
Initial assessments and/or recertification performed by a single member of the team must be reviewed, approved, signed and dated by the case management supervisor on the bottom of the last page of the assessment. The case management supervisor should write "reviewed and approved" before signing and dating the form. If the documentation by the case manager is inaccurate, incomplete, or otherwise does not meet the supervisor's approval, the case management supervisor must immediately take appropriate corrective action to obtain the quality of documentation necessary to sustain approval. A copy of the unapproved documentation should be kept in a separate record.

Homemaker Services

Homemaker services are supportive services provided or accomplished primarily in the home by a trained homemaker. Services include education and/or provision of home management tasks to assist in strengthening family life, promoting self-sufficiency, and enhancing quality of life.

The purpose of Homemaker services is to assist functionally impaired persons to remain in their home by providing assistance in the activities of daily living, housekeeping, laundry, meal planning, marketing, food preparation, and other types of home management tasks to prevent the risk of institutionalization.

Homemaker and home health aides must not perform the same services at the same time. (Example: both the homemaker and home health aide cannot give the beneficiary a bath or make the beneficiary's bed and then bill for the service. **It is recommended that the homemaker and home health aide not be in the client's home at the same time, and that they perform separate duties. If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance should be thoroughly documented.**

Adult Day Care Services

Adult Day Care is a structured, comprehensive program which provides a variety of health, social and related supportive services in a protected setting during daytime and early evening hours. This community-based service is designed to meet the needs of aged and disabled beneficiaries through an individualized care plan that includes the following:

- Personal care and supervision
- Provision of meals as long as meals do not constitute a full nutritional regimen
- Provision of limited health care
- Transportation to and from the site
- Social, health, and recreational activities

Adult Day Care activities must be included in the plan of care, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the beneficiary's assigned case manager. Activities that are diversionary in nature are not allowed.

The beneficiary must be at the facility at least four (4) hours per day (but may stay longer if desired), but less than (24) hours per day for Medicaid reimbursement.

Institutional or In-Home Respite Services

Respite Care provides assistance to beneficiaries unable to care for themselves. Care is furnished on a

short-term basis because of the absence of, or the need to provide relief to, the primary caregiver(s).

1. Institutional Respite Services

Institutional respite may only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities. Providers must meet all certification and licensure requirements applicable to the type of respite service provided, and must obtain a separate provider number specifically for this service.

Eligible beneficiaries may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.

2. In-Home Respite Services

In-Home Respite services are provided to beneficiaries unable to care for themselves. Criteria for in-home respite services include **all** of the following:

- Beneficiary must be home-bound due to physical or mental impairments, **and**
- Beneficiary must require twenty-four (24) hour assistance by the caregiver, i.e., cannot be left alone/unattended for any period of time, **and**
- Caregiver must live in the home and document that the beneficiary has no other family member who is able to assist.

In-Home Respite services are limited to no more than forty (40) hours per month.

Home Delivered Meals

Home Delivered Meals are nutritionally balanced meals delivered to the home of a beneficiary who is unable to leave home without assistance and/or is unable to prepare meals. All eligible beneficiaries may receive a minimum of one (1) meal per day, five (5) days per week. If there is no responsible caregiver to prepare meals, the beneficiary may qualify to receive a maximum of one (1) meal per day, seven (7) days per week.

Home Delivered Meals services are not provided by individual providers. The Area Agencies on Aging provide the services through a contractual agreement with the Division of Medicaid.

Escorted Transportation

Escorted Transportation is provided when the State Plan Non-Emergency Transportation is either not available or inadequate to accommodate the needs of the E&D Waiver beneficiary. Whenever possible, family, neighbors, friends, or community agencies will be utilized in lieu of Escorted Transportation.

Escorted Transportation must be prior approved and arranged by the beneficiary's waiver case manager.

Providers must maintain documentation that includes, at a minimum, the date of services, time of departure from the beneficiary's residence, time of arrival at the destination, number of miles traveled to the destination, time of departure from the location, and time of arrival back at beneficiary's residence. Documentation must be signed and dated by both the provider and the beneficiary.

Expanded Home Health Services

Beneficiaries may receive twenty-five (25) home health visits each fiscal year through the regular Medicaid program. Services must be pre-certified. Through the Elderly and Disabled Waiver, beneficiaries may receive additional home health visits after the initial twenty-five (25) have been exhausted, **but only with prior approval of the DOM HCBS Program Nurse.**

Home Health Agencies must follow all rules and regulations set forth in Section 40 of this manual. The word "waiver" does not apply to anything other than Home Health visits with prior approval of the **DOM HCBS Program Nurse.** The Elderly and Disabled Waiver allows for extended state plan home health services **only after** the 25 visits allowed under the state plan have been exhausted. Waiver beneficiaries are subject to home health co-payment requirements through the 25th visit. Starting with the 26th home health visit, within the state fiscal year, the Waiver beneficiary is exempt from home health co-payment requirements.

Providers must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, furnish the Division of Medicaid (DOM) with a copy of its certification and/or recertification, meet all applicable state and federal laws and regulations, provide DOM with a copy of its certificate of need approval when applicable, and execute a participation agreement with DOM.

Homemaker and home health aides must not perform the same services at the same time. (Example: both the homemaker and home health aide cannot give the beneficiary's bath or make the beneficiary's bed and then bill for the service. **It is recommended that the homemaker and home health aide not be in the client's home at the same time, and that they perform separate duties.** If an extenuating circumstance occurs and scheduling cannot be worked out, this circumstance should be thoroughly documented.

Transition Assistance

Transition Assistance services are services provided to a beneficiary currently residing in a nursing facility who wishes to transition from the nursing facility to the Elderly and Disabled Waiver program. Transition Assistance is a one-time initial expense required for setting up a household. The expenses must be included in the approved plan of care. **Transition Assistance Services are capped at \$800.00 one-time initial expense per lifetime.**

1. Eligibility

To be eligible for Transition Services the beneficiary must meet **all** of the following criteria:

- Beneficiary must be a nursing facility resident whose nursing facility services are paid for by DOM, **and**
- Beneficiary must have no other source to fund or attain the necessary items/support, **and**
- Beneficiary must be moving from a nursing facility where these items/services were provided, **and**
- Beneficiary must be moving to a residence where these items/services are not normally furnished.

2. Services

Transition Assistance Services include the following:

- Security deposits required to obtain a lease on an apartment or home
- Essential furnishings such as bed, table, chairs, window blinds, eating utensils, and food preparation items (Items such as televisions, cable TV access or VCR's are not considered furnishings)
- Moving expenses
- Fees/deposits for utilities or service access such as telephone, electricity, etc.
- Health and safety assurances such as pest eradication, allergen control, or one-time cleaning prior to occupancy

3. Exclusions

Transition Assistance is not available for beneficiaries whose stay in a nursing facility is 90 days or less.