer signature should be annotated in the Remarks section. When submitted to the Social Security administration, this form can act as the application for a determination of financial eligibility. The OPTIONS sites must establish that the applicant is receiving SSI or has completed the application for the determination of financial eligibility which is made by SSA. This can be done by phone contact to SSA or other locally developed procedure. To meet this requirement, a copy of the signed SSA 1610 may be FAXed to SSA, if this procedure is approved by the local SSA. The OPTIONS site is only to establish that the applicant is already receiving SSI or has made application for the State Supplement by completing an application at the local SSA office.

Following the completion of the application forms, the applicant must have a (MA-51) Medical Evaluation form completed by a licensed physician and submitted to the site within 60 days of the examination.

The OPTIONS site will triage referrals as outlined in Book I, Section 1., Program Requirements in order to establish time frames for completion of assessments. The

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assessment is to be completed on the OPTIONS Assessment Form developed by the Department and is to include the Decision Narrative.

Following the completion of the assessment, the OPTIONS assessor is to complete the Consumer Determination Report.

It will also be necessary for the OPTIONS site to have the provider sign the PA-761 or PA 1-D to verify the date the applicant entered the home. The PA-761 has been revised to include an area in section #3 where the date that the consumer entered the home can be added. As per the MA Eligibility Handbook, the OPTIONS site is to forward the PA-761 or PA 1-D, the Consumer Determination Report, the MA-51, the SSA 1610, and the Certificate of Compliance to the CAO. Copies of this information should be retained in the consumer record.

There will be cases when the AAA receives a completed PA-761 or PA 1-D prior to receiving the MA-51. The AAA must notify the consumer in writing of the date that the required information is due and the consequences if the deadline is not met. A sample notification letter can be found in Appendix M. the established date, i.e. the date the MA-51 is due, is either 60 days from receipt of the PA-761 (or PA 1-D) or a later date if a request is made by the consumer. If the consumer does not submit the MA-51 by the established date or contact the AAA to establish a new date, the AAA is to notify the CAO. The AAA is to forward to the CAO the PA-761 (or PA 1-D) and a copy of the notification sent to the consumer with a notation that the MA-51 was not received by the established date. the CAO will formally notify the consumer that their application has been rejected.

The OPTIONS assessor may release a copy of the assessment information to the home provider with consent of the consumer. The OPTIONS site is responsible for annually recertifying consumers who wish to continue to receive the Special State Supplement for PCH/Dom Care. The OPTIONS site must notify the consumer and/or home provider two months prior to the annual recertification date to allow time for the completion of the new MA-51. The OPTIONS site must develop a system to track when the recertifications are due. Specific procedures are outlined in the RECERTIFICATION Section.

9. DPW Attendant Care (AC) Waiver Assessment Requirements:

- ◆ For DPW AC Waiver applicants the following must be completed:
 - ◆ MA-51
 - ◆ NF OAF as revised for these assessments
 - ◆ Determination Report as revised
- ◆ A PASARR-ID is NOT to be completed i.e. - no OBRA assessment.
- ◆ There will be no express screen assessments.
- ◆ NF clinical eligibility "yes or no" is the only determination to be made without regard to availability and feasibility of using more economical alternative facilities and services. We are acting as agents for DPW to simply determine NF clinical eligibility which in turn determines eligibility for DPW AC waiver services.

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- ◆ Services already being provided by the Attendant Care Program (ACP) contractor are not to be considered.
- ◆ The ACP contractor carries primary responsibility for completion of the PA-600. However, DPW and PDA have agreed that whatever arrangements are mutually agreed to locally between the ACP, CAO and AAA regarding completion of the PA-600 will govern how it is locally completed.
- ◆ The ACP contractor is responsible to obtain the completed MA-51.
- ◆ A referral, completed MA-51 and lavender color coded face sheet is received from the DPW ACP contractor.
- ◆ An assessment interview is scheduled in coordination with the ACP contractor, as someone (whoever the ACP contractor designates) from the ACP is to be present to facilitate the interaction (but NOT co-assess) with the face-to-face NF OAF assessment. Local AAA procedures prevail in coordination with local ACP contractor.
- ◆ The assessment is to be completed with the following changes to the NF OAF instrument:
 - ◆ Replace the face sheet with the ACP modified lavender color coded face sheet found in Appendix I.
 - ◆ Remove page 17, the Decision Narrative. The logic for NF yes/no will be documented on the ACP Determination Report found in Appendix H. Be as comprehensive as possible to provide adequate information in case of an appeal.
 - ◆ MA-51: Q.21.A, check Medically Eligible "Yes" box; Q.22., "Comments", write in "ACP Waiver"; Reviewer's signature = assessor or assessor's supervisor.
- ◆ Send completed NF OAF, Determination Report and signed MA-51 to the ACP contractor.
- ◆ Once the assessment is completed and sent to the ACP contractor, OPTIONS has no further responsibility for follow-up, services or care planning; this is the responsibility of the ACP contractor.

NOTE: For referrals received from the ACP Contractor for consumers applying for the DPW AC Waiver Program who are already enrolled in the OPTIONS Program and receiving AAA Community Services, the following protocols are to be followed:

- ◆ Upon receipt of the referral and a completed MA-51, determine when the applicant's most recent NF OAF assessment occurred.
- ◆ If the last NF OAF assessment occurred within the last twelve (12) months, it is not necessary to do another one for the DPW AC waiver application.

I.14

- ◆ Conduct an Administrative Review (AR) using the current MA-51 submitted by the ACP contractor to assure that the applicant's condition and the information on the MA-51 are in agreement and reflect Nursing Facility (NF) clinical eligibility. Administrative review is described in Book I, Section A, #17.
- ◆ Obtain information from the applicant's OPTIONS care manager to confirm that NF clinical eligibility is still present.
- ◆ The NF yes/no decision is made based on the AR and information received from the OPTIONS care manager. Appropriate documentation should be included in the file to support the level of care decision.
- ◆ Resume protocol as outlined on page I.13, "DPW AC Waiver Assessment Requirements", 8th through 11th bullet.
- ◆ Attach a note to the NF OAF indicating that it was completed within the last 12 months and highlight the date.
- ◆ If there is any question at all concerning NF eligibility following the AR, a full NF OAF must be completed.
- ◆ Those DPW AC Waiver applicants retained in a community services OPTIONS program will continue to be fully assessed with the COAF and reassessed within the time frames as required by OPTIONS policy standards.

10. OSP/Independence Waiver Requirements:

(NOTE: The AAA process for assessment of persons applying for ORC/Independence Waiver services has not changed because of revised age eligibility criteria for persons to be served. The process remains the same no matter when the age of onset of the ORC.)

- ◆ For OSP/Independence Waiver applicants the following must be completed:
 - ◆ PASRR-ID
 - ◆ MA-51
 - ◆ NF OAF as revised for these assessments
 - ◆ Determination Report as revised
- ◆ There will be no express screen assessments.
- ◆ NF clinical eligibility "yes or no" is the only determination to be made without regard to availability and feasibility of using more economical alternative facilities and services. We are acting as agents for DPW to simply determine NF clinical eligibility which in turn determines eligibility for OSP/Independence Waiver services.
- ◆ Services already being provided by the Community Service Program for Persons with Physical Disabilities (CSPPPD) contractor are not to be considered.

APPENDIX G

**SERVICES TO CONSUMERS OVER AGE 60 IN THE MEDICAID WAIVER FOR
ATTENDANT CARE SERVICES**

SERVICE TO CONSUMERS OVER AGE 60 IN THE MEDICAID WAIVER FOR ATTENDANT CARE SERVICES

The Department of Public Welfare has agreed to continue to administer attendant care services for certain individuals who have reached age 60 and meet Waiver eligibility requirements. This appendix is provided as general information. The current procedures and details are as follows:

- The program includes only persons who have been served in the under-60 Attendant Care Waiver prior to reaching age 60.
- Service requirements for the persons who are served under this program expansion will be identical to those for the existing Waiver Program, except that these consumers will be over age 60. Any consumer over the age of 60 who loses Waiver eligibility will continue to receive attendant care services through the local Area Agency on Aging.
- The Office of Social Programs is the administrative entity responsible for persons served under this initiative. All operational procedures are identical to those for the Medicaid Waiver. For example, service plan addenda are submitted to the Office of Social Programs in the same manner as for the Medicaid Waiver.
- Billing is done through the claims processing system at the same rates that apply to the under-60 Waiver Program.
- This program expansion has no impact on the arrangements between Act 150 contractors and the Area Agencies on Aging to serve persons over age 60 who do not meet Waiver eligibility requirements.
- Contractors must continue to make the notifications required in the Attendant Care Program Requirements, even for under-60 Waiver consumers who are likely to remain in the Medicaid Waiver after reaching age 60.

APPENDIX H

**ATTENDANT CARE PROGRAM
PROGRAM MONITORING INSTRUMENT**

**ATTENDANT CARE PROGRAM
MONITORING INSTRUMENT**

**PROVIDER:
LOCATION:**

DATE COMPLETED:

PART A - Service Requirements

1. **Outreach and Intake** – How and when does agency conduct outreach, community education activities? Attach documentation of these activities.

Where does the agency refer consumers who were inappropriately referred for Attendant Care?

Where is this information documented?

2. **Persons Determined Ineligible** – Provide a copy of the recent monitoring year's Inquiry Log on all individuals requesting Attendant Care Service?

When are written notices (PW 1299) sent to ineligible clients noting the reason and the appeal process? Where are these documents kept?

How does the agency notify OSP when an ineligible applicant appeals the decision?

PART B - Service Delivery

1. **Nature/Scope** – Explain how the Contractor provides the Pennsylvania Model of Attendant Care Service.

How and when are the models of service options explained to the consumers?

2. **Agency Priority Care Procedures** – Provide copy of agency's procedure for handling priority care situations.

How does the Contractor have the capability, directly or through subcontractors, to respond to priority care situations 24 hours per day/7 days per week?

3. **Service Coordination/Utilization** – Are the consumer, AAA and the Office of Social Programs provided advance written notification of transition to PDA at 18, 12 and 4 months prior to consumer's 60th birthday?

4. **Appeals/Grievances** – How are consumers informed of the agency's local grievance procedure? When?

How does the agency inform consumers of their right for assistance in filing an appeal?

Does the agency forward a copy of the appeal (PW1299) and envelope to Bureau of Hearings and Appeals as well as Office of Social Programs?

How does the agency track appeals?

5. **Interruptions of Service:** Describe the process of informing consumers and attendants regarding in state and out of state travel.

Are administrative waivers requested for consumers traveling outside of the state for longer than 30 days?

Describe the process of informing the consumers regarding hospitalizations and nursing facility stays.

After the initial explanation, are the consumers updated? When?

Describe how quarterly telephone calls and monitoring visits are completed if there is a prolonged absence from their home.

6. **Tickler System-** Provide a copy of the tickler system utilized to ensure timely consumer visits and contacts.

PART C - Personnel

1. **Recruitment/Hiring Practices** - Provide the agency non-discrimination procedures for hiring.

Does the agency check references or do criminal record checks?

How does the agency assure that attendants, both agency employed and consumer employed, meet the qualifications for employment established in the Waiver?

Does the agency assure that Service Coordinators working with Waiver consumer meet the qualifications for employment set forth in the ACP Waiver.

2. **Job Descriptions/Performance Evaluations** Does the agency have provisions for a registered nurse as an employee or as a consultant in the program? Provide a copy of the license.

3. **Training** - Does the agency provide annual training on blood borne pathogens? Provide dates of the trainings, information used, attendance record, name and qualifications of the trainer.

What is the agency policy and procedure regarding inoculations?

PART D - Administration

1. **Subcontracts** - Provide copies of the agency annual program evaluation of all subcontractors involved with consumers using DPW's Monitoring Instrument.

Has the agency had any problems with any subcontractors or subcontracted attendants? If yes, was DPW notified?

How are consumers involved in the monitoring of subcontractors?

2. **Program Monitoring/Evaluation – Provide a copy of the completed annual internal Attendant Care Program Monitoring Instrument.**

Who conducts the evaluation?

Who is responsible for the resolutions of non-compliances?

Monitoring Notes:

APPENDIX I

CONSUMER RECORD REVIEW FORM

RECORD REVIEW COMMENT SHEET

Application Process
Date AC Services requested
Date original application completed
(Within 15 days of request)
Original application in file
Service preference form complete
Service Plans/Addendums
Date SP developed
Directions to consumer's home
Long Term Goal
Short Term Goal
Unique Circumstances
Reviewed/Updated w/ Consumer
Date Reviewed/Updated
Responsibility documented on SP
Basic Services provided
of Service hours/ day correct
of Service hours/ week correct
All items on SP complete
Priority Care/Back up identified
Consumer Signature/date
Agency Signature/date
Addendums to SP in file
Assessment/Reassessment
Original assessment in file
Dates of reassessments:
Reassessments timely
Back up verified at reassessment
Service Plan Updated
Signature of Consumer/date
Signature of Agency/date
Documented in Service Notes
In Home Monitoring Visits
Dates of visits:
Timely/Separated by 3 months
Annual documentation

CONSUMER RECORD REVIEW FORM

NAME:
DOB:(58 or > AAA notice)
PROGRAM/ MODEL:
DISABILITY:
DATE COMPLETED:

PROVIDER:
DATE LAST VISIT:
SERVICE COOR:
LOCATION:

Application Process	Yes	No
Date AC Services requested		
Date original application completed		
(Within 15 days of request)		
Original application in file		
Service preference form complete		

Quarterly Contacts	Yes	No
Documented in service notes		
Dates:		
Timely		
Contact made with consumer		
Issues identified		
Issues follow/up		

Service Plans/Addendums	Yes	No
Date SP developed		
Directions to consumer's home		
Long Term Goal		
Short Term Goal		
Unique Circumstances		
Reviewed/Updated w/ Consumer		
Date Reviewed/Updated		
Responsibility documented on SP		
Basic Services provided		
# of Service hours/ day correct		
# of Service hours/ week correct		
All items on SP complete		
Priority Care/Back up identified		
Consumer Signature/date		
Agency Signature/date		
Addendums to SP in file		

Service Notes	Yes	No
Objective		
Cohérent		
Coded		
Signature/Dated		

Fees	Yes	No
Dates of redeterminations:		
Redetermination Timely		
Accurate		
Verification of allowable deductions		
Begin/End dates of expenses		

Assessment/Reassessment	Yes	No
Original assessment in file		
Dates of reassessments:		
Reassessments timely		
Back up verified at reassessment		
Service Plan Updated		
Signature of Consumer/date		
Signature of Agency/date		
Documented in Service Notes		

DPW 1299	Yes	No
Alternative format (language,senses)		
Initial(w/in 10 working days of appl)		
Reassessments(w/in 10 working days)		
Redetermination(w/in 10 working days)		
Reason for decision completed		
Notice of right to assistance w/ 1299		

In Home Monitoring Visits	Yes	No
Dates of visits:		
Timely/Separated by 3 months		
Annual documentation		

AAA Notices	Yes	No
18 month notice timely/date		
12 month notice timely/date		
4 month notice timely/date		

Related Forms	Yes	No
Consmr Selection AC Control Option		
Service Agreement btwn Cons/Agency		
*Consmr designation Tasks/Activities		
*Consumer/Employer Appt of Agent		
*Criminal record Check Policy		
*Agreement btwn Consmr & attendant		

* Consumer/Employer only

RECORD REVIEW COMMENT SHEET

Quarterly Contacts
Documented in service notes
Timely
Dates:
Contact made with consumer
Issues identified
Issues follow/up
Service Notes
Objective
Coherent
Coded
Signature/Dated
Fees
Dates of redeterminations:
Redetermination Timely
Accurate
Verification of allowable deductions
Begin/End dates of expenses
DPW 1299
Alternative format (language,senses)
Initial(w/in10 working days of appl)
Reassessments(w/in 10 working days)
Redetermination(w/in10 working days)
Reason for decision completed
Notice of right to assistance w/ 1299
AAA Notices
18 month notice timely/date
12 month notice timely/date
4 month notice timely/date
Related Forms
Consmr Selection AC Control Option
Service Agreement btwn Cons/Agency
*Consmr designation of Tasks/Activities
*Consumer/Employer Appt of Agent
*Criminal record Check Policy
*Agreement btwn Consmr & attendant

* Consumer/Employer only

APPENDIX J

ACT 28

18 Pa. C. S. A. § 2713

§2713. Neglect of care-dependent person

- (a) **Offense defined.** – A caretaker is guilty of neglect of a care-dependent person if he:
- (1) Intentionally, knowingly or recklessly causes bodily injury or serious bodily injury by failing to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person for whom he is responsible to provide care.
 - (2) Intentionally or knowingly uses a physical restraint or chemical restraint or medication on a care-dependent person, or isolates a care-dependent person contrary to law or regulation, such that bodily injury or serious bodily injury results.
- (b) **Penalty.** –
- (1) A violation of subsection (a) (1) constitutes a misdemeanor of the first degree if the victim suffers bodily injury.
 - (2) A violation of subsection (a)(1) constitutes a felony of the first degree if the victim suffers serious bodily injury.
 - (3) A violation of subsection (a)(2) constitutes a misdemeanor of the first degree if the victim suffers bodily injury.
 - (4) A violation of subsection (a)(2) constitutes a felony of the first degree if the victim suffers serious bodily injury.
- (c) **Report during investigation.** – When in the course of conducting any regulatory or investigative responsibility, the Department of Aging, the Department of Health or the Department of Public Welfare has a reasonable cause to believe that a care-dependent person or care-dependent persons residing in a facility have suffered bodily injury or been unlawfully restrained in violation of subsection (a)(1) or (2), a report shall be made immediately to the local law enforcement agency or to the Office of Attorney General.
- (d) **Enforcement.** –
- (1) The district attorneys of the several counties shall have authority to investigate and to institute criminal proceedings for any violations of this section.
 - (2) In addition to the authority conferred upon the Attorney General under the act of October 15, 1980 (P.L. 950, No. 164), known as the Commonwealth Attorneys Act, the Attorney General shall have the authority to investigate and institute criminal proceedings for any violation of this section. A person charged with a violation of this section by the Attorney General shall not have standing to

challenge the authority of the attorney General to investigate or prosecute the case, and, if any such challenge is made, the challenge shall be dismissed and no relief shall be available in the courts of this Commonwealth to the person making the challenge.

- (e) **Treatment in conformance with care-dependent person's right to accept or refuse services.** – A caretaker or any other individual or facility may offer an affirmative defense to charges filed pursuant to this section if the caretaker, individual or facility can demonstrate through a preponderance of the evidence that the alleged violations result directly from:

- (1) the caretaker's, individual's or facility's lawful compliance with a care-dependent person's advance directive for health care as provided in 20 Pa.C.S. Ch. 54 (relating to advance directive for health care);
- (2) the caretaker's, individual's or facility's lawful compliance with the care-dependent person's written, signed and witnessed instructions, composed when the care-dependent person is competent as to the treatment he wishes to receive;
- (3) the caretaker's, individual's or facility's lawful compliance with the direction of the care-dependent person's attorney-in-fact acting pursuant to a lawful durable power of attorney; or
- (4) the caretaker's, individual's or facility's lawful compliance with a "Do Not Resuscitate" order written and signed by the care-dependent person's attending physician.

- (f) **Definitions.** – As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Care-dependent person." Any adult who, due to physical or cognitive disability or impairment, requires assistance to meet his needs for food, shelter, clothing, personal care or health care.

"**Caretaker,**" Any person who:

- (1) is an owner, operator, manager or employee of a nursing home, personal care home, domiciliary care home, community residential facility, intermediate care facility for the mentally retarded, adult daily living center, home health agency or home health service provider whether licensed or unlicensed;
- (2) provides care to a care-dependent person in the setting described in paragraph (1) ; or
- (3) has an obligation to care for a care-dependent person for monetary consideration in the settings described in paragraph (1) or in the care-dependent person's home.

"**Person,**" A natural person, corporation, partnership, unincorporated association or other business entity.

1995, July 6, P.L. 242, No. 28, § 1, effective in 60 days. Amended 1997, June 25, P.L. 284, No. 26, § 1, effective in 60 days; 1998, June 18, P. L. 503, No. 70, § 1, effective in 60 days.

171 P.S. § 732—101 et. seq.

Historical and Statutory Notes

The 1997 amendment, in subsec. (f), in the definition of “caretaker”, in par. (1), inserted “intermediate care facility for the mentally retarded”.

Act 1998-70, in subsec. (d)(2), at the end of the first sentence; deleted “or any

series of such violations involving more than one county of this Commonwealth or involving any county of this Commonwealth and another state”.

Library References

Negligence ↻ 1803.
WESTLAW Topic No. 272.