Chapter 16:
Home and Community-Based Services

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Chapter 16
Home and Community Based Services

16-1: Description of Home and Community Based Services

The goal of the Home and Community Based Services (HCBS) is to provide eligible adults age 60 and over and adults with physical disabilities who are at risk of entering long-term care facilities the option of receiving services in their homes or in a community setting. Home and community-based services are state-funded (OPTIONS for Community Living) and federally-funded (Older Americans Act Title IIIB).

16-1-.01: Home and Community Based Services

(1) OPTIONS for Community Living

OPTIONS for Community Living (referred to as OPTIONS) is a state-funded program created to provide home and community-based services to adults age 60 and over and adults (18 years of age or older) with disabilities. OPTIONS is available through the local Area Agencies on Aging and Disability (AAAD). Services may include homemaker, personal care, and home delivered meals.

The authority for the Options program comes from *Tennessee Code Annotated 71-5-1416* as follows:

> **Funding to increase access to home and community-based services in the state-funded options program.**
>
> Subject to the availability of funding, the commissioner shall designate in each year's appropriations bill an amount of money that can be used to increase access to home and community-based services in the state-funded options program for persons who do not qualify for medicaid long-term care services. This funding may be used to provide services such as home-delivered meals, homemaker services and personal care, and to reduce the waiting list for these services under the options program, or to offer transportation services or assistance to non-medicaid-eligible individuals.

(2) Older Americans Act (OAA) Title IIIB

The Older Americans Act authorizes grants to the States under State approved plans for supportive services. One directive under this act includes providing "services

designed to assist older individuals in avoiding institutionalization and to assist individuals in long-term care institutions who are able to return to their communities." The services are designed to enhance the capacity of individuals age 60 and over to remain self-sufficient in their homes and to maximize the informal support provided by caregivers. The services may include homemaker services, personal care services, adult day services, and chore services.

The AAADs receive the OAA federal funding from the Tennessee Commission on Aging and Disability (TCAD) to provide the identified services. All individuals age 60 and over are eligible for services; however, priority is given to those with greatest economic and social need.

16-1-.02: Program Eligibility

(1) To be eligible for OPTIONS, the individual must:

(a) be a resident of Tennessee;

(b) be an adult age 60 and over and/or an adult age 18 and over with a documented assessment of a physical impairment;

(c) verify his/her age as 18 and over by utilizing any of the following documents: birth certificate, State issued ID, or military/veteran's identification card. For individuals over the age of 60 who do not have access to necessary documents, they may complete and sign an Age Declaration statement.

(d) be assessed with a pre-defined level of limitations as determined by the most updated TCAD approved SAMS ILA (Appendix A);

(e) not be found eligible for TennCare CHOICES; and

(f) have a residence that is a safe setting for the individual and any service provider(s).

(2) To be eligible of OAA Title IIIB, the individual must:

(a) reside in Tennessee;

(b) be an adult age 60 or over

(c) verify his/her age as 60 and over by utilizing any of the following documents: birth certificate, State issued ID, or military/veteran's identification card. For individuals over the age of 60 who do not have access to necessary documents, they may complete and sign an Age Declaration statement.

(d) be assessed with a pre-defined level of limitations as determined by the most updated TCAD approved SAMS ILA (Appendix A); and

(e) have a residence that is a safe setting for the individual and any service provider(s).

16-1-.03: Steps to Obtaining Home and Community Based Services

For the person contacting the AAAD for Home and Community Based Services (HCBS) and are eligible to receive services funded through OPTIONS or Title IIIB, the following outline the steps in the process to receive those services:

(1) The AAAD will provide initial screening in order to determine the most appropriate referrals.

(a) When an individual appears to meet the functional and financial eligibility for TennCare CHOICES, the individual should be referred to the TennCare CHOICES Counselor. If an individual refuses the referral, individual may be screened and if appropriate placed on the waiting list for Nutrition Services or Title IIIB Supportive Services.

(b) All other individuals will be referred to other community services, and, if necessary, prioritized and placed on the waiting list for OPTIONS, Nutrition Services, or Title IIIB Supportive Services.

(2) The AAAD will conduct an in-home assessment of those with ADL or IADL limitations to determine the need for in-home services.

(3) The AAAD and the individual will develop a care plan to identify the services needed.

(4) The AAAD with input from the individual will arrange for the delivery of HCBS either through an outside vendor or through the self-directed care component.

(5) The AAAD will send authorization for services to the provider(s) selected.

(6) Services identified in the care plan will begin within 5 working days of the receipt of the Provider Authorization by the service provider.

OPTIONS or Title IIIB funding for in-home services is limited. OPTIONS or Title IIIB funding is not intended to pay for services to meet all the needs of the individual.

16-1-.04: Options Counselor

Each individual shall have an assigned Options Counselor and shall be notified of the name, business address, and telephone number of the Options Counselor. The Options Counselor focuses on the personal goals of the individual for the long-term care supports needed for the individual to live as independently as possible in the setting of his/her choice. The Options Counselor assists the individual to make informed choices about long-term care supports; understand the home and community-based services available; understand the resources available to help pay for the services; and encourage the effective and efficient use of home and community-based services.

(1) The Options Counselor must have the appropriate qualifications to work with adults age 60 and over and adults with disabilities utilizing a person-centered approach to making decisions about long-term supports and services as the alternative to nursing facilities or institutional placement.

(a) The minimum qualifications for the position of Options Counselor are as follows:

(i) A Bachelor's Degree in social work, psychology, gerontology, sociology, counseling, nursing, or equivalent degree; or

(ii) A minimum of completion of two (2) years attendance at an accredited college or university and a minimum of two (2) years experience in the field of social work or a related field.

(2) The Options Counselor should have the following skills and knowledge:

(a) Understand the individual's right to control, choice, self-direction, dignity of risk, and self-determination in the provision of home and community based long-term care supports and services.

(b) Understand how to adapt communication methods to the sensory, verbal, physical, and cognitive abilities of adults age 60 and over and adults with disabilities.

(c) Utilize communication skills to support the individual in the decision-making process such as, but not limited to, active listening, paraphrasing, effective ways to ask questions while providing resources, and decision support to engage the individual and/or family/caregiver during the process.

(d) Understand the concepts of individual choice, self-determination, and participation in the selection of the long-term supports and services.

(e) Able to identify and refer the individual to community programs, services, and/or resources, including, but not limited to, medical, nutritional, transportation, and self-directed programs, that are available to meet the needs of the individual.

(f) Understand diversity and multicultural considerations that need to be considered during each step of the process and programs and services that are appropriate to the individual's cultural needs.

(g) Assist the individual to understand the concept and implications of aging in place and identify available services and resources as well as barriers to aging in place.

(h) Recognize the common mental health conditions that can affect adults age 60 and over and adults with disabilities and know the referral resources and organizations available to address their needs.

If the Options Counselor does not have all the appropriate skills and knowledge required, the AAAD should have the Options Counselor participate in local education and training programs that have a focus in the person-centered approach.

16-1-.05: Service Coordination

The Options Counselor will provide service coordination whether it is in the form of access to services or care coordination to the individual who is experiencing diminished functioning capacity, personal conditions, and other characteristics that require service and meet the eligibility requirements.

Service coordination supports information sharing among agencies/organizations, service providers, types and levels of service, service sites, and timeframes to ensure that the individual's needs and preferences are achieved and that services are efficient and of high quality. Activities of service coordination include assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services, follow-up and reassessment. Service coordination ensures non-duplication of services by identifying the services and/or service providers, the informal supports, and resources that are currently being utilized and/or provided to the individual.

16-1-.06: Care Plan

The Options Counselor shall work with the individual and the family support system to develop care plan**.** The care plan specifies the types, frequency, and amount of in-home services provided to an individual based on a comprehensive assessment of the individual's needs. Service decisions shall always be made in the best interest of the individual. The care plan must be discussed and developed with the participation of individual ensuring the plan meets their needs. The care plan must be documented in the SAMS database. Individuals must sign the Signature Page (Appendix J) including marking the section "Care Plan" which indicates that the individual was involved in the development of their care plan. If an individual is unable sign, it must be signed by their Authorized Representative.

(1) Care Plan Components

The care plan in the SAMS database must document at a minimum the following:

(a) The specific support services needed including the frequency and duration of each service;

(b) Start and end date of services;

(c) Primary care manager (Options Counselor);

(d) Allocated units of service;

(e) The name of the provider that will be providing the service; and,

(f) Cost of services

(2) Changes to Care Plan

Care Plans must be updated when a service is decreased, increased, discontinued, or a new service is added. Any changes to the Care Plan must be approved by the individual during an in-home visit or by phone. Changes to the Care Plan must be documented in a case note that the change was discussed and approved by the individual.

An individual is considered in Interrupted Status if the individual does not receive services for thirty (30) days due to hospitalization or other causes. The Options Counselor should maintain regular contact with the individual during this time.

The AAAD may terminate an individual from the program after the care recipient has been in Interrupted Status for thirty (30) days. If an individual has been terminated for services due to being in Interrupted Status and they return home from hospital or nursing home facility

and they are still in need of services, the AAAD may choose to reassess and reactivate services without placing the individual on the waiting list if there is a slot available.

(3) Care Plan Not Developed

If any of the following conditions apply, a care plan shall not be developed:

(a) if the individual (and/or his/her representative) notifies/tells the Options Counselor that he/she does not want to proceed with the development of the care plan;

(b) if the individual (and/or his/her representative) refuses to release or provide information that is necessary to the development of the care plan; or

c) if the community resources are not available or the cost is above the $7,000 limit to develop and carry out the care plan.

16-1-.07: Services

(1) Assessment and Reassessment

The most updated SAMS Independent Living Assessment developed by TCAD shall be used by the AAAD to assess the individual's risk of losing his/her independence and to assist in the development of a care plan, if appropriate. The assessment gathers information about health and nutritional status, financial status, Activities of Daily Living (eating, bathing, dressing, toileting, transferring/walking, and continence), Instrumental Activities of Daily Living (ability to use telephone, shopping, food preparation, housekeeping, laundry, transportation, responsibility for own medications, and ability to handle finances), physical environment, and social support system. All assessments shall be completed in a face-to-face interview with the individual and family support.

A reassessment is required at least annually to be completed within 30 days of the previous assessment end date for all in-home services; however, the Options Counselor should be alert for changes in an individual's condition or circumstances that may warrant a reassessment at an earlier date. A six (6) month reassessment may be completed on an individual if the Options Counselor sees the need. During the in-home reassessment, if the OPTIONS individual appears to functionally and financially qualify for CHOICES, then he or she must be referred to CHOICES. If TennCare determines that the individual is eligible for CHOICES but the individual declines CHOICES, then

the individual must be removed from OPTIONS services; however, the individual may be placed on the Title III-B Supportive Services or Nutrition program or waiting list.

The individual may be functionally impaired as determined by the following for each of the services:

(a) homemaker: a total score (ADL/IADL) of at least three (3) with one (1) being an IADL;

(b) personal care: a total score (ADL/IADL) of at least three (3) with one (1) being an ADL;

(c) home-delivered meals: in order to receive meals, an individual shall be:

(i) physically or mentally unable to obtain food, prepare meals, or lack support to have meals provided for them – meal preparation IADL; and

(ii) frail (45 CFR 1321.69; defined at 45 USC Sec. 102 [22] – 2 ADL limitations or cognitive impairment; or

(iii) homebound or otherwise isolated (45 CFR 1321.69) – response to homebound screen (on ILA) and documented in case notes based on the following:

a. Leaving home is not recommended due to the condition of the individual; or

b. Leaving home takes a considerable and taxing effort; or

c. The individual's condition keeps him/her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); or

d. The individual is unable to access a congregate meal site.

(2) Funded Services

The services provided by the state-funded OPTIONS or through OAA Title IIIB include the following:

(a) Homemaker Services

The Homemaker Services provider completes household tasks that enable an individual to live in a clean, safe, and sanitary home environment, including those Instrumental Activities of Daily Living (IADL), such as:

(i) shopping for groceries and personal items;

(ii) meal preparation;

(iii) managing money;

(iv) using the telephone; and

(v) light housework.

(b) Personal Care

The Personal Care provider provides personal assistance, stand-by assistance, or supervision for the individual having difficulty with one or more of the Activities of Daily Living (ADL). These ADLs include:

(i) eating;

(ii) dressing;

(iii) bathing;

(iv) walking;

(v) toileting; and/or

(vi) transferring in and out of bed or chair.

Homemaker Services and Personal Care must be provided in accordance with the Rules of the Department of Mental and Developmental Disabilities Office of Licensure Chapter 0940-5-38, Minimum Requirements for Personal Support Service Agencies or Rules of the Tennessee Department of Intellectual and Developmental Disabilities Office of Licensure Chapter 0465-02-17, Minimum Program Requirements for Intellectual and Developmental Disabilities Personal Support Services Agencies.

(c) Home-delivered Meals

Home-delivered Meals are nutritionally-balanced and meet at least one-third (1/3) of the current Dietary Reference Intakes (DRI) and is delivered to the individual's house.

(d) Other Services

Other services may be provided if the Options Counselor sees there is a need to provide minimal services in order to maintain the individual within the home. Any other services provided by State allocation must have prior approval by the Director of the AAAD. These services may include Personal Emergency Response System (PERS), pest control, and limited home modifications.

(3) Home Environment and Safety

A Home Environment Checklist shall be completed by the Options Counselor to assess the safety and accessibility of an individual's homes prior to individual receiving services. This checklist is a part of the SAMS ILA. The Options Counselor may use this checklist to determine the safety of both the individual and service providers. The checklist may also be used as an opportunity to talk with the individual about assistance that may be available to correct problems in and around the home and to offer the necessary referrals.

Each AAAD will be responsible for having a written policy to review the potential denial of services due to home environment and safety. An individual denied services due to home environment and safety has the right to make a grievance complaint, if desired. Grievance complaints will be reviewed by the grantee agency in accordance with the agency's grievance policy.

(4) Individual's Right to Self-Determination

Each individual has the right to choose how they will live as well as where they will live, if he/she are competent to make that decision and are able to understand the consequences of their actions. All adult individuals are presumed legally competent unless deemed incompetent by a court. However, it is essential that the Options Counselor not approve in-home services for individuals who are in an environment or situation that is clearly unsafe for the individual or for the workers who come into the home.

Reports to Adult Protective Services (APS) are mandated by state law when "any person" has reasonable cause to suspect abuse, neglect (including self-neglect), or financial exploitation. This includes neighbors, friends, relatives, doctors, dentists, caregivers, agency personnel, etc. (Adult Protection Act T.C.A. 71-6-103(b); https://reportadultabuse.dhs.tn.gov/)

(5) Follow-Up

It is recommended that the Options Counselor contact the individual semi-annually following the implementation of the care plan to ensure that the needs of the individual are being met. If follow-up calls are completed, they should be documented in a case note.

16-1-.08: Priority for Provision of Services

In providing home and community-based services, priority shall be given to Adult Protective Service (APS) clients and low-income individuals.

(1) Adult Protective Service

The following conditions apply:

(a) Funding to provide services must be available.

(b) The APS Referral for Priority HCBS Services form (Appendix B) must be approved and signed by the APS Unit Supervisor before the referral is submitted to the AAAD. If a referral is submitted to the AAAD prior to APS Unit Supervisor's approval, the AAAD must return the referral**.**

(c) The APS case will be kept open for at least 30 days following the date of the referral or from the date of the individual receiving OPTIONS services. This time period allows the Options Counselor and the assigned APS staff to communicate to assure that services are appropriate. The assigned APS staff must communicate the intent to close the APS care before it is closed.

(d) The individual's needs must be determined by APS to be severe and without intervention to stabilize the home environment there would be harm to the individual.

(e) The Intake Screening will be completed by the I&A staff at the AAAD based on the information provided in the APS referral document as well as phone call with individual if needed. If the score and the level of need for the APS clients are comparable to non-APS individuals on the AAAD wait list, the APS client will be added to the existing program wait list. A Notice of Action will be provided to the APS staff informing them of this decision. Individuals with the highest score and are on the wait list the longest, will be pulled off first to be assessed when there is funding available.

(2) Low income individuals

The following conditions apply:

(a) Must meet the Federal Poverty Guidelines that change annually. (Appendix E)

(b) Funding to provide services must be available.

16-1-.09: Administrative Requirements

(1) TCAD shall:

(a) designate a coordinator to oversee program development implementation of the home and home and community-based services

(b) develop and maintain consistent standards and mechanisms

(c) provide technical assistance as needed

(d) assume quality assurance responsibilities for all home and community-based services programs to ensure compliance with standards, policies, and procedures of TCAD.

(2) At a minimum, each AAAD shall:

(a) coordinate HCBS with other program and service systems serving adults age 60 and over and adults with disabilities

(b) conduct competitive bid process and choose service providers for authorization

(c) conduct contract compliance monitoring with service providers annually and renew contracts based upon performance and satisfactory compliance with contract specifications and quality assurance monitoring including service providers who provide service coordination

(d) apply Cost Sharing Plan

(e) compile and maintain a wait list for OPTIONS, OAA Title IIIB, and Nutrition

(f) ensure appropriate program/financial reporting, billing, and budget reconciliation.

(3) Service providers must:

(a) be licensed in accordance with the regulations of the State prior to performing any services. Service providers providing in-home services (homemaker and personal care) must have a PSSA license or be licensed as a home health care agency

(b) provide services and units of service that is consistent with the Provider Authorization

(c) notify the Options Counselor of any changes in an individual's condition/health/needs to the AAAD within five business days by phone or email and document in the individual's case note.

(d) keep documentation of all contact with or on the behalf of the individual and ensure that the assigned task identified in the Provider Checklist are carried out

(e) keep documentation of each service provided with each visit, which includes a services rendered checklist that is signed by the individual and the worker

(f) have methods and procedures in place for the collection and reporting of individual specific data, including but not limited to rosters, invoices, and daily logs and provide to the AAAD by the 10th day of the month following the month being reported

(g) comply with all state laws relating to mandated reporting of abuse, neglect, and/or exploitation and shall immediately make a report to appropriate officials for follow-up, conditions or circumstances which place the individual, or the household of the individual, in danger.

16-1-.10: Confidentiality

Details and identity shall not be disclosed without the individual's informed consent, except in compliance with court orders or to report elder abuse as required by T.C.A. 71-6-101, The Tennessee Adult Protection Act. The following protocols cover day-to-day situations involving individual records and office procedures and the protection of the individual's right to confidentiality:

(1) All individual files must be locked during non-working hours. During working hours, files may be unlocked if staff is present in the area. If staff is out of the office for more than one-half hour, even if in the building, the files should be locked.

(a) The key to the file cabinet should be controlled in each office.

(b) The original individual files must not leave the office.

(c) Copies of assessments that are done in individual homes must be secured in a locked file.

(d) Discretion in discussing individual information shall always be employed. Many staff share office space with program staff from other agencies. Files should not be left on desks in plain view. No lists of names are to be left in view on bulletin boards. Discussion of individual information shall not be held in hallways or with staff not authorized to be involved with the individual.

(e) Data that are transferred electronically must be adequately secured to avoid unauthorized access.

(f) A confidentiality notice must accompany all facsimile (FAX) transmissions.

(2) All electronic client data shall be maintained on agency controlled or authorized computers.

(a) All computers must be password protected.

(b) All electronic client data must be encrypted while stored on mobile or remote computing platforms and protected from unauthorized access, modification, and/or destruction at all times.

(c) AAAD shall have a written internal policy and procedure addressing the security of electronic client data that complies with HIPAA requirements.

(3) The AAAD shall always maintain the confidentiality of individual files and records. Such files and records shall not be disclosed except:

(a) to the individual or his/her representative;

(b) to TCAD or other state agencies for purposes of monitoring and securing home and community-based services with a signed Release of Information;

(c) to Tennessee Department of Human Services/Adult Protective Services Division worker; and

(d) under court order.

(4) The AAAD shall use individual records for purpose of the coordination of other related services only. Any disclosure of information in an individual's file for purposes of coordinating related services shall be limited to the information that is directly relevant to and required by the other related services.

16-1-.11: Records

(1) Each AAAD shall maintain separate records for each individual who applies for or receives home and community-based services. Records for each individual must include at a minimum the following:

(a) individual's name, address, and telephone number (cell number and email information, if available);

(b) individual's date of birth, gender, race/ethnicity;

(c) physician's name, address, and telephone number; (cell number and email information, if available);

(d) name, address, and telephone number of a person, other than spouse or relative with whom the individual resides, to contact in case of emergency (cell phone and/or email, if available);

(e) ADL/IADL status;

(f) documented disability due to a physical impairment;

(g) rural status;

(h) living alone status;

(i) whether or not the individual has an income at or below the poverty level for intake and reporting purposes; and

(j) eligibility requirements for service authorization as determined by ADLs/IADLs.

(2) Each individual's records shall be maintained by the AAAD for five (5) years plus the current year.

16-1-.12: Funding

The following guidelines apply to funding expenditures. Reimbursement rate for services is contained in Appendix C.

(1) The in-home support services must relate directly and clearly to the individual's care plan.

(2) The allowable cost for each individual is the maximum amount of funds that can be used to provide services to the individual and the care plan total cost must not exceed the maximum allowable cost.

(3) Funds cannot pay for services provided through or covered by any other provider or any other insurance or payment system.

(4) Home and community-based services provided under OPTIONS or Title IIIB shall not exceed a maximum of $7,000 annually per individual.

(5) In an effort to ensure program and financial accountability for the State OPTIONS funding, the AAAD shall not move individuals from Federal Title III funding to State OPTIONS funding.

(6) The total maximum annual amount of funding per individual must not exceed $7,000 regardless of the funding source including when individuals receive services from multiple funding sources.

16-1-.13: Cost Sharing and Participant Contribution Requirements

1) Administrative Requirements

a) Utilize a sliding fee scale with the following considerations:

i) Cost sharing shall be based solely on household income and the cost of delivering services to determine the cost share for HCBS.

ii) Determine eligibility for cost share by declaration of income with no requirement for verification.

iii) Assets, savings, or other property owned by the individual shall not be considered when defining low-income individual who is exempt from cost sharing, when creating a sliding scale for cost sharing or when seeking contributions.

iv) The cost share computation form may be found in Appendix D.

b) adhere to the cost sharing requirements for the individual funded in whole or in part by HCBS funding

c) implement cost sharing for all HCBS services except for:

i) information and assistance, outreach, benefits counseling, or case management services;

ii) ombudsman, elder abuse prevention, legal assistance, or other individual protection services;

iii) congregate and home delivered meals; and

iv) any services delivered through tribal organizations.

d) any funds received as the result of cost sharing must be:

(i) put back in the program as program income.

(ii) disbursed in a timely manner.

(iii) used to expand the service for which the income was given.

(iv) not be used for matching.

e) use methods for receiving cost share payments and contributions that protect the privacy and confidential of each individual in declaration or non-declaration of income and to any share of costs paid or unpaid by the individual.

f) invoice the individual for the cost share amount, issue a receipt of payment to the individual, and keep a record of accounts receivable for cost share payment.

g) not deny OAA funding to any individual due to the income of the individual or the individual's failure to make cost sharing payment.

h) make a good faith effort to collect cost sharing obligation above $25 per month. TCAD may approve a waiver for the AAAD if:

(i) a significant proportion of persons receiving HCBS have low incomes below the threshold established by TCAD (See Appendix E for Federal Poverty Guidelines); or

(ii) cost sharing would be an unreasonable administrative or financial burden on the AAAD.

2) Cost Share Procedure

The following identify the steps in developing the cost share plan based on the individual's care plan and notifying the individual about the amount of cost share.

a) During initial home visit, determine household income for the individual and/or spouse.

b) For individual's above the Federal Poverty Line, the Options Counselor will complete the Cost Share Worksheet (Appendix D) to determine an estimated cost share amount to be paid by the individual and will advise the individual of the estimated amount.

c) The individual will receive an enrollment letter with the estimated amount of the individual's cost share.

16-1-.14: Cost Effectiveness and Non-Duplication of Services

In order to ensure that all individuals eligible for HCBS can be served in a cost effective and efficient manner, three separate waiting lists will be maintained including one for Title IIIB Supportive Services, Nutrition, and OPTIONS.

(1) All individuals who are screened and appear to be eligible for CHOICES will be referred directly to the CHOICES Counselor.

(2) Individuals who are screened and appear to be eligible for Title IIIB Supportive Services, Nutrition Services, or OPTIONS will be placed on the appropriate waiting list.

(3) Individuals who are qualified for CHOICES and declines CHOICES are not eligible to receive OPTIONS services; however, they may be placed on the Title IIIB Supportive Services waiting list, on the Nutrition waiting list, or may choose the private pay option.

(4) When an individual receiving OPTIONS services is reassessed for services during the annual visit and is found to be eligible for CHOICES, the Options Counselor will make a referral to CHOICES. Options services may continue for up to 10 days from the CHOICES date the Options Counselor is notified of enrollment to ensure that the individual retains services until CHOICES services begin.

(5) If the individual who is receiving OPTIONS is found to be qualified for CHOICES but declines CHOICES, the AAAD may move the individual to Title IIIB Supportive Services.

16-1-.15: Reduction in Services

The AAAD shall reduce services in any of the following circumstances:

(1) The assessed level of need diminishes as established by an updated care plan.

(2) The AAAD's funds are insufficient to meet the service commitment to current individuals; all reasonable efforts have been made to secure resources to avoid services reductions; the AAAD has stopped performing new assessments and care plans; and the AAAD has adopted a fair and equitable policy for distributing service reductions among individuals. The fair equitable policy should be based upon the following criteria:

(a) The agency will suspend new enrollment.

(b) Upon the discharge or death of an individual, the agency will not fill the vacant slot.

(c) The Options Counselors will reduce all care plans not to exceed $2,500 per plan.

(d) If necessary, the AAAD will terminate individuals from the program on a case-by-case basis.

16-1-.16: Termination of Services

The AAAD shall terminate services in any of the following situations:

(1) The individual currently receiving OPTIONS services is re-assessed and qualifies for CHOICES, OPTIONS funding will continue until the individual begins receiving services from CHOICES.

(2) The current individual becomes eligible for HCBS from other sources for which the individual was not previously eligible and is now receiving those services.

(3) The individual's health or personal circumstances have improved so that the person no longer needs HCBS to maintain his/her independence in a safe, non-institutional environment.

(4) Other resources become available in the community and the individual begins receiving those services that were not available at the time of the development of the previous care plan.

(5) The health, welfare, or safety of the individual or providers can no longer be reasonably assured.

(6) The individual (or his/her representative) has fraudulently obtained or misused HCBS funded services.

(7) The individual is in the hospital for longer than thirty (30) days or has a permanent placement in a nursing facility.

(8) The individual receiving services passed away.

(9) The individual (or his/her representative) voluntarily requests termination.

(10) The individual (or his/her representative) refuses service necessary for his/her health and well-being.

(11) No service providers are willing to provide services, or no service providers are available in the area.

16-1-.17: Missed Visits

"Missed visit" is the term used when the provider fails to keep the scheduled appointment for services or the individual receiving services fails to be available for a scheduled appointment. "Missed visit" applies to both the provider and individual. Any missed visit by either the provider or individual should be reported to the Options Counselor and be recorded in the missed visit log. If a service provider misses three (3) visits within a year without notifying the individual and the individual is available to receive services, the individual will be advised to change providers. If the individual fails to be available to receive services three (3) times within a year without notifying the provider of the change in schedule, the individual will receive a letter from the AAAD advising him/her that services may be terminated.

16-1-.18: Quality Assurance

The AAAD will monitor the following:

(1) Individual Satisfaction Surveys

The program should conduct individual satisfaction surveys on an annual basis. The results of the surveys shall be analyzed, and a report produced that documents the evaluation of provider efforts.

(2) Provider Review

The AAAD shall conduct an annual review of service providers to ensure that all services are in compliance with the provider contract and to track the performance of the service provider utilizing the Service Provider Compliance Review tool developed by TCAD.

(a) Complaints and Incidents

A complaint may be any verbal or written communication that expresses dissatisfaction with something or someone. An incident is an occurrence that caused or had the potential to cause harm and/or a breach of security and/or confidentiality. Complaints and/or incidents must be promptly noted in the Complaint and Incident Log. The Log must document and detail the nature of the complaint and/or incident, the individuals involved, and the resolution of the complaint and/or incident. It should also be noted and corrected whenever providers consistently show up on the Complaints and Incidents list.

(b) Missed Visits

The Missed Visit Report will be checked to ensure that both the provider and the individual receive services as scheduled and that action has been taken to resolve the impact on the provider and/or the individual. The Missed Visit Report shall include the date(s) of the missed visit, the reason(s) for the missed visit, and the action taken to resolve the situation.

16-1-.19: Reporting Requirements

The data shall be entered into SAMS no later than the 20th of the month following the month being reported. When the due date falls on a weekend or holiday, the report will be due on the following business day. TCAD will review the SAMS data on a monthly basis. As required by the State Budget Office, the AAAD will submit monthly statistical data regarding OPTIONS that includes monthly enrollment, overall monthly expenditures, contracted services expenditures, and number of individuals on the waiting list.

16-1-.20: Background Checks

This program must be in compliance with Background Check Chapter of the TCAD Program and Policy Manual.

16-1-.21: Individual Transfers Between AAADs

Current individuals who move from one region to another region within Tennessee shall continue to receive services maintaining a seamless system. The individual shall be transferred to the AAAD that serves the county to which the individual moved. If there is an open slot, then the receiving AAAD would place the individual into that open slot. If the receiving AAAD has no open slot available, the receiving AAAD would not deny services, but would arrange for services to be provided to the individual and would bill the transferring AAAD the cost to provide services to the individual. The receiving AAAD would continue to bill the transferring AAAD on a monthly basis until an open slot becomes available. The receiving AAAD shall provide the transferring AAAD with written notice of the available slot and final billing.

16-1-.22: OPTIONS for Community Living: Self Directed Care

If an individual meets all the eligibility requirements for OPTIONS but would like more control over his/her services and providers than offered by the previously described OPTIONS program, the individual may select OPTIONS: Self-Directed Care often referred to as "consumer directed". The individual has the decision-making authority over his/her services and providers and takes direct responsibility for managing his/her services. The individual (or his/her authorized representative) will work with the OPTIONS Counselor to:

1) identify his/her needs;
2) determine how and when those needs will be met;
3) select the providers, such as family, friends, agency, etc.;
4) develop a spending plan for use of the funds; and
5) evaluate the quality of services he/she receives.

The individual will be responsible for providing training to and supervising those providing the services. A fiscal intermediary service provides assistance to the individual to ensure all the fiscal requirements are met by the individual as the employer.

TCAD has contracted with a provider of fiscal intermediary services. An individual assessed by the AAAD as eligible for self-directed services can hire his/her own personal assistant or other help whose job duties might include housekeeping, laundry, cooking, personal

care, and transportation. The goal of the program is to avoid institutionalization and related higher costs.

For OPTIONS: Self-Directed Care, general program policies include the following:

(1) The individual will not be able to have the fiscal intermediary service pay employees and/or providers on his/her behalf until:

(a) the individual enrollment paperwork is complete;

(b) the provider employee paperwork is complete;

(c) the provider training and background checks are complete; and

(d) the fiscal intermediary service receives an approved authorization from the Options Counselor.

The fiscal intermediary service's standard method of paperwork distribution is for the Options Counselor to download provider packets from the program website. However, packets can be mailed upon request.

(2) The individual will be the employer of record (EOR) unless the family determines that he/she needs a representative to serve in this capacity or the individual has an existing Employer Identification Number (EIN).

(3) If the individual has a conservator/Power of Attorney, conservatorship paperwork must be sent to the fiscal intermediary service.

(4) All documents for individuals and providers will be stored in the document management system for viewing on the Web Portal.

(5) Spouses and conservators of participants/employers/authorized representatives may not provide services in this program.

(6) There is no limit to the number of providers a consumer may hire; however, providers may only be on staff for more than one consumer if they have a Personal Support Service Agency (PSSA) license.

(7) Background and registry checks are conducted for all employees.

For further specifics regarding the program, the complete document can be found in Appendix F.

Appendix A

Social Assistance Management System Independent Living Assessment (SAMS ILA) and Guide

SAMS ILA 2018

A	Intake/Assessment			Req?
	Intake/Assessment	1144	1	What is the date of the assessment? Month – Day – Year	Yes
		1145	2	Specify the type of assessment, or the reason for the assessment. ☐ 1 Initial assessment ☐ 2 Reassessment	Yes
		1001	3	What is the name of the person conducting this assessment?	Yes
		2999	4	Describe formal/informal supports already in place.	No
		5695	5	Comment on type of assistance requested.	Yes

B	Individual Identification			Req?
	Individual Identification	1128	1	What is the client's first name?	Yes
		1493	2	Enter the client's 'also known as' first name.	No
		1129	3	What is the client's middle initial?	No
		1127	4	What is the client's last name?	Yes
		1134	5	What is the client's date of birth? Month – Day – Year	Yes
		4297	6	What document was used to verify the client's age? ☐ 1 Birth certificate	Yes

B	Individual Identification			Req?
			☐ **2** State issued identification ☐ **3** Military/veteran's identification card ☐ **4** Self declaration ☐ **5** Other (Answer next question if this is chosen)	
	4298	7	What other document was used to verify the client's age? _____	No
	1131	8	What is the client's Pension/Social Security Number? (Optional or collect if making CHOICES referral) _____-_____-_____	No
	1495	9	Enter the client's telephone number. _____	Yes
	6627	10	Alternate telephone number for client _____	No
	5362	11	What is the client's e-mail address? _____ _____	No
	1501	12	Enter the client's residential address. _____	Yes
	1502	13	Enter the client's residential city or town. _____	Yes
	1408	14	Enter the client's state of residence. _____	Yes
	1409	15	Enter the client's residential zip code. _____	Yes
	1724	16	What county does the client reside in? _____	Yes
	1505	17	Describe how to get to the client's home. _____ _____ _____	No
	1497	18	Enter the client's mailing street address or Post Office box. _____	Yes
	1498	19	Enter the client's mailing city or town. _____	Yes

B	Individual Identification			Req?
		1499 20	Enter the client's mailing state.	Yes
		1500 21	Enter the client's mailing ZIP code.	Yes
		1012 22	Select the client's current living arrangement.	Yes
		Score: 3	☐ **1** Lives Alone (3) ☐ **2** Lives with spouse only ☐ **3** Lives with spouse and others ☐ **4** Lives with others.	

C	Demographics			Req?
	Demographics	4005 1	What is the client's ethnicity?	Yes
			☐ **1** Hispanic or Latino ☐ **2** Not Hispanic or Latino ☐ **3** Unknown	
		4006 2	What is the client's race?	Yes
			☐ **1** American Indian/Native Alaskan ☐ **2** Asian ☐ **3** Black/African American ☐ **4** Native Hawaiian/Other Pacific Islander ☐ **5** Non-Minority (White, Non-Hispanic) ☐ **6** White-Hispanic ☐ **7** Other	
		1133 3	What is the client's gender?	Yes
			☐ **1** Male ☐ **2** Female ☐ **3** Other	
		1010 4	Select the client's current marital status.	Yes
			☐ **1** Single ☐ **2** Married ☐ **3** Divorced ☐ **4** Widowed ☐ **5** Separated ☐ **6** Other	

D	Caregiver Identification			Req?
	Caregiver Identification	1066 1	Does the client have an identified primary (informal) helper/caregiver who provides care on a regular basis?	Yes
			☐ **1** Yes	
		Score: 2	☐ **2** No, If no, skip to next section. (2)	

D	Caregiver Identification			Req?
		4732 2	What is the caregiver's first name?	No
		4731 3	What is the caregiver's last name?	No
		2531 4	Caregiver's birth date? ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)	No
		4734 5	What is the caregiver's telephone number?	No
		5363 6	What is the caregiver's e-mail address?	No
		2545 7	What is the address of the client's caregiver?	No
		2548 8	What is the client's caregiver's Zip Code?	No
		5360 9	What is the caregiver's relationship to the elderly care recipient? ☐ 1 Child ☐ 2 Spouse/Partner/Significant other ☐ 3 Other relative ☐ 4 Other non-relative	No
		1429 10	How often does the client receive assistance from the primary caregiver? ☐ 1 Daily ☐ 2 Several times a week ☐ 3 Weekly ☐ 4 Less than weekly	No

E	Emergency Contacts			Req?
	Emergency Contacts	2400 1	Name of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes
		2401 2	Relationship of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes

E	Emergency Contacts			Req?
		2402 3	Primary Telephone Number of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes
		2403 4	Alternate Telephone Number of Friend or Relative (outside client's home) to contact in case of an Emergency.	No
		1040 5	What is the name of a second relative or friend of the client?	No
		1503 6	What is the home phone number of the second relative or friend of the client?	No
		1504 7	What is the alternate phone number of the second relative or friend of the client?	No
		1514 8	Does the client have a power of attorney? ☐ **1** Yes, Health ☐ **2** Yes, Finances ☐ **3** Yes, Both ☐ **4** No (If no, skip to question #11) ☐ **5** Don't Know (If don't know, skip to question # 11)	No
		1515 9	What is the name of the client's power of attorney?	No
		1517 10	Enter the phone number of the client's power of attorney.	No
		2228 11	Does the client have a living will? ☐ **1** Yes ☐ **2** No	No

F	Social Screening			Req?
	Social Screening	1559 1	Is there a friend or relative that could take care of the client for a few days? ☐ **1** Yes Score: 3 ☐ **2** No (3)	Yes

G	Health Screening			Req?
	Health Screening	1561 1	How does the client rate his/her health? ☐ **1** Excellent ☐ **2** Good Score: 1 ☐ **3** Fair (1) Score: 2 ☐ **4** Poor (2)	Yes

G	Health Screening			Req?
		4292 2	In the past year, how many times has the client stayed overnight in a hospital?	Yes
			☐ **1** Not at all	
		Score: 1	☐ **2** Once (1)	
		Score: 2	☐ **3** 2 or 3 times (2)	
		Score: 3	☐ **4** More than 3 times (3)	
		1566 3	Has the client fallen in the past three months?	Yes
		Score: 3	☐ **1** Yes (3)	
			☐ **2** No	
		2714 4	Is the client homebound?	Yes
		Score: 3	☐ **1** Yes (3)	
			☐ **2** No	
		1124 5	Indicate which of the following conditions/diagnoses the client currently has.	Yes
			☐ Alzheimers disease/other Dementia	
			☐ Ankle/leg swelling	
			☐ Any urinary or bowel problems	
			☐ Arthritis/rheumatic disease/gout	
			☐ Cancer	
			☐ Chronic pain	
			☐ Contagious/Communicable Disease	
			☐ Do you take any medication for depression or anxiety	
			☐ Diabetes	
			☐ Have you ever had a stroke	
			☐ Hearing impairment	
			☐ Heart problems	
			☐ Hypertension	
			☐ Intellectual/Developmental disability	
			☐ Memory Loss	
			☐ Missing limb (e.g., amputation)	
			☐ Problems with breathing	
			☐ Tremors	
			☐ Vision problems	
			☐ Other significant illness	
			☐ None of the Above	
		1126 6	Enter any comments regarding the client's medical conditions/diagnoses.	No
			_____	
			_____	
			_____	

H	Mental Health Observations			Req?
	Mental Health Observations	7406 1	Can the client express basic needs and wants? ☐ 1 Yes ☐ 2 No	No
		1936 2 Score: 1 Score: 2	How many days per week does the client have problems making him/herself understood? ☐ 1 Never ☐ 2 Sometimes (1) ☐ 3 Always (2)**	Yes
		7391 3	Can the client understand and follow simple instructions? ☐ 1 Yes ☐ 2 No	No
		1938 4 Score: 1 Score: 2	How many days per week does the client have problems understanding others? ☐ 1 Never ☐ 2 Sometimes (1) ☐ 3 Always (2)**	Yes
		1978 5 Score: 1 Score: 2	How is the client's orientation to people? ☐ 1 No apparent problem ☐ 2 Sometimes a problem - 1 to 3 days (1) ☐ 3 Often a problem - 4 to 7 days (2) **	Yes
		1969 6 Score: 1 Score: 2	How is the client's orientation to place? ☐ 1 No apparent problem ☐ 2 Sometimes a problem - 1 to 3 days (1) ☐ 3 Often a problem - 4 to 7 days (2) **	Yes
		4888 7 Score: 1 Score: 2	Has the individual exhibited behavior problems? ☐ 1 No apparent problem ☐ 2 Sometimes a problem - 1 to 3 days (1) ☐ 3 Often a problem - 4 to 7 days (2) **	Yes
		1460 8	Indicate the behaviors the client has demonstrated. ☐ Verbal disruption ☐ Physical aggression ☐ Disruptive behavior ☐ Delusional ☐ Getting lost/wandering ☐ Presents other problems	No

I	ADL/IADL and Other Limitations			Req?
	ADL	1081 1 Score: 1	During the past 7 days, and considering all episodes, was the client able to BATHE without help? ☐ 1 Yes ☐ 2 No, required assistive technology - 1	Yes

I	ADL/IADL and Other Limitations			Req?
	Score: 2	☐ 3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐ 4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐ 5	No, required extensive/total assistance (4 to 7 days a week hands on help) - 4	
	1077 2	During the past 7 days, and considering all episodes, was the client able to Dressing without help?		Yes
		☐ 1	Yes	
	Score: 1	☐ 2	No, required assistive technology - 1	
	Score: 2	☐ 3	No, required supervision (SBA -Verbal someone there to watch or prompt) - 2	
	Score: 3	☐ 4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐ 5	No, required extensive/total assistance (4 to 7 days a week hands on help) - 4	
	1074 3	During the past 7 days, and considering all episodes, was the client able to TRANSFER without help?		Yes
		☐ 1	Yes	
	Score: 1	☐ 2	No, required assistive technology - 1	
	Score: 2	☐ 3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐ 4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐ 5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	1076 4	During the past 7 days, and considering all episodes, was the client able to GET AROUND THE HOME without help?		Yes
		☐ 1	Yes	
	Score: 1	☐ 2	No, required assistive technology - 1	
	Score: 2	☐ 3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐ 4	No, required limited assistance (1 to 3 days physical hands on help)- 3	
	Score: 4	☐ 5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	1078 5	During the past 7 days, and considering all episodes, was the client able to EAT without help?		Yes
		☐ 1	Yes	
	Score: 1	☐ 2	No, required assistive technology - 1	
	Score: 2	☐ 3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐ 4	No, required limited assistance (1 to 3 days physical hands on help) - 3	
	Score: 4	☐ 5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	1079 6	During the past 7 days, and considering all episodes, was the client able to USE THE TOILET without help?		Yes
		☐ 1	Yes	
	Score: 1	☐ 2	No, required assistive technology - 1	
	Score: 2	☐ 3	No, required supervision (SBA - Verbal someone there to watch or prompt) - 2	
	Score: 3	☐ 4	No, required limited assistance (1 to 3 days physical hands on help)- 3	
	Score: 4	☐ 5	No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
	2118 7	Enter the total ADL impairments as calculated above. (This is the SAMS ADL score and cannot be greater than 6. They get 1 point for each ADL question they answered No to.)		Yes
			☐	

I	ADL/IADL and Other Limitations			Req?
	IADL	1084 1	During the past 7 days, and considering all episodes, was the client able to MANAGE MEDICATIONS without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No, required assistive technology - 1	
		Score: 2	☐ 3 No, required supervision (SBA -Verbal somone there to watch or prompt) - 2	
		Score: 3	☐ 4 No, required limited assistance (1 to 3 days physical hands on help) - 3	
		Score: 4	☐ 5 No, required extensive/total assistance (4 to 7 days a week hands on help)** - 4	
		1901 2	Is the client able to MANAGE MONEY without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1086 3	Is the client able to SHOP without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1082 4	Is the client able to PREPARE MEALS without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1902 5	Is the client able to do HEAVY HOUSEWORK without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1903 6	Is the client able to do LIGHT HOUSEKEEPING without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1087 7	Is the client able to USE TRANSPORTATION without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		3820 8	Is the client able to USE THE TELEPHONE without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		2119 9	Enter the Total IADL impariements as calculated above. (This is the SAMS IADL Score. It cannot be greater than 8. They receive 1 point for each question they answered No to.) ☐	Yes
		4384 10	Comment on the client's functional ability. _____ _____ _____	No
	Adaptive Equipment	5380 1	Does the client have any of the following devices or equipment?	No
			☐ 1 Artificial limb	
			☐ 2 Bath stool	

I	ADL/IADL and Other Limitations			Req?
			☐ **3** Bedside commode ☐ **4** Cane ☐ **5** Dentures ☐ **6** Extended shower head ☐ **7** Eyeglasses ☐ **8** Grab bars ☐ **9** Hand Held Shower ☐ **10** Hearing aid ☐ **11** Hospital bed ☐ **12** Lift chair ☐ **13** Nebulizer ☐ **14** Oxygen ☐ **15** Raised toilet seat ☐ **16** Ramp ☐ **17** Walker ☐ **18** Wheelchair ☐ **19** Other	
		6772 2	Please specify the other assistive devices the client uses. _____ _____ _____	No
		5785 3	If the client did not receive agency funded services, would the client have enough help to remain independent? ☐ **1** Yes, without difficulty ☐ **2** Yes, with difficulty ☐ **3** No/not sure	No

J	Nutrition Screening			Req?
	Nutrition Screening	2383 1 Score: 2	Has the client made any changes in lifelong eating habits because of health problems? ☐ **1** Yes - 2 ☐ **2** No	Yes
		1108 2 Score: 3	Does the client eat fewer than 2 meals per day? ☐ **1** Yes - 3 ☐ **2** No	Yes
		1110 3 Score: 2	Does the client have 3 or more drinks of beer, liquor or wine almost every day? ☐ **1** Yes - 2 ☐ **2** No	Yes
		2384 4	Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?	Yes

J	Nutrition Screening			Req?
		Score: 1	☐ 1 Yes - 1 ☐ 2 No	
		2385 5	Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?	Yes
		Score: 1	☐ 1 Yes - 1 ☐ 2 No	
		1818 6	Does the client have trouble eating well due to problems with chewing/swallowing?	Yes
		Score: 2	☐ 1 Yes - 2 ☐ 2 No	
		1112 7	Does the client sometimes not have enough money to buy food?	Yes
		Score: 4	☐ 1 Yes - 4 ☐ 2 No	
		1113 8	Does the client eat alone most of the time?	Yes
		Score: 1	☐ 1 Yes - 1 ☐ 2 No	
		1114 9	Does the client take 3 or more different prescribed or over-the-counter drugs per day?	Yes
		Score: 1	☐ 1 Yes - 1 ☐ 2 No	
		1115 10	Without wanting to, has the client lost or gained 10 pounds in the past 6 months?	Yes
		Score: 2	☐ 1 Yes - 2 ☐ 2 No	
		1116 11	Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?	Yes
		Score: 2	☐ 1 Yes - 2 ☐ 2 No	
		2563	Total score of Nutritional Risk Questions. ☐	Yes
		2116 12	Is the client at a high nutritional risk level? (Scored 6 or more)	Yes
			☐ 1 Yes ☐ 2 No	

K	Current Health Status			Req?
	Current Health Status	1804 1	Describe the client's allergies, if any.	No
		1817 2	Describe the client's special diet(s).	No

K	Current Health Status			Req?
			_____ _____ _____	

L	Home Hazards			Req?
	Home Hazards	4052 1	Is there evidence of pets/animals that are a danger to those who come to the client's home? ☐ **1** Yes ☐ **2** No	No

M	Home Environment			Req?
	Environmental Checklist	1941 1	Does the client have problems with dangerous stairs or floors in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1942 2	Is it difficult for the client to get to the entrance of his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1943 3	Is it difficult for the client to get to the bathroom or bedroom in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1944 4	Does the client have problems with the major appliances or toilet in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1945 5	Does the client have problems with the heating or cooling in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1946 6	Does the client have problems getting water or hot water in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1947 7	Does the client have difficulties keeping his/her home free from odor or pests? ☐ **1** Yes ☐ **2** No	Yes
		1948 8	Does the client need a smoke alarm in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1949 9	Does the client have problems with electrical hazards in his/her home? ☐ **1** Yes	Yes

M	Home Environment				Req?
				☐ **2** No	
		1950	10	Does the client have problems with poor lighting in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1951	11	Does the client have problems with an unsafe stove in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1952	12	Does the client have problems with loose slippery rugs in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1953	13	Does the client have problems with inadequate locks on the doors and/or windows in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1954	14	Does the client have problems keeping his/her home clean and free of clutter? ☐ **1** Yes ☐ **2** No	Yes
		1955	15	Does the client have any other environmental problems in his/her home? ☐ **1** Yes ☐ **2** No	Yes
		1956	16	Describe any other environmental problems. _____ _____ _____	Yes
		1957	17	In the case of an emergency, would the client be able to get out of his/her home safely? ☐ **1** Yes ☐ **2** No	Yes
		1958	18	In the case of an emergency, would the client be able to summon help to his/her home? ☐ **1** Yes ☐ **2** No	Yes
		4227	19	Comment on the client's home environment in general. _____ _____ _____	Yes

N	Financial Resources				Req?
	Total Resources	2068	1	What is the total income of the client's household per month?	Yes

N	Financial Resources			Req?
		2529 2	How many people does the houshold income support? ☐☐☐	Yes
		2115 3	Is the client's income level below the national poverty level?	Yes
		Score: 2	☐ 2 Yes (2)	
			☐ 2 No	
		1555 4	Specify the client's monthly income (or client and spouse if married).	No
		3910 5	What is the client's Monthly Income Range?	Yes
		Score: 3	☐ 1 Below 150% federal poverty level (3)	
			☐ 2 Over 150% of poverty level up to 200% of poverty level	
			☐ 3 More than 200% of poverty level but less than 300% of FBR	
			☐ 4 Over 300% federal benefit rate	
		5802 6	Does the client have excessive expenses, such as medical bills, that prevent them from meeting their needs?	Yes
		Score: 1	☐ 1 Yes (1)	
			☐ 2 No	
	Other Assistance	1552 1	Does the client want to apply for any of the following services or programs?	Yes
			☐ 1 Energy assistance (LIHEAP)	
			☐ 2 Food stamps (SNAP)	
			☐ 3 Home Repair/Weatherization	
			☐ 4 QMB/SLMB/LIS/Q1	
			☐ 5 SSI	
			☐ 6 Medicare Counseling	
			☐ 7 None	
		2123 2	Is the client a veteran or the spouse/widow of a veteran?	Yes
			☐ 1 Yes	
			☐ 2 No	
	Health Insurance	1780 1	Does the client have Medicare A health insurance?	Yes
			☐ 1 Yes	
			☐ 2 No (Skip next two questions)	
			☐ 3 Don't know	
		1002 2	Enter the client's Medicare number. _____	No
		1781 3	What is the effective date of the client's Medicare A policy? ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)	No
		1782 4	Does the client have Medicare B health insurance?	No
			☐ 1 Yes	
			☐ 2 No (Skip next question)	

N	Financial Resources			Req?
			☐ **3** Don't know	
		1783 5	What is the effective date of the client's Medicare B policy?	No
			☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	
		1785 6	Does the client have Medigap health insurance?	No
			☐ **1** Yes	
			☐ **2** No	
		5979 7	Does the client have Medicare D health insurance?	No
			☐ **1** Yes	
			☐ **2** No	
		1788 8	Does the client have LTC health insurance?	No
			☐ **1** Yes	
			☐ **2** No	
		13430 9	Does the client have Medicaid or TennCare?	No
			☐ **1** Yes	
			☐ **2** No	
		1791 10	Does the client have other health insurance?	No
			☐ **1** Yes	
			☐ **2** No	
		2440 11	Please indicate if the individual has QMB/SLMB	No
			_____	
			_____	

O	CHOICES Screening			Req?
	CHOICES	5991 1	Does the client own his/her home or any other property?	No
			☐ **1** Yes	
			☐ **2** No	
		7140 2	What are the client's resources/assets?	No
			☐ **1** Certificate of Deposits	
			☐ **2** Checking Account	
			☐ **3** Savings certificate	
			☐ **4** IRA or Annuity	
			☐ **5** Savings Account	
			☐ **6** Stocks, Bonds	
			☐ **7** Burial contract	
			☐ **8** Life insurance policy with cash value	
			☐ **9** Property other than home	
		8131 3	Are the Consumer's assets valued at less than $2000?	No
			☐ **1** Yes	

O	CHOICES Screening			Req?
			☐ **2** No ☐ **3** Don't Know	
		6332 4	Has the client transferred any property or money in the last five years? ☐ **1** Yes ☐ **2** No	No
		11925 5	While you are more likely to get more services sooner by getting CHOICES, getting CHOICES also means that any property and assets you have are subject to Estate Recovery. Knowing this, would you still like to be screened for CHOICES? ☐ **1** Yes ☐ **2** No	No
		3989 6	What is the date of the consumer's last medical evaluation by a physician? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	No
		1025 7	What is the name of the client's primary care physician? _____	No
		1028 8	What is the work phone number for the client's primary care physician? _____	No

P	Other Observations			Req?
	Other Observations	4044 1	Client is assigned for in-depth assessment for the following programs? ☐ **1** CHOICES ☐ **2** OPTIONS ☐ **3** Title IIIE, NFCSP services ☐ **4** Title IIIB ☐ **5** Title IIIC, Home Delivered Meals ☐ **6** None	Yes
		4688 2	Enter assessment comments. _____ _____ _____	No

Q	Prioritization			Req?
	Prioritization	2486 1	Is this an APS Referral? ☐ **1** Yes ☐ **2** No	No
		5353 2	Other Factors _____ _____	No

Q	Prioritization			Req?
		1778 3	Enter the Total Priority Score as calculated above	No
		15055 4	Total Risk Level	No
			☐ **1** Low Risk (1 to 15)	
			☐ **2** Moderate Risk (16 to 30)	
			☐ **3** High Risk (31-70)	

Tennessee Commission on Aging and Disability Uniform Assessment Form Guidance Manual

April 2018

Introduction

With over 100 Tennesseans turning sixty every day and soaring demand for a limited pool of state-funded home and community based services (HCBS), in the summer of 2015, the Tennessee Commission on Aging and Disability (TCAD) in partnership with the aging network sought to revise and update its screening and assessment policies and processes. The end goal was to develop a system in place that was focused on the individual and could efficiently identify and prioritize their needs. To achieve this goal TCAD enlisted the help of the Department of Finance and Administration's Office of Consulting Services (now under the Governor's Office of Customer Focused Government) to use the Lean process to revamp the current system. The Lean process brought together stakeholders from TCAD, four Area Agencies on Aging and Disability (AAAD), and a service provider to reimagine and reengineer a new way of screening and assessing individuals seeking state-funded HCBS services.

This manual is one of the many products of the Lean process that designed to create a more efficient and consistent screening and assessment process. This manual will help ensure that anyone using the Intake and Assessment Form will have clear instructions on how to use it and that collected information is consistent from initial contact to reassessment and across all districts.

Special thanks to the following individuals for making this possible:

Emily Passino	Susie Tucker
Mary Kennedy	Genie Guinn
Holly Williams	Kaitlin Carlson
Debra Holmes	Andrea Morrow
Donna Odom	Kathy Zamata
Tabitha Satterfield	Keith Barnes

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Overview

Items presented in the Intake and Assessment Form should not be read word for word. Instead they should be presented in a natural and conversational manner. For example, instead of asking, "What is the client's date of birth?" Ask, "When is your birthday? What year were you born?"

Each item contained in the Intake and Assessment Form is included in this manual. There are instructions for how each item should be completed. For more complicated items, there is also a description that provides background on the importance of the item and help in understanding and collecting the right information.

An asterisk (*) at the end of an item denotes that the item should generally be completed during an I&A screening. All items should be completed for an in-home assessment with the exception of the Medicare subsection in Section I: Financial Resources.

The following symbols at the end of an item denote that an item is especially important to complete:

[E] = item used for eligibility

[P] = item used to evaluate priority

[R] = item required to report to funders

Intake/Assessment (Section A)

1 What is the date of the assessment? *

Instructions: Enter the date the assessment is conducted.

2 Specify the type of assessment, or reason for the assessment? *

Instructions: Select whether this is an initial assessment or a reassessment.

3 What is the name of the person conducting this assessment? *

Instructions: Enter the name of the person conducting the assessment.

4 Describe formal/informal supports already in place. P

Instructions: Enter the current formal and informal services and supports the individual is currently receiving.

5 Comment on the type of assistance requested.*

Instructions: Note the type of assistance the individual is seeking.

Individual Identification (Section B)

1 What is the client's first name? *

Instructions: Enter the first name of the person being assessed.

2 What is the client's 'also known as' first name?

Instructions: Enter the preferred name of address of the person being assessed.

3 What is client's middle initial?

Instructions: Enter the middle initial of the person being assessed.

4 What is the client's last name? *

Instructions: Enter the last name of the person being assessed.

5 What is the client's date of birth? *ER

Description: With a few exceptions, services under the Older Americans Act may only be provided to individuals age 60 or over therefore this item is the key eligibility determinant and must be collected.

Instructions: Enter the date of birth of the person being assessed.

6/7 What document was used to verify the client's age?* What other document was used to verify the client's age?

Description: Because age is the key eligibility determinant, verification is strongly encouraged. However, in some situations an individual may be unable to provide documentation. They may choose to self-declare by completing the appropriate portion of the signature page.

Instructions: Select the documentation used to very age. If a document other than those outlined in Question 6 was used, note what that documentation was in Question 7.

8 What is the client's Pension/ Social Security Number? (Optional or collect if making CHOICES referral)

Description: Social Security Number may be needed to refer an individual to other services such as TennCare CHOICES or the State Health Insurance Assistance Program (SHIP). They are not required to provide this to receive any services offered under the Older Americans Act.

Instructions: Enter the Social Security Number of the person being assessed if they would like to be screened for additional services and supports such as CHOICES or SHIP.

9 Enter the client's telephone number. *

Instructions: Enter the best phone number for reaching the person being assessed.

10 Enter the client's alternate phone number.

Instructions: Enter the client's alternate phone number if available.

11 What is the client's e-mail address?

Instructions: Enter the client's e-mail address if available.

12/13/14 Enter the client's residential street address .* Enter the client's residential city or town.* Enter the client's residential zip code. *ER

Description: Services may only be provided to individuals residing in Tennessee with limited exceptions for the Family Caregiver Support Program. Aside from the obvious need to know where services are to be delivered, the zip code where the individual resides is used to determine if they live in a rural area for federal reporting purposes.

Instructions: Enter the address including zip code where the person being assessed lives.

15 What county does the client reside in? *R

Instructions: Enter the county where the person being assessed lives.

16 Describe how to get to the client's home. (Optional)

Description: Generally, this will not need to be included unless the individual lives somewhere that is difficult to navigate to.

Instructions: Enter a directions to the home of the person being assessed in enough detail that someone who has never been there before could use them.

17/18/19/20 Enter the client's mailing street address or Post Office box. * Enter the client's mailing city or town. * Enter the client's mailing state. * Enter the client's mailing ZIP code. *

Description: There are occasions where important program information may need to be mailed to the individual.

Instructions: If the person being assessed receives mail at another address, enter the mailing address.

21 Select the client's current living arrangement. *R

Description: It is well documented that individuals living along are at higher risk for a number of adverse health and mental health outcomes. Collecting this information can help assess if there are other services to explore in support the individual.

Instructions: Select the current living arrangement of the person being assessed.

Demographics (Section C)

1 What is the client's ethnicity? *R

Instructions: Select the ethnicity that the person being assessed identifies as.

2 What is the client's race? *R

Instructions: Select the race that the person being assessed identifies as.

3 What is the client's gender? *R

Instructions: Select the gender that the person being assessed identifies as.

4 Select the client's current marital status. *

Instructions: Select the current marital status of the person being assessed.

Caregiver Identification (Section D)

1 Does the client have an identified primary (informal/unpaid) helper/caregiver who provides care? *P

Instructions: Select whether the client has someone who acts as an informal/unpaid caregiver. If yes, complete the rest of the Caregiver Identification Subsection. If no, continue to the Emergency Contact Subsection.

2 What is the caregiver's first name?

Instructions: Enter the caregiver's first name.

3 What is the caregiver's last name?

Instructions: Enter the caregiver's last name.

4 Caregiver's birth date?

Instructions: Enter the caregiver's date of birth.

5 What is the caregiver's telephone number?

Instructions: Enter the best phone number to reach the caregiver.

6 What is the caregiver's e-mail address?

Instructions: Enter the caregiver's e-mail address if available.

7 What is the address of the client's primary caregiver?

Instructions: Enter the primary caregiver's address including street, city, state, and apartment number.

8 What is the client's primary caregiver's Zip Code?

Instructions: Enter the primary caregiver's Zip Code.

9 What is the caregiver's relationship to the care recipient?

Instructions: Select the relationship type between caregiver and care recipient.

10 How often does the client receive assistance from the primary caregiver? P

Description: This item will better help us to understand the level of involvement the caregiver has in helping the care recipient meet their basic activities of daily living and other needs required to live independently.

Instructions: Select how often the caregiver provides assistance to the care recipient.

Emergency Contacts (Section E)

1/2/3/4 Name of friend or relative (outside client's home) to contact in case of an emergency. * Relationship of friend or relative (outside client's home) to contact in case of an emergency. * Primary telephone number of friend or relative (outside client's home) to contact in case of an emergency. * Alternate telephone number of friend or relative (outside client's home) to contact in case of an emergency.

Description: There are occasions where the AAAD or service provider will need to notify someone of an emergency involving the person receiving services. The purpose of these questions are to provide a contact outside the home that may be reach in the case of an emergency.

Instructions: Enter the name and contact information for friend or relative who may serve as an emergency contact.

5/6/7 What is the name of a second relative or friend of the client's? What is the primary phone number of the second relative or friend of the client's? What is the alternate phone number of the second relative or friend of the client's?

Description: An alternate contact may be needed in some situations.

Instructions: Enter the name and contact information for a second friend or relative of the person being assessed.

8 Does the client have a power of attorney?

Description: In some cases, if an individual has a power of attorney, that individual will need to be notified before further action can be taken to assist the person seeking services. This is also an opportunity to help the individual plan ahead for their eventual needs.

Instructions: Select the type of power of attorney the person has if any.

9/10 What is the name of the client's power of attorney? Enter the phone number of the client's power of attorney.

Description: If the person being assessed has a power of attorney, we need to know how to reach that person if anything they need to be aware of occurs.

Instructions: If the person being assessed has a power of attorney, enter their name and phone number.

11 Does the client have a living will?

Description: A living will is an important document that lays out in advance an individual's end of life wishes in the event that they are not able to voice those wishes. We can help the individual navigate this process if they haven't already done so before.

Instructions: Select whether the person being assessed has a living will.

Social Screening (Section F)

1 Is there a friend or relative that could take care of the client for a few days? *

Description: Older individuals often face situations such as recovery from illness or injury that requires significant but short-term care. If an individual does not have someone who can provide this care, additional services may be needed to support them through these episodes.

Instructions: Select whether the individual has a friend or relative who could take care of them for a few days.

Health Screening (Section G)

1 How does the client rate his/her health? *P

Description: Self-rated health is an important indicator of an individual's general health and well-being. That means that if an individual rates their health poorly, even if they may not have significant health problems currently, they are likely to get worse soon.

Instructions: Select the individual's self-rate level of health.

2 In the past year, how many times has the client stayed overnight in a hospital? *P

Description: Overnight hospital stays are a strong indicator of significant health problems that may signal further decline.

Instructions: Select whether or not the individual has had an overnight hospital stay in the last year for any reason.

3 Has the client fallen in the past three months? *P

Description: Falls are an indication that the individual's mobility is beginning to decline and are an early sign of the onset of frailty. This question is also important because it is used to determine CHOICES eligibility.

Instructions: Select whether or not the individual has had a fall in the last three months for any reason.

4 Is the client homebound? *EP

Description: Federal Regulations require that priority for services be given to individuals who are homebound or otherwise isolated. An individual is considered homebound if they meet one or more of the following criteria:

- Leaving home is not recommended due to the condition of the individual; or
- Leaving home takes a considerable and taxing effort; or
- The individual's condition keeps him/her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); or
- The individual is unable to access a congregate meal site.

An individual may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services and still be considered homebound.

Instructions: Using the guidelines in the description above, select whether or not the individual is homebound.

5 Indicate which of the following conditions/ diagnoses the client currently has. *

Description: Knowing what health and mental conditions the individual has can help better tailor services to meet the individual's needs. Also, knowing the number of individuals with a certain diagnoses receiving or waiting to receive service can help in pursuing additional funding opportunities.

Instructions: Ask the individual what conditions a doctor or other professional has told them that they have. Select any of the health conditions and diagnoses that the individual reports.

6 Enter any comments regarding the client's medical conditions/ diagnoses.

Description: This item is a space for additional notes on the individual's medical conditions and diagnoses. This includes conditions not covered in the previous item as well as any important details about conditions already noted.

Instructions: Enter any additional notes about the individual's health conditions and diagnoses.

Mental Health Observations (Section H)

1 Can the individual express basic needs and wants?

Description: The individual is incapable of reliably communicating basic needs and wants (e.g. need for assistance with toileting, presence of pain) in a manner that can be understood by others, including through the use of assistive devices.

Instructions: Select whether or not the individual can express basic needs and wants. If there is a limitation, document medical conditions that led to this limitation.

2 How many days per week does the individual have problems making him/herself understood? *

Description: This information is needed because CHOICES eligibility is determined by the level of unmet need the individual has.

Instructions: Select how often the individual has difficulty making him/herself understood.

3 Can the individual understand and follow simple instructions?

Description: The individual is incapable of understanding and following very simple instructions and commands (e.g. raise the client's right and point to the client's nose) without continual intervention.

Instructions: Select whether or not the individual can express basic needs and wants. If there is a limitation, document medical conditions that led to this limitation.

4 How many days per week does the individual have problems understanding others?

Description: This information is needed because CHOICES eligibility is determined by the level of unmet need the individual has.

Instructions: Select how often the individual has difficulty understanding others.

5/6 How is the client's orientation to people? *P How is the client's orientation to place? *P

Description: The individual is disoriented to person (e.g. fails to remember own name or recognize immediate family members) or place (e.g. does not know residence).

Instructions: Select whether or not the individual is oriented to person or place. If there is a limitation, document medical conditions that led to this limitation.

7/8 Has the individual exhibited behavior problems? * Indicate the behaviors the client has demonstrated at least once a week?

Description: These can be used as qualifiers for programs, including the CHOICES program.

Instructions: Select whether or not the individual displays any behavior problems. Check what behaviors apply to the individual.

ADL/IADL and Other Limitations (Section I)

Description: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) refer to the physical and cognitive limitations that prevent an individual from doing the activities they need to maintain independence. ADLs and IADLs include the following activities of daily livings which will be addressed in more detail below:

ADLs

- Transferring
- Getting around (Mobility)
- Eating
- Toileting
- Bathing
- Dressing

IADLs

- Managing money
- Shopping
- Managing medications
- Preparing meals
- Doing heavy housework
- Doing light housekeeping
- Transportation

Each ADL and IADL is assessed by the following question:

1. During the past 7 days, and considering all episodes, was the client able to [ADL or IADL] without help?

Following is a general description and instructions for each of these questions. More detailed information for each ADL and IADL is provided further down.

During the past 7 days, and considering all episodes, was the client able to (ADL or IADL) without help? *EPR

Description: This question is used to screen for and determine eligibility for TCAD-funded services in two ways. First, most in-home services require that a person be frail which is defined as two ADL limitations. Second, to be eligible for home-delivered meals, an individual must have a limitation in preparing meals. Additionally, ADLs and the medication management IADL are used to screen for CHOICES eligibility.

If an individual can and does use adaptive equipment, such as a shower chair for bathing or a cane for walking, safely and without significant burden to the individual then a no response should be selected to this question.

Instructions: Using the description above and the guidance for each ADL and IADL below, select whether or not the individual was able to perform ADL or IADL without help or if they did require help whether it is human help or adaptive equipment. If the answer is yes skip to the next ADL or IADL. If no, continue to ask the next question in the series.

For ADLs and Medication Management:

- If the individual can complete the activity without any assistance, select 'Yes'.

- If the individual can complete the activity by using an assistive device that they already possess (e.g. using a shower chair to bathe, a cane to walk, etc.), select 'No, required assistive technology'.
- If the individual can complete the activity but requires oversight, encouragement, or cueing to complete the task, select 'No, required supervision (SBA-Verbal someone there to watch or prompt)'.
- If the individual can complete the activity but requires limited physical assistance such as maneuvering of limbs or other non-weight bearing assistance, select 'No, required limited assistance (1 to 3 days physical hands on help)'.
- If the individual is completely unable to complete the activity without physical assistance, select 'No, required extensive/total assistance (4 to 7 days a week hands on help)'.

For other IADLs:

In addition to an individual requiring help to complete the task, other reasons to select a yes response to this question include if the individual takes a significantly longer period of time than normal to complete the task (e.g. preparing a simple meal takes over an hour) or if completing the task leads to over-exertion and inability to resume normal activity (e.g. light housework causes sever exhaustion requiring several hours to recuperate).

Detailed Descriptions and Instructions for Each ADL and IADL

Activities of Daily Living

Bathing

Is the client able to BATHE (include shower, full tub or sponge bath, exclude washing back or hair) without help?

Considerations: Not being able to get in and out of the tub/shower without assistance from a human being or an assistive device (this includes standby assistance). Not being able to prepare and dispose of things needed for a sponge bath? Not being able to bathe when no one else is home in case of a fall. Bathing less frequently because of limitation. Takes an extended period of time (45 minutes). Counselor's observation of hygiene is also a consideration.

Dressing

Is the client able to DRESS without help?

Considerations: Not wearing certain clothing to accommodate limitations. Not being able to pick out clothing or get clothing out of the closet or dresser. Not having dexterity to button clothing. Takes an extended period of time (30 minutes).

Transferring

Is the client able to TRANSFER without help?

Considerations: Needing standby assistance to supervise for safety. Staying in the bed or in the same spot for most of the day because of this limitation. Needing someone to put the client's legs/feet in and out of the bed. Taking an extensive amount of time and effort to transfer. Individual reports falling while transferring at least twice within the past 3 months.

Mobility

Is the client able to get around the home without help?

Considerations: Standby assistance or fall risk (reports at least 2 falls in the past 3 months). Becomes noticeably winded or short of breath quickly and must rest. Individual stays in one spot most of the day because of limitation. Counselor's observation of unsteady gait and/or safety risk is a consideration.

Eating

Is the client able to EAT without help?

Considerations: Prompting or reminding to eat. Thickened foods and liquids or supervision while eating because of choking hazard. Holding food in the mouth and being prompted to swallow.

Toileting

Is the client able to USE TOILET without help?

Considerations: Constant prompting or reminding to toilet. Not being able to adjust clothing, wipe properly or clean self properly after toileting or an incontinent episode. Frequent UTIs in females and improper wiping habits. Not being able to change/empty bedside commode independently.

Instrumental Activities of Daily Living

Medication Management

Is the client able to MANAGE MEDICATIONS without help? *

Considerations: If the pharmacy or anyone other than the individual fixes a medication box. If the individual forgets to have prescriptions refilled. Needs prompting or reminders to take medications. If medications have to be crushed or put in apple sauce because of swallowing problems. Counselor observation of med box or pills on the floor is considered.

Money Management

Is the client able to MANAGE MONEY without help? *

Considerations: The individual needs someone to write checks, balance checkbook or go get money orders to pay bills. All bills are paid through auto draft because the individual is unable to understand how to budget money or pay bills on time. A POA over finances does not always mean a deficiency unless the individual specifies that the POA manages their finances.

Shopping

Is the client able to SHOP without help?

Considerations: Inability to physically or safely shop independently in a store and might require assistance from employees. Can only shop if is a scooter is available. Can only go and pick up a few items from local corner store. Inability to transfer groceries from the store to the car or carry groceries into the home.

Meal Preparation

Is the client able to perform MEAL PREPARATION without help? *

Considerations: Forgets to turn off the stove or burns food frequently. Doesn't prepare food or eat balanced meals often because of this limitation. Unable to physically stand long enough to prepare a meal or needs to sit while preparing a meal (and this method does not adequately meet the need).

Heavy Housework

Is the client able to perform HEAVY HOUSEWORK without help? *

Considerations: Heavy housework is considered household chores that require moving furniture, getting down on the ground or floor, dusting baseboards, washing windows, heavy lifting, packing boxes, mowing the lawn.

Light Housekeeping

Is the client able to perform LIGHT HOUSEKEEPING without help? *

Considerations: Light housekeeping is considered light household chores like sweeping, mopping, dusting, vacuuming, wiping counters, washing dishes, changing bed linens, and doing the laundry. Consider a deficit if the individual is not physically or safely able to do light housework. It takes the individual all week to complete household chores or if after doing chores, they are hurting or unable to do anything the next day. Individual must to sit on chair or use a device to assist with this need.

Transportation

Is the client able to perform TRANSPORTATION without help? *

Considerations: The individual needs help walking to the car, getting in and out of the car, putting legs in the car, closing the door, buckling the seat belt, or needs help getting wheelchair or walker into the car. Consider a deficit if the individual does not have access to transportation. Consider all types of vehicles (for example if they need help getting into their son's truck or medical transportation van but not into their friend's sedan).

Telephone

Is the client able to use the Telephone without help? *

Considerations: The individual can answer the phone but cannot see to dial out or does not understand how to dial out. A deficit may be considered if the individual is deaf, visually impaired or unable to speak and/or does not have assistive devices to address this need (activity does not occur).

Adaptive Equipment Subsection

1/2 Does the client have any of the following devices or equipment? Please specify the other assistive devices the client uses.

Description: Assistive technology can help individuals adapt to many limitations they may have. Knowing what devices they currently can help identify other devices that might be helpful.

Instructions: Note any devices that are observed in use. If the individual stated that they use a device to assist with a certain ADL, follow up by asking what devices specifically are used and also check to see if there are any other devices that individual uses. Select all of the devices the individual currently uses. If the device is not listed, enter it into the space provided in the following item.

3 If the client did not receive agency-funded services, would the client have enough help to remain independent?

Description: We need to be able to demonstrate to our funders whether our services are successful in helping individuals to remain independent.

Instructions: List the services that the agency currently funds for the individual and then ask if they believed they could remain independent without those services. Select the appropriate response.

Nutrition Screening (Section J)

Description: The Administration for Community Living requires that any individuals receiving nutrition services be screened annually using the eleven questions above. These questions are designed to assess whether the individual is at risk of nutritional deficiencies that can lead to larger health problems. Because these questions are so strongly linked to other health issues, they are also used in determining priority for all TCAD-funded services.

Instructions: If an individual will be receiving nutrition services, for each of the items (below) in the Nutrition Screening section, ask the individual the question and select the yes or no response that they give.

1 Has the client made any changes in lifelong eating habits because of health problems? *

2 Does the client eat fewer than 2 meals per day? *

3 Does the client have 3 or more drinks of beer, liquor or wine almost every

day? *

4 Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day? *

5 Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day? *

6 Does the client have trouble eating well due to problems with chewing/swallowing? *

7 Does the client sometimes not have enough money to buy food? *

8 Does the client eat alone most of the time? *

9 Does the client take 3 or more different prescribed or over-the-counter drugs per day? *

10 Without wanting to, has the client lost or gained 10 pounds in the past 6 months? *

11 Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)? *

12 Is the client at a high nutritional risk level (score of 6 or higher)? *R

Description: Each of the nutrition screen questions is weighted. An individual who score six or higher is considered to be at high nutritional risk. Individuals identified as high risk must be referred to nutrition counseling.

Instructions: If completed electronically, this will automatically be determined. If not, the score for each response to the questions in the nutrition screening section must be added up. If the individual receives a score of six or higher, select that the individual is high nutritional risk.

Health Status (Section K)

1 Describe the client's allergies, if any.

Description: We want to be sure that any services that we provide do not trigger allergies for the individual.

Instructions: Note any allergies, particularly food allergies that the individual has.

2 Describe the client's special diet(s).

Description: While we cannot meet every need, we strive to provide each individual with the most appropriate diet available.

Instructions: Note any special diets the individual requires for cultural, religious, or health reasons such as diabetic, sodium-restricted, vegetarian, or kosher.

Home Hazards (Section L)

1 Is there evidence of pets/animals that are a danger to those who come to the client's home?

Description: Service coordinators should be aware of any potentially harmful conditions they may encounter prior to entering into a home.

Instructions: Note any issues the individual may have related to unsafe/unsanitary living conditions or any potential threats to visitors from hostile pets.

Home Environment Checklist (Section M)

Description: The purpose of this section is to determine whether the individual's home is safe and accessible and to identify additional services that may assist the individual in remaining at home safely.

Instructions: For each item, select whether or not applies based on the individual's responses and/or the client's own observations of the home environment. Discuss issues of concern with the individual and provide information about resources or offer to make referrals on their behalf.

General observations for completing this section should include:

- Access
    - Bedrooms and bath on second floor if the individual has limited mobility
    - Clutter or loose runners on stairs
    - Stairs with narrow steps/no rails
    - Need for visual marks or non-slip surfaces at stair edges
    - Pathways between bedroom/bed and bathroom unobstructed

    - Lack of elevator to living quarters if multi-story apartment
    - Doorways too narrow for wheelchairs
- Structural/Electrical
    - Exposed or frayed wiring or electrical cords
    - Over-use of extension cords
    - Damaged/improperly used electrical heaters
    - Uneven floors or ceiling with watermarks
    - Bathroom/kitchen for potential problems such as slippery floors
    - Poor/glaring lighting
    - Need for adaptive equipment such as grab bars
    - Thresholds which present tripping hazards
    - Skid proof strips in tub or shower
    - Elevated toilet seat if needed
    - Sinking or leaning toilet
- Other Hazards
    - Unsafe use of oxygen (e.g. open flame or smokers in home)
    - Unvented or improperly used space heaters
    - Dangerous wood stove installation/chimney
    - No fire extinguisher
    - Rugs not secured with non-slip backing
    - Wall-to-wall clutter
    - Unsanitary conditions may be indicated by odors, pest or pet droppings, dirty clothing, etc.
    - Dirty dishes may indicate a lack of hot water.

1 Does the client have problems with dangerous stairs or floors in his/her home? *

2 Is it difficult for the client to get to the entrance of his/her home? *

3 Is it difficult for the client to get to the bathroom or bedroom in his/her home? *

4 Does the client have problems with the major appliances or toilet in his/her home? *

5 Does the client have problems with the heating or cooling in his/her home? *

6 Does the client have problems getting water or hot water in his/her home? *

7 Does the client have difficulties keeping his/her home free from odor or pests? *

8 Does the client need a smoke alarm in his/her home? *

9 Does the client have problems with electrical hazards in his/her home? *

10 Does the client have problems with poor lighting in his/her home? *

11 Does the client have problems with an unsafe stove in his/her home? *

12 Does the client have problems with loose slippery rugs in his/her home? *

13 Does the client have problems with inadequate locks on the doors and/or windows in his/her home? *

14 Does the client have problems keeping his/her home clean and free of clutter? *

15 Does the client have any other environmental problems in his/her home? *

16 Describe any other environmental problems. *

17 In the case of an emergency, would the client be able to get out of the client's home safely? *

Instructions: In addition to considering responses to the previous items, look for locks that make doors difficult to open; check for windows painted, nailed, or barred shut; and ask whether a caregiver is present to help in an evacuation. Based on these observations, select whether or not the individual would be able to get out of their home safely in an emergency.

18 In the case of an emergency, would the client be able to summon help to his/her home? *

Instructions: Based on the individual's response, observe whether there is a telephone that is accessible and in working order and if the individual has a Personal Emergency Response System (PERS). Based on these observations, select whether or not the individual could summon help to their home in an emergency.

19 Comment on the client's home environment in general. *

Instructions: Record specifics about problems in the comment box. Indicate clearly whether these are the client's concerns or those of the individual. Also, indicate if any of the problems are of immediate/serious danger to the individual or may interfere in the provision of services. Document any resources provided or referrals to be made on their behalf.

Financial Resources (Section N)

Total Resources Subsection

1/2 What is the total income of the client's household per month? * How many people does the household income support? *

Description: This question is important for accessing eligibility for programs such as SNAP or LIHEAP, which typically want information on the household as a whole.

Instructions: For this item, consider the income of the individual being assessed, their spouse, and all individuals living in the household if applicable. This should include all sources of income including Social Security, pensions, earned income, and any other revenue received. The response is based on the self-report of the individual although they should be made aware that the accuracy of their response is important for connecting them with the appropriate services and supports. Enter the dollar amount of the individual's household's total monthly income and the number of people this income supports.

3 Is the client's income level below the national poverty level? *PR

Description: This question is critical for several reasons. Although Older Americans Act services are not means-tested, we do use this information to prioritize individuals when there is a waiting list for services. Additionally, individuals with incomes below this mark are eligible for many assistance programs not available to individuals at higher incomes such as QMB and/or are more likely to receive more services quicker such as SNAP.

Instructions: Using the current year Income Thresholds Card, select whether the individual is below poverty.

4 Specify the client's monthly income (or client and spouse if married).

Description: This question is critical for several reasons. Although Older Americans Act services are not means-tested, we do use this information to prioritize individuals when there is a waiting list for services. Additionally, individuals with incomes below this mark are eligible for many assistance programs not available to individuals at higher incomes such as QMB and/or are more likely to receive more services quicker such as SNAP.

Instructions: For this item, consider the income of the individual being assessed and their spouse, if applicable. This should include all sources of income including Social Security, pensions, earned income, and any other revenue received. The response is based on the self-report of the individual although they should be made aware that the accuracy of their response is important for connecting them with the appropriate services and supports. Enter the dollar amount of the individual's household's total monthly income and the number of people this income supports.

5 What is the client's monthly income range? *P

Description: Select the most appropriate option for the individual's monthly income range. Following are descriptions of each the levels and why that information is important:

> Below 150% Federal Poverty Level
> Description: This question is critical for several reasons. Although Older Americans Act services are not means-tested, we do use this information to prioritize individuals when there is a waiting list for services. Additionally, individuals with incomes below this mark are eligible for many assistance programs such as LIS/Extra Help and LIHEAP.
>
> Below 200% Federal Poverty Level
> Description: An individual is exempt from Options cost share requirements, if their income is below this level.
>
> Below 300% of the current Federal benefit rate
> Description: This question is critical for screening for CHOICES. CHOICES is TennCare's long-term services and supports program that can help provide the assistance an individual needs to stay in their homes.

Instructions: Using the current year Income Thresholds Card, select the most appropriate response that reflects the individual's income range. For example in 2016:

- If their income is $841/month for one person, select "Below 100% Federal Poverty Level".
- If their income is $2,297/month for two people, select "Below 300% of the current Federal benefit rate".

6 Does the client have excessive expenses, such as medical bills, that prevent them from meeting their needs? * P

Description: There are many instances where an individual may not have the resources to meet their needs but are not low income. Consideration should be given to large expenses or debts that that leave very little income left over. For example, the individual may have high medical costs or property tax liens. Giving consideration to this can help prevent the individual from further declining or increasing their expenses to the point that they will need even more costly assistance.

Instructions: Select whether or not the individual is able to meet their needs with the financial resources they have available to them.

Other Assistance Subsection

1 Does the client want to apply for any of the following services or programs? *

Description: While this is intended primarily for use in more intensive client interactions, it is important to at least offer to provide an overview of these programs during screening and eligibility determination activities. This question is used to identify additional assistance that the individual may be eligible for and/or is interested in apply for. Below is a guide to each program identified as a potential response.

Instructions: Provide the individual with an explanation of each of the programs and mark those for which they are interested in receiving more information or applying for.

Energy Assistance (LIHEAP)

Overview

Low-Income Home Energy Assistance (LIHEAP) provides low-income households with financial assistance to cover high home heating and cooling costs. Assistance is subject to funding availability.

Eligibility

A household must bear responsibility for covering its heating and cooling costs and at minimum, meet the following limits:

Household Size	**Monthly Income**	**Asset Limits**
1 or 2	150% FPL	No Limit

How to Apply

Application should be submitted to the local LIHEAP agency. Applications and agency info are both available here: http://thda.org/business-partners/low-income-home-energy-assistance-program

SNAP (Food Stamps)

Overview

SNAP provides extra money for buying food. Specific assistance depends on net income but is a minimum of $16/month and for the average person over 60 is $106/month.

Eligibility

Older adults (60+) and persons with disabilities have less restrictive eligibility requirements than the general population. They must meet the following net income and asset requirements:

Household Size	Monthly Net Income (2015)^	Asset Limits ^^
1 or 2	100% FPL	3,250

^ Calculating net income involves removing certain expenses for housing, utilities, and medical costs among other expenses. Additionally, public benefits and some types of income such as OAA Title V (SCSEP) payments are not counted. Additional information available in "SNAP Outreach for Older Adults" handout.

^^ Many types of assets are excluded including home, vehicle, and personal effects among other resourced. Additional information available in "SNAP Outreach for Older Adults" handout.

How to Apply
Submit an application (available here: http://www.tennessee.gov/humanservices/article/supplemental-nutrition-assistance-program-snap) to County DHS office or call 1-866-311-4287 for assistance.

Home Repair/Weatherization

Overview
Multiple agencies and programs in the state provide assistance in home repair and weatherization:

THDA – Emergency Repair for the Elderly Program. This program assists older adults in making needed home repairs.

THDA – Weatherization Assistance Program. This program is available to low-income households for minor home modifications to improve energy efficiency.

USDA Rural Development – Rural Housing Repair Program. This program provides low-interest loans up $20,000 to low-income households (and grants up to $7,500 to very low-income persons 62+) for home repairs in rural communities.

Eligibility
THDA – Emergency Repair for the Elderly Program.

THDA – Weatherization Assistance Program.

USDA Rural Development – Rural Housing Repair Program. To qualify for a loan, must be a homeowner and below 50% of area median income (See: Very Low Income rows:
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http://www.huduser.gov/datasets/il/il15/FY2015_IL_tn.pdf). To qualify for a grant, must meet income requirements, be 62+, and be unable to repay loan.

How to Apply

THDA – Emergency Repair for the Elderly Program. Contact THDA at 615-815-2030 to be directed to a local agency.

THDA – Weatherization Assistance Program. Contact THDA at 615-815-2030 to be directed to a local agency.

USDA Rural Development – Rural Housing Repair Program. Contact Don Harris with TN USDA Rural Development at 615-783-1388.

QMB/SLMB/QI/LIS

Overview

These programs help reduce costs associated with Medicare. Specifically:

QMB covers a Medicare enrollee's Parts A and B premiums, deductibles, and co-insurance. It also covers Part D premium and deductible and reduces copays.

SLMB covers a Medicare enrollee's Part B premium. It also covers Part D premium and deductible and reduces copays.

QI covers a Medicare enrollee's Part B premium. It also covers Part D premium and deductible and reduces copays.

Extra Help (or LIS) covers a Medicare enrollee's Part D premium and deductible and reduces copays.

Eligibility

You must be a Medicare enrollee and meet the following income and asset limit requirements:

Monthly Income Limits (Including Medicare premiums)				
Household Size	QMB	SLMB	QI	LIS/Extra Help
1 or 2	100% FPL	120% FPL	135% FPL	150% FPL

Asset Limits **(Excludes house, vehicle, personal effects, burial**

funds, public assistance)		
Household Size	QMB/SLMB/QI	LIS
1	7,280	12,140
2	10,930	24,250

How to Apply
Call the State Health Insurance Assistance Program (SHIP) hotline at 1-877-801-0044.

SSI

Overview
Supplemental Security Income (SSI) is a Federal income supplement program. It is designed to help aged, blind, and disabled people, who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter.

Eligibility
An individual must be aged (65+), blind, or disabled and fall below the following income and asset limits:

Household Size	**Monthly Income**	**Asset Limits (excluding home and vehicle)**
1	100% FBR (~74% FPL)	2,000
2	(~82% FPL)	3,000

How to Apply
Call the Social Security Administration at 1-800-772-1213 or schedule an appointment with the client's local SSA office.

2 Is the client a veteran or the widow of a veteran? *

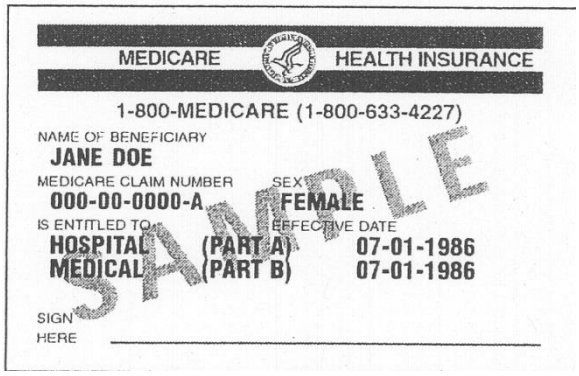
Description: Some veterans may qualify for additional assistance provided through the Veterans Administration (VA). Additionally, many other agencies and organizations offer additional programs and assistance to veterans. Some spouses and widows of veterans may also qualify

for additional assistance provided through the Veterans Administration (VA) and other programs.

Instructions: Select whether or not the individual is a veteran of US Armed Forces or the spouse or widow of a veteran.

Health Insurance Subsection

Collecting the information in this section is not required but is encouraged because SHIP (State Health Insurance Assistance Program) counselors can use it to assist program participants in identifying the best Medicare plan for them. SHIP counselors can also help connect low-income participants to QMB, SLMB, QI, and LIS services listed above. Much of the information needed in this section can be found on the participant's Medicare card.



1 Does the client have Medicare A health insurance? *

Description: Medicare Part A is an Original Medicare service and covers hospital and certain other healthcare facility services.

Instructions: Mark whether the participant has Medicare Part A. If yes, answer the next question regarding Medicare A effective date.

2 Enter the client's Medicare Number?

Instructions: If the participant has Original Medicare (i.e. the Red, White, and Blue Card), enter the participant's Medicare Number. If the participant has Medicare Advantage (e.g. Cigna Healthspring, Blue Cross Blue Shield, AARP, etc.), make a notation including the name of the plan, plan number, and note if it includes drug coverage.

3 What is the effective date of the client's Medicare Part A policy?

Instructions: Enter the effective date of Medicare A coverage.

4 Does the client have Medicare Part B Health Insurance?

Description: Medicare Part B is an Original Medicare service and covers most medical services, such as doctor's visits, and outpatient services.

Instructions: Mark whether the participant has Medicare Part B. If yes, answer the next question regarding Medicare B effective date.

5 What is the effective date of the client's Medicare Part B policy?

Instructions: Enter the effective date of Medicare B coverage.

6 Does the client have Medigap health insurance?

Description: Medigap supplement insurance is a private policy that helps cover medical expenses not covered by Original Medicare.

Instructions: Mark whether the participant has Medigap coverage.

7 Does the client have Medicare Part D Health Insurance?

Description: Medicare Part D is an additional Medicare program that covers the costs of prescription drugs.

Instructions: Mark whether the participant has Medicare Part D coverage.

8 Does the client have LTC health insurance?

Description: LTC (long-term care) health insurance covers certain costs related to nursing home care and alternative long-term care services and supports, such as homemaker and personal care.

Instructions: Mark whether the participant has long-term care health insurance.

9 Does the client have Medicaid or TennCare?

Description: Individual may be participating in the state's Medicaid or TennCare program, this can effect where referrals go for individual for programs such as the CHOICES program.

Instructions: Mark whether the participate has Medicaid or TennCare.

10 Does the client have other health insurance?

Description: Other health insurance may include services such as private coverage through a spouse's employer or veteran's health coverage.

Instructions: Mark whether the participant has any other health insurance.

11 Please indicate if the individual has QMB/SLMB

Instructions: Enter additional information regarding the individual's participation in these programs that may be helpful in connecting them to services such as the specific program they are in (e.g. QMB vs. SLMB).

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CHOICES Screening (Section O)

1 Does the client own his/her home or any other property?

Description: State and federal law requires the state to recover funds spent by TennCare on behalf of individuals age 55 and older. Participating in CHOICES requires the individual to agree to estate recovery. This means that when they pass away, TennCare will have first claim to any assets left behind in order to make up for the cost of services provided.

Instructions: Select whether or not the individual owns their home or any other property.

2What are the client's resources/ assets?

Description: In order to qualify for CHOICES an individual must not have assets above a certain amount. Home, vehicle, and personal effects are generally excluded, but most other assets are counted.

Instructions: Select any of the resources and assets the individual has.

3 Are the Consumer's assets valued at less than $2,000?

Description: This response to this question should take into account all of the financial resources identified in the last two questions. The response should not include home, vehicles, or personal effects. If an individual is over the asset limit, they will need to "spend down" their assets for noncountable assets such as paying off a mortgage or prepaying for a burial plan. If the individual is married, special exceptions may allow the household to have additional resources.

Instructions: Ask the individual to consider all of the financial resources identified in the last two items. Select whether or not those resources are below the appropriate limit.

4 Has the client transferred any property or money in the last five years?

Description: To prevent someone from hiding their assets by giving them to a friend or family member, TennCare does not allow individuals to participate in CHOICES if they have transferred a substantial amount of property or other resources in the previous five years. This also applies if the individual sold property or other assets for significantly less than it is worth.

Instructions: Select whether the individual has transferred property or other resources in the last five years.

5 While you are more likely to get more services sooner by getting CHOICES, getting CHOICES also means that any property and assets you have are subject to Estate Recovery. Knowing this, would you still like to be screened for CHOICES?

Description: CHOICES services can be very costly, and TennCare is required to attempt to recover those costs from the estates of individuals receiving CHOICES services after they pass away. While there are instances where an individual is exempt from TennCare Estate Recovery requirements, the individual should be aware that it is a possibility that they may be subject to it. Older Americans Act and state-

funded Options services do not have this requirement, but funds for these alternative services are extremely limited.

Instructions: Select whether or not the individual understands and agrees to Estate Recovery as part of participation in CHOICES.

6 What is the date of the client's last medical evaluation by a physician?

Description: The CHOICES application requires a recent (i.e. the last 365 days) medical history and physical. This is also an indicator of whether or not the individual has access to and receives regular medical care.

Instructions: Enter the date of the last medical evaluation the individual received from a physician. If exact date is not known, enter closest approximation.

7 What is the name of the client's primary care physician? / 8 The work phone number for the client's primary care physician.

Description: Part of the CHOICES eligibility determination process may involve contacting the individual's primary care physician.

Instructions: Enter the name and phone number of the individual's primary care physician.

Observations (Section P)

1 Client is assigned for in-depth assessment for the following additional programs: *

Instructions: Following a screening, note the programs services that the individual appears to be eligible for/ should be referred to.

2 Enter intake/referral comments.

Instructions: Note any other important or useful observations made during the screening process.

Prioritization (Section Q)

1 Is this an APS Referral?

Description: See TCAD Policy and Procedure Chapter 16-1-.08 for guidance on prioritizing APS referrals.

Instructions: Select if this was an APS referral or not.

2 Other Factors

Instructions: If other factors are taken into consideration when determining the individual's score, these factors must be documented in this section.

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3 Enter the Total Priority Score as calculated above

Description: Score is automatically calculated within the assessment based on answers to key questions in the Intake Screening. This negates the need for a separate prioritization form.

Instructions: Enter the Total Priority Score calculated above.

4 Total Risk Level

Instructions: Choose the appropriate level of Risk based on calculated score. Low Risk will have a score 1 to 15. Moderate Risk will have a score 16 to 30. High Risk will have a score 31 to 70.

Appendix B

Adult Protective Services (APS) Referral for Priority HCBS Form

Print Form

APS REFERRAL FOR PRIORITY HCBS SERVICES

(Please Print)

Date of Referral:		
APS INFORMATION		
Name of APS Unit Supervisor Making Referral:		
Unit Supervisor Phone:	Unit Supervisor Cell:	Unit Supervisor Email:
Name of APS Field Worker:		
Field Worker Phone:	Field Worker Cell:	Field Worker Email:
APS Fax Number:		

CONSUMER INFORMATION			
Consumer Last Name:	First:	MI:	Date of Birth: / /
Home Address:			City:
County:	Zip Code:		Home Phone No.:
Does the consumer have dementia or any other condition that prevents him/her from participating in the screening? ❑ Yes ❑ No			
Who do we contact for the initial screening? (Primary and Secondary)			
Primary Name:	Home Phone No.:		Cell Phone No.:
Relationship to Consumer (Please check one box): ❑ Family ❑ Friend ❑ Caregiver ❑ Neighbor ❑ Professional ❑ Other _____			
Secondary Name:	Home Phone No.:		Cell Phone No.:
Relationship to Consumer (Please check one box): ❑ Family ❑ Friend ❑ Caregiver ❑ Neighbor ❑ Professional ❑ Other _____			
What HCBS services are needed? (Please check all applicable boxes): ❑ Homemaker ❑ Personal Care ❑ Home-delivered Meals ❑ Other _____			
What referrals to other services have been made by APS?			
What current services are in the home? (Identify service and end date):			

What is the **risk of harm** to the consumer?
Is there anyone who might try to prevent services to the consumer? If so, specifiy the person and their relationship.
Provide any symptoms/situations the HCBS Worker needs to be aware of when visiting the consumer.

Current location of consumer:	Phone No:
Signature of APS Field Worker (Sign and Date)**:**	
Signature of APS Unit Supervisor Making Referral (Sign and Date):	

Appendix C

Reimbursement Rate for Services

Reimbursement Rate

OPTIONS for Community Living (State-Funded)
Older Americans Act – Title III (Federally Funded)

Service	Reimbursement Rate
Personal Care – OAA Title III	*The lesser of* $20.52 per hr. or usual and customary charges*
Personal Care – State Funds	*The lesser of* $20.52 per hr. or usual and customary charges*
Homemaker Services – OAA Title III	*The lesser of* $20.52 per hr. or usual and customary charges*
Homemaker Services – State Funds	*The lesser of* $20.52 per hr. or usual and customary charges*
In-home Respite – OAA Title III	*The lesser of* $16.28 per hr. or usual and customary charges*
Hot Home-Delivered Meals – OAA Title III	*The lesser of* $7.00 per meal or usual and customary charges*
Hot Home-Delivered Meals – State Funds	*The lesser of* $7.00 per meal or usual and customary charges*
Frozen Home-Delivered Meals – OAA Title III	*The lesser of* $6.00 per meal or usual and customary charges*
Frozen Home-Delivered Meals – State Funds	*The lesser of* $6.00 per meal or usual and customary charges*

**For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service. The same requirements are to be applied in the above noted programs. Thus, only the lesser of the maximum rate as specified above or the usual and customary charges for each service should be billed.*

These are the maximum rates which may **not** be exceeded; a lesser amount should be billed and reimbursed, if the provider's usual and customary charge to persons not participating in these programs is lower. Reimbursement rates for OAA and State-Funded services shall not exceed the TennCare reimbursement rates.

Appendix D

Cost Share Forms

COST SHARE WORKSHEET

OPTIONS, OAA

Name _____ Date: _____

DOB _____ Id#: _____

1

Household Size	1	2
Declared Monthly Income	$0.00	$0.00
200% of FBR (*Update yearly*)	$1,542.00	$ 2,314.00
Income Subject to Cost Share	**-$1,542.00**	**-$2,314.00**

2 Action Plan Estimation (HDM is subject to donation only)

	Units/Month or Year	Unit Cost	Total
Homemaker	0	$ -	$ -
Personal Care	0	$ -	$ -

Monthly or Yearly Cost Estimate for Service $ -

3 **Cost Share Rate** (Income subject to Cost Share divided by the amount given for the appropriate number in the household)

Cost Share Rate:	-50.00%	1	$ 3,084.00	(Update yearly with FBR x 4)
	-50.00%	2	$ 4,628.00	(Update yearly with FBR x 4)

4 **Cost Share**

$0.00	Household 1
$0.00	Household 2

Options Counselor _____ Date _____

Note: The amount of cost share cannot exceed 45% of their declared income

Note: If cost share is less then $25/month, the Individual will not be required to pay

If assessed a cost share, 1 copy for Fiscal and original for file

FINANCIAL RESOURCES-INCOME

Name:	**Id:**

Income

INCOME	Individual	Spouse (if applicable)
Social Security		
SSI		
Retirement/Pension		
Interest from Savings, CDs, etc		
VA Benefits		
Wages/Salaries/Earnings		
Other (specify)		
TOTAL	0	0

Savings/Assets

Type of Asset	Amount	Comments
Checking		
Savings		
CDs		
Other		

Monthly Living Cost

SOURCE	AMOUNT PER MONTH	COMMENTS
Rent/Mortgage		
Heat		
Electric		
Water/Garbage		
Telephone		
Cable		
Property Tax		
Home Insurance/Rental Insurance		
Medical Insurance		
Medications		
Transportation		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
TOTAL	0	

Available Income	0	

Fee Waived: _____ Yes ____ No

Options Counselor		Date:	

Comments:

Appendix E

Federal Poverty Guidelines

HHS 2019 POVERTY INCOME GUIDELINES

100% POVERTY LEVEL

Persons in family/household	Poverty guideline
1	$12,490
2	16,910
3	21,330
4	25,750
5	30,170
6	34,590
7	39,010
8	43,430
For families/households with more than 8 persons, add $4,420 for each additional person.	

The poverty guidelines in this table were published in the **FEDERAL REGISTER** on February 1, 2019. These figures are to be used by Area Agencies and Service Providers receiving funds under Title III and/or Title VII of the Older Americans Act in determining "greatest economic need: for reporting and targeting purposes.

These poverty guidelines do change each year. Updated Poverty Income Guidelines can be found through the United States Department of Health and Human Services by viewing the following website, http://aspe.hhs.gov/poverty.

Income Thresholds
2019

Annual Income				
	100% FPL	**150% FPL**	**300% FBR**	**600% FBR**
1	$12,490	$18,735	$27,756	$55,512
2	$16,910	$25,365	N/A	$83,304
Monthly Income				
	100% FPL	**150% FPL**	**300% FBR**	**600% FBR**
1	$1,041	$1,561	$2,313	$4,626
2	$1,409	$2,114	N/A	$6,942

Income Thresholds
2019

Annual Income				
	100% FPL	**150% FPL**	**300% FBR**	**600% FBR**
1	$12,490	$18,735	$27,756	$55,512
2	$16,910	$25,365	N/A	$83,304
Monthly Income				
	100% FPL	**150% FPL**	**300% FBR**	**600% FBR**
1	$1,041	$1,561	$2,313	$4,626
2	$1,409	$2,114	N/A	$6,942

Income Thresholds
2019

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Appendix F

TCAD Options Program/Self-Directed Care Program, Public Partnerships, LLC (PPL) Financial Administration Service

PCG Public Partnerships

Public Focus. Proven Results.™

TCAD Options Program
Self-Directed Care Program
Public Partnerships, LLC Financial Administration Services

PROGRAM BUSINESS RULES

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Introduction

The Tennessee Commission on Aging and Disability (TCAD) and the nine Area Agencies on Aging and Disability (AAADs) have created an opportunity to serve consumers of any age that are at risk of nursing home placement and their family caregivers. Through the TCAD Options program, consumers will receive home and community based services to enable them to continue to live in their homes and communities.

The Tennessee Commission on Aging and Disability selected Public Partnerships, LLC to be a provider of financial intermediary services in their Consumer-Directed Home and Community-based Services Program. The program, called Options, was developed in partnership with the federal Agency on Aging (AoA) and Tennessee's nine Area Agencies on Aging and Disabilities (AAADD).

Consumer direction is a model of service delivery which affords participants more choice and control in the delivery of home and community-based services. Supported by PPL, a person assessed by an AAADD as eligible can hire their own personal assistant or other help, whose job duties might include housekeeping, laundry, cooking, personal care, and transportation. The goal of the program is to avoid institutionalization and related higher costs. PPL performs functions related to the performance of payroll, accounts payable, and related tasks. AAADs provide support brokerage. TCAD provides administrative and programmatic oversight.

The following is a list of core business rules for the TN Options Self-Direction as of the date of signature. This list may be updated as rules are added, clarified or omitted during the course of the program. The document will be updated and signed by the program stakeholders each time changes occur.

General Program Policies

1. Consumers must be 18 years of age or older
2. Consumer must be a resident of Tennessee.
3. Consumer must meet functional eligibility requirements for the Options program.
4. Consumers will not be able to have PPL pay providers on their behalf until the consumer enrollment paperwork is complete, provider employee paperwork is complete, provider training and background checks are complete and PPL receives an approved authorization.
5. The consumer will be the employer of record unless the family determines that he/she needs a representative to serve in this capacity or the consumer has an existing EIN. It is acceptable for the EOR to be the consumer's conservator. If it is the conservator, the Supports Broker will obtain a copy of the legal paperwork and provide it to PPL.
    a. If the identified employer has an active Employer Identification Number, another employer will need to be identified, unless the EOR can obtain an IRS transcript that says that the EIN is inactive and has no liabilities.
6. If the consumer has a conservator/Power of Attorney, conservatorship paperwork must be sent to PPL.
7. All documents for consumers and providers will be stored in the document management system for viewing on the Web Portal.
8. Spouses and conservators of participants/employers/representatives may not provide services in this program.
9. Authorized representatives cannot be employees.
10. If a Veteran opts to assign a new EOR in their place they will need to complete a Change of EOR form to PPL. Forms will be made available through the PPL Web Portal. Employer of Record changes must coincide with a fiscal quarter end, unless a significant circumstance is demonstrated.
11. There is no limit to the number of providers a consumer may hire, however, providers may only be on staff for more than one consumer if they have a PSSA license.
12. PPL's standard method of paperwork distribution is for support brokers and EORs to download provider packets from the program website. However, packets can be mailed upon request.
13. Background and registry checks for providers are good for life. However, any EOR can request checks to be re-run, and all EORs should be aware of any fail/approves.

Consumer Enrollment

1. At the point of home assessment, the AAAD support broker will ask the consumer if s/he is interested in self-direction. The support broker will also provide options counseling services, determine a budget level, and create an approved Care Plan. If appropriate, this conversation can happen telephonically.
2. If the person is interested in self-direction, the support broker will schedule a follow up appointment at which the employer of record and worker will all be present to sign paperwork. If appropriate, this can happen at the same time as the home assessment.
3. Prior to going to the home to review paperwork, the AAAD support broker will enter consumer information in the Web Portal. This will include all required fields to become an employer:
    a. First & last name
    b. Address line 1 (must be street address)
    c. Address line 2 (can be PO Box)
    d. City, state, zip
    e. Gender
    f. Date of Birth
    g. SSN
    h. Phone
    i. Email (if any)
    j. Participant ID as assigned by AAAD (DOB + last for SSN)
    k. Employer name, address, phone, and social security number
    l. Authorized representative contact information (if any)
    m. AAAD association
    n. Support broker name
4. The support broker will then print out the pre-populated EOR packet. The support broker will have access to the standard general enrollment documents. The support broker should bring the following:
    a. Pre-populated EOR packet
        i. IRS SS-4
        ii. IRS 2678
        iii. IRS 2848
        iv. IRS 8821
        v. TN LB-0441
        vi. TN LB-0927
        vii. Representative Form
    b. AAAD docs – tracked by the AAADs
        i. Participant Signature Page
        ii. Consumer Direction Rights & Responsibilities
        iii. Medical Release form
    c. Employer Information Packet
        i. Explanation of all employer documentation
        ii. Pay schedule
        iii. Timesheet instructions (for Web Portal & fax submission)
        iv. Provider Change Termination Form
    d. Employer Poster Packet (required employment posters)

   e. Employee application & instructions *(see provider enrollment)*
   f. Vendor packet & instructions *(see vendor enrollment/invoice payment)*
5. The support broker reviews the PPL documents with the consumer/EOR and worker and helps them complete the enrollment paperwork.
6. Consumer/support broker/employee sends enrollment paperwork back to PPL via mail, fax, or email.
7. PPL enters the packet into the Web Portal, obtains EIN, and follows up until the packet is fully completed. PPL's standard processing time is 3-5 business days for paperwork processing. (Obtaining EINs is dependent upon current IRS processing time.)
8. PPL Customer Service is available to help with questions.
9. All paperwork receipt and status will be documented in the PPL Web Portal in support tickets.

Consumer Disenrollment

1. Upon learning of a consumer becoming disenrolled from Options, the AAAD Supports Broker will mark the consumer inactive on the consumer profile in the PPL Web Portal and enter the date in the Enrollment End Date field in the consumer profile. [This will pend any payments or invoices submitted past the Enrollment End Date.]
2. There are situations where TCAD, the AAAD, or PPL may recommend that a consumer disenroll from the program because of extenuating circumstances (such as fraud, consistent underutilization, home environment unsafe, needs change, etc). The oversight committee makes the final decision as a group.

Employee Enrollment

1. The support broker will bring and review the employee paperwork and requirements with the consumer. The consumer will provide employees with the paperwork and train the employee on providing him/her with care.
2. Paperwork will include:
    i. Employee Application & Criminal background release
    ii. Service agreement
    iii. Rate agreement
    iv. I-9 & instructions
    v. W-4
    vi. Tax Exemption Information
    vii. Direct Deposit Enrollment
3. The employees will send paperwork to PPL.
4. PPL will enter all paperwork into the PPL Web Portal and establish provider IDs. AAAD support brokers can view good-to-go status in the PPL Web Portal.
5. PPL staff will run the following registry checks on all providers and document the results in the PPL Web Portal. If the employee fails any of the registry checks, the provider cannot work in this program.
    i. Felony offender list
    ii. Sexual offender list
    iii. Health abuse registry
6. If the employee passes the registry checks, PPL will run a criminal background check using Kroll. This will be paid out of the consumer's budget.
    i. Failing criteria for the background check:
        - Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug.
        - Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held.
    ii. Criteria for waiving background check results:
        - Exceptions to disqualifications may be granted at the consumer's discretion and only if all of the following conditions are met:
            - Offense is a misdemeanor;
            - Offense occurred more than five (5) years ago;
            - Offense is not related to physical or sexual or emotional abuse of another person;
            - Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and
            - There is only one disqualifying offense.
7. PPL staff will mark the background check:
    i. Pass
    ii. Fail
        i. PPL will notify the support broker and the EOR.
    iii. Fail—approved

    i. PPL will notify the support broker. The support broker will then go in and look at the documents in the Web Portal to ensure that the consumer's safety is not at risk.

8. It is the employer's responsibility to hire, fire, train, and manage his/her employees. Firings require a provider change termination form prior to the next immediate pay period.
9. Employees can begin working upon the first date where all background and registry check is complete and all provider/consumer paperwork is complete, provided an authorization has been established for the consumer. PPL will notify the EOR when all employee paperwork is complete and confirm good-to-go (GTG) status.
10. Directly-hired employees will be able to provide all hourly services. They will only be able to provide transportation if they provide auto insurance information and valid driver's license.
11. PPL will be checking the OIG List of Excluded Individuals/Entities on a monthly basis. If a provider is found to have been added to the list and continued to provide services to an Options consumer, PPL will immediately report the provider to the Tennessee Bureau of Investigation and the Office of the Inspector General. PPL will also invoice the provider for any services provided since the last clean run of the OIG List of Excluded Individuals/Entities. Passing the OIG registry check is required for provider good-to-go.

Independent Contractors/Vendors/Agency Provider Enrollment

1. Independent contractors and agency providers must hold a PSSA (or other appropriate) license. License expiration dates will be tracked in the Web Portal as part of each provider's profile. Out of state licenses will be reviewed on a case-by-case basis.
    i. Independent Contractor is an individual who holds a PSSA (or other appropriate) license.
    ii. Agency provider is an organization that holds a PSSA license (or other appropriate) .
    iii. Vendor is a commercial store that does not hold a PSSA license (or other appropriate) (i.e., a Walmart).
2. Vendor information packet
    i. W-9 – required for all
    ii. License – required for independent contractors and agency providers (but not for vendors, as they are stores).
    iii. *Information sheet about presenting checks*
    iv. *Invoice submission instructions*
    v. *Warning against fraud*

Good to Go Requirements

1. Consumer
    a. All EOR documentation
    b. Obtained EIN
2. Employee
    a. All background/registry checks passed (including the OIG registry check)
    b. All employee/employer paperwork complete
3. Independent Contractor
    a. License
    b. W-9
4. Agency
    a. License
    b. W-9
5. Vendor
    a. W-9

Service Authorizations

1. The AAAD support broker will enter the spending plan into the Web Portal. Authorization can be entered at any time once the consumer has been referred.
2. Spending plans are authorized for one year, broken down by month. There is a soft cap of $5,000, with a maximum of $7,000 (approved by the AAAD).
    a. Administrative funds will be deducted from the consumer's budget in advance of other services.
    b. Consumers will only be able to view their budget after administrative funds have been deducted.
3. The service matrix is as follows:

Service Name	Code	Unit	Daily/ Hourly	High Pay Rate	Low Pay Rate	Additional Limits/Notes
Attendant Care Services	DHS1	15 min	Hourly	$15	Min Wage ($7.25)	Timesheet
Homemaking	DHS2	15 min	Hourly	$15	Min Wage ($7.25)	Timesheet
Transportation - Mileage	FCS1	1 mile	Unit/mile	$.47 (state rate as of March 2012)		Invoice
Transportation – Cab	FCS2	1 trip	Unit/trip			
Daily Respite	FCS5	1 day	Daily	$63.50, $195, or $231		Timesheet: One rate for the day, must be 8 hours or more. Day cannot be crossed.
Hourly Respite	FCS6	15 min	Hourly	$15	Min Wage ($7.25)	Timesheet: Max 8 hours
Other Consumable Goods	MSG6	1 item	Unit			Invoice
Durable Medical Equipment	MSG1	1 item	Unit			Invoice
Personal/Home Monitoring (PERS)	ATEV4	1 item	Unit			Invoice
Criminal Background Check Fees	ADM4	1 item	Unit			Invoice
Home Delivered Meals	FCS4	1 item	Unit			Invoice

4. Rate rules:

   a. Billable rate for hourly services is the pay rate plus any employer taxes. If the employer has no tax obligation for a given employee, the bill rate will be equal to the pay rate.
5. The support brokers will establish, maintain and revise consumer budgets.
6. If a consumer under-spends, the under-spent amount can be made accessible to the consumer in later months through an authorization amendment by the support broker.
7. Authorizations will be entered in terms of dollars.
8. A support broker can amend an authorization at any time. S/he cannot retro-actively change an authorization to an amount less than what has already been purchased.

Timesheets

1. Standard rules:
    i. Timesheets must be signed by both the employee and employer (or the representative). If a timesheet is not signed, it needs to be returned and resubmitted before payment.
    ii. In the case of a legal guardian being the representative, the legal guardian will be responsible for signing the timesheets. In the case of Designated Representative, the Designated Representative may sign the timesheet. It is always acceptable for the consumer to sign the timesheet.
    iii. PPL will round time to the closest 15 min. increment (7 min, round down – 8 min. round up)
    iv. Providers may not be compensated for the provision of services in excess of 40 hours per employer per workweek (Monday through Sunday).
    v.Consumers cannot be served by more than one provider at a time. Providers cannot serve more than one individual at a time. Shifts may not overlap.
    vi. If a timesheet is received for more hours that are left on a consumer's authorization, PPL will issue payment up to the available units and pend the exceeding amount. The pended amount will be paid out only if an amended authorization is submitted by the support broker. If denied, the employer is responsible for paying the provider the remaining funds.
    vii. Providers must select the appropriate service code when completing a timesheet.
2. Timesheets can be submitted by fax, mail, or via the Web Portal.
3. Workers will be required to keep daily notes of services provided. The Daily Notes will be kept in the home or in the Web Portal. Workers will record services provided and unusual activity related to the individual.
4. Timesheets and invoices must be submitted within one month of the payroll schedule timesheet deadline.
5. PPL will mail checks directly to the provider or transmitted via Electronic File Transmission/Direct Deposit (EFT/DD). The posted Pay Date will be the day checks are mailed and EFTs are posted to the PPL corporate account. PPL cannot guarantee mailing times or when local bank branches pick up EFT transmissions, and therefore cannot guarantee a payment receipt date, however PPL ensures the payments are paid within the state labor law limits.
6. Timesheets submitted 60 days or more after the last dayof the pay period will be denied for payment unless authorized by the AAAD Supports Broker.
7. Expense Account Requests submitted 60 days or later after the last day of a given pay period will not be paid unless authorized by the AAAD Supports Broker.
8. PPL will not make payments that are outside the budget start or end dates or exceed authorization dollars.

Invoice Process

1. All goods or services must be documented in the consumer's spending plan, either under goods or services or in planned savings. The consumer is responsible for covering all purchases s/he makes which are not in his/her budget. The Supports Broker is responsible for authorizing purchases in the web portal.
2. The EOR will submit an invoice (either by paper or via the Web Portal) to the AAAD. The invoice will contain detailed information regarding the item, its exact cost, and its purpose.
    a. If the vendor for the item is not in PPL's system, the EOR will submit a W-9 form capturing the vendor's tax identification number (TIN). PPL has the TIN for big box stores and chains on file.
    b. Providers will need to submit a mapquest (or comparable document) along with their transportation form when requesting transportation reimbursement.
3. The AAAD support broker will approve/not approve the item (either by paper or via the Web Portal).
    a. While the AAAD support broker must approve all requests, there are no specific limits on purchases (other than the general cap).
4. PPL will cut a check made out to the vendor and send it to the consumer.
5. If the good or service is a different price than the check, the EOR/consumer must call PPL to address the issue at the point before purchase.
6. Consumers will not receive cash stipends.

Payment Schedule

1. The pay period will be the 1st through the 15th and the 16th through the end of the month.
2. Payroll schedule is twice monthly. Timesheets can be faxed or mailed to PPL any time after the work for the pay period has been completed up until the timesheet due date.
3. Timesheets will be due at 5:00 pm EST two business days following the end of the pay period. PPL cannot guarantee normally scheduled payment for timesheets submitted after the due date. Any timesheets received after the deadline will be processed in an off cycle check run scheduled for one week after the primary pay cycle.
4. Any timesheets received after the deadline will be processed in an off cycle check run on Friday of the following week.
5. The Payment Schedule will account for pay days that fall on a weekend day or holiday and make payment on the business day after to the weekend day or holiday.
6. PPL will mail checks directly to the providers (or remittance advices, in the case of direct deposit).
7. Tennessee final paycheck laws require that whenever an employee quits or is fired, the final paycheck must be given on the next scheduled payday or within 21 days, whichever is later. As payroll is done twice a month, PPL will automatically comply with this.

Reporting

1. PPL will manage, track and provide reports in the receipt and disbursement of funds on behalf of the participants monthly. AAADs and TCAD will be able to view this information via the PPL Web Portal.
2. PPL will provide TCAD and the EOR with a monthly utilization report.
3. TCAD staff will have privileges to retrieve a multitude of customizable reports through Web Portal on the PPL Universal Reports Server.

Worker's Compensation

1. Workers compensation will not be offered in this program. As a result, no employer may have more than 4 employees associated to him/her at a time.

Administrative and Service Billing

1. PPL will bill TCAD directly for both administrative and services billing.
2. The PMPM for each person is $95/person/month. The criterion for billing is consumers enrolled during the given month.
3. Upon completion of the payroll processing (i.e. verifying timesheets and testing submitted time again allocations as well as entering and testing payment request forms for self directed goods and services), PPL will transmit (via secure email) to TCAD an invoice for total service payments.

Advance for Service Payments

1. TCAD will calculate and pay PPL a 1 month service advance prior to the first check run.
2. Services begin for Month 1
3. TCAD will calculate and pay PPL an advance for month 2 of services prior to the second month.
4. PPL will invoice TCAD for month 1's actual services on or around the 15th of month 2.
5. TCAD will process actual service invoice for month 1 then send to Finance and Administration Department (F&A) around the 21st of the second month. F&A will process the invoice; then PPL will receive payment thru ACH in 3 to 7 business days.
6. PPL will invoice TCAD for month 2's actual services on or around the 15th of month 3.
7. TCAD will process actual service invoice for month 2 then send to F&A no later than the 21st of month 3. F&A will process invoice; then PPL will receive payment thru ACH in 3 to 7 business days.
8. At the end of the contract, PPL & TCAD will reconcile advance with actual.

Web Portal User Management and Role Based Security Model

1. EORS will have roles configured with access to functionalities that support usage and prohibit access to other EORs' information as well as privileges to modify authorization and payroll information.
2. Other read/write privileges for project staff will be defined during program start up based on defined roles.

Customer Service

1. PPL will maintain a U.S. based toll free customer service line available from 9:00 a.m. to 5:00 p.m. Eastern Standard Time Monday through Friday excluding state holidays.
2. PPL will also maintain a program administrative fax and email account.
3. All voice mails, faxes, and emails will be responded to within one business day.

Signatures

_____	_____
Public Partnerships, LLC	Date
_____	_____
Tennessee Commission on Aging & Disability	Date

Appendix G

Missed Visit Report

MISSED VISIT REPORT

Individual's Name: _____ **Id#:** _____

If NFCSP, Care Recipient Name: _____ **Id#:** _____

Provider Agency: _____ **County:** _____

Program *(check one)*: ☐ **OPTIONS** ☐ **NFCSP (Caregiver, Title III-E)** ☐ **OAA (Title III)**

Dates of Missed Visit: _____

_____

Type of Visit:

☐ Personal Care ☐ Home Delivered Meals ☐ In-Home Respite

☐ Homemaker ☐ Other: _____

Reason for Missed Visit:

☐ Individual/Care Recipient had unscheduled appointment

☐ Individual/Care Recipient hospitalized

☐ Individual/Care Recipient refused services

☐ Individual/Care Recipient refused alternate staff member services

☐ Individual/Care Recipient unavailable: ☐ Hospital ☐ Nursing Home ☐ Other:

_____

☐ Knocked – No Response: Contact Person Notified/Response: _____

☐ Called – No Answer: Contact Person Notified/Response: _____

☐ Scheduling error

☐ Hazardous weather

☐ Holiday scheduling – ☐ Provider canceled ☐ Individual/Care Recipient canceled

☐ Provider unable to provide service because: _____

_____

Additional Provider Comments: _____

_____

Signature of Agency Representative: _____ **Date:** _____

AAAD Use Only: ☐ Provider Liable ☐ Consumer Liable ☐ No Fault

FAX/SCAN WITHIN 5 BUSINESS DAYS OF MISSED VISIT TO AAAD

Appendix H

Provider Authorization/Notification of Change

PROVIDER AUTHORIZATION/NOTIFICATION OF CHANGE

☐ Service Start ☐ Service Change ☐ Change of Information ☐ Service End

☐ Hold as of: _____ ☐ Resume Services as of: _____

I. Individual's Information

Name:	DOB:	Id#:	County:
Street Address:		City/Zip Code:	
Phone #:	Emergency Contact:	EC Phone #:	
If Title III-E (NFCSP), Name of Care Recipient:		Care Recipient Id#:	

II. Service Authorization

Service	Date Service Authorized	Provider Name	Funding Source	Units/ Frequency	Unit Cost	End Date
Homemaker						
Personal Care						
Home Delivered Meal						
Chore						
In-Home Respite						
Adult Day Care						
Other:						

Special Frequency Instructions:

Comments/Considerations:

Options Counselor: _____ Phone: _____

Date Faxed: _____ If Change of Services, Date Individual Notified: _____

III. Service Provider

☐ Accepted ☐ Declined Service Start Date: _____ Date Ended: _____

Authorized Provider Signature: _____ Date:_____

FAX/SCAN REPLY WITH START DATE WITHIN 5 WORKING DAYS TO AAAD

Appendix I

Provider Checklist

PROVIDER CHECKLIST

Date: _____ County: _____

Individual's Name: _____ Id#: _____

If NFCSP, Care Recipient: _____ Id#: _____

☐ **PERSONAL CARE**

Type of Bath:
☐ Tub Bath
☐ Shower
☐ Complete bed bath
☐ Complete sponge bath
☐ Partial sponge bath

Foot Care:
☐ Foot soak
☐ Lotion Feet
☐ Other _____

Hair Care:
☐ Shampoo in shower
☐ Shampoo in sink
☐ Shampoo in bed
☐ Brush hair
☐ Shave
☐ Other_____

Mouth Care:
☐ Brush teeth
☐ Clean dentures
☐ Swab mouth

Dressing:
☐ Dressing Assistance

Skin Care:
☐ Lotion massage
☐ Other_____

Nail Care:
☐ Clean nails
☐ Other_____

Ambulation:
☐ Assist to ambulate
☐ With assistive device
☐ Do not ambulate

Other Duties:
☐ Assist with eating
☐ Assist with toileting

☐ **HOMEMAKER**
☐ Straighten/Pick up
☐ Vacuuming
☐ Mop
☐ Laundry/Laundromat
☐ Dusting
☐ Empty trash
☐ Prescription pickup
☐ Shopping
☐ Grocery shopping

Bedroom:
☐ Change bed linen
☐ Straighten bed linen
☐ Other_____

Bathroom:
☐ Clean tub/shower
☐ Clean bath basin
☐ Clean commode
☐ Other_____

Kitchen:
☐ Clean stove
☐ Clean countertop
☐ Clean refrigerator
☐ Clean dishes
☐ Meal preparation
☐ Other_____

☐ Special Instructions:

☐ Safety needs identified:

_____ _____
Signature of Individual or Authorized Representative **Date**

Appendix J

Signature Page

SIGNATURE PAGE

Individual's Name: _____ Individual's ID: _____

☐ **AGE DECLARATION** – I am unable to provide proof of age and I declare that I am 60 years of age or older and that my date of birth, _____ (Month/Day/Year), is correct to the best of my knowledge.

☐ **ASSESSMENT** – I certify that the information provided to the Options Counselor regarding my functional assessment, social and financial circumstances is accurate and complete. I understand that if it is determined at a later date that the information collected is incorrect, my eligibility for services may be affected.

☐ **CHOICE OF PROVIDERS** – I have been offered a choice of service providers from a list of available service providers in my county for each service I am authorized to receive. I understand that it is my choice as to whom I want to provide the in-home services.

☐ **PRIVACY PRACTICES AND INDIVIDUAL RIGHTS AND RESPONSIBILITIES** – By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and a copy of the Individual Rights and Responsibilities. I also acknowledge that I understand the information provided in the Notice of Privacy Practices and the Rights and Responsibilities.

☐ **RELEASE OF INFORMATION FOR STATISTICAL REPORTING –** I understand that the information released will not be identified with me personally. It will be used in statistical reports. I give my permission to use the information for statistical reporting.

☐ **REQUEST FOR INTERAGENCY INFORMATION SHARING** – I receive services for more than one program funded through the Tennessee Commission on Aging and Disability and the Area Agency on Aging and Disability. I request the information from my assessment be shared with agencies that would otherwise have to interview me again to collect the same data.

☐ **SERVICES POLICY** – I understand that initiating/continuing services is based upon the availability of funding from State/Federal sources. Additionally, change(s) in Individual circumstances may determine eligibility for an increase or decrease in services.

☐ **TITLE VI** – I understand that I have the right not to be discriminated against on the ground of race, color, or national origin. I understand the procedures for filing a complaint if I feel that I have been discriminated against.

☐ **VOLUNTARY CONTRIBUTIONS** – I understand how to make a voluntary contribution to help pay for the cost of my services paid for by the AAAD. I understand that my contribution can be made anonymously and/or confidentially if that is my preference. I also understand that my contribution will have no effect on the care I receive.

☐ **COST SHARING** – I understand there is a possibility that I will have cost share and that I will be receiving a letter informing me about my cost sharing responsibilities if my income exceeds 200% of the Federal Benefit Rate. I understand that prior to my services starting; I will be informed of my costs, if any.

_____ _____ _____ _____

Initials of Individual/Authorized Representative Date Initials of Care Recipient (If NFCSP) Date

Individual's Name: _____ Individual's ID: _____

☐ **RECEIPT OF ADVANCED DIRECTIVE INFORMATION** – I have received written information on my right to create an advanced directive.

☐ **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)** – I understand that if I have PERS equipment and stop receiving PERS services that the equipment will be removed from the home when the service ends.

☐ **NUTRITION COUNSELING** – I understand that due to identified nutritional risk factors, I have been referred for Nutrition Counseling. ☐ Accept or ☐ Deny

☐ **CARE PLAN –** I was permitted to be involved in the development of my care plan and the services that will be provided will help me to remain independent within my home or will assist in my ability to provide care to my family. I understand that if changes are needed to be made in the care plan, I can contact my Options Counselor.

☐ **AUTHORIZATION FOR REFERRAL FOR SERVICES** – I give permission for the Area Agency on Aging and Disability to contact, on my behalf, the agencies or persons listed below and/or on my care plan and to release only such information to them as may be needed to determine the level and types of services that I may need. I also grant permission to the receiving agencies to report back regarding services that I may or may not receive and/or any additional information that may significantly reflect on my need for services. This authorization may be revoked at any time by my written statement and is automatically revoked at my transfer from the agency or at notification of death to include a period of six (6) months.

AGENCY	PURPOSE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

☐ **CLIENT AGREEMENT** – By my signature, I affirm that I have read, or have had explained to me, the above statements. The telephone number I need for questions or complaints has been left with me, and I do give the authorization for release of information as listed above. Unless otherwise stated, this expires in one year.

_____ _____
Signature of Individual or Authorized Representative Date

_____ _____
Signature of Care Recipient (When enrolled in NFCSP) Date

_____ _____
Signature of Options Counselor Date