The Elderly and Disabled Waiver provides services to individuals age twenty-one (21) or older who, but for the provision of such services, would require placement in a nursing facility. It is a statewide program that allows qualified beneficiaries to remain in a home or community-based setting.

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool that encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm that will generate a numerical score. The score will be compared to a set numerical threshold that determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. Refer to Provider Policy Manual Section 64.0 for Long Term Care/Pre-Admission Screening policy. Nursing Home level of care must be certified by a physician. The level of care must be re-evaluated every twelve (12) months at a minimum.

Medicaid Beneficiary Eligibility

Individuals must also qualify for full Medicaid benefits in one of the following Categories of Eligibility (COE):

- SSI (COE – 001)
- **OR** an aged, blind, or disabled individual who meets all factors of eligibility can qualify if income is under 300% of the SSI limit for an individual. If income exceeds the 300% limit, the individual must pay the amount that is over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible. COE – 063 denotes eligibility in the Elderly and Disabled Waiver.

It is the responsibility of all waiver providers to check the beneficiary's eligibility status. The eligibility status must be checked at least monthly, or when deemed necessary.

Beneficiaries enrolled in the Elderly & Disabled Waiver cannot reside in a licensed personal care home and are prohibited from receiving additional Medicaid services through hospice, nursing facility, and/or another waiver program.

Providers interested in becoming providers of Elderly and Disabled Waiver services must complete a proposal package and enter into a provider agreement with the Division of Medicaid. A proposal packet may be obtained from the Division of Medicaid, Bureau of Long Term Care. Upon completion, the proposal packet must be mailed back to the Division of Medicaid, Bureau of Long Term Care for review and approval. Providers may not submit the proposal or the enrollment application for waiver services electronically.

All providers of E&D Waiver services are required to do the following:

- Conduct a criminal background check on all employees prior to employment and maintain the record in the employee personnel file.
- Establish a Mississippi based physical address/office prior to enrollment. A Mississippi based physical address/office must be maintained until the provider agreement is terminated. Post office boxes are not acceptable.

Adult Day Care Services Facility Inspection

Upon completion of the proposal packet for Adult Day Care Services, DOM HCBS staff will inspect the facility to ensure that the facility meets the waiver services specifications.

Provider Qualifications: Adult Day Care, Homemaker Services, and In-Home Respite

All providers of E&D waiver services must have an annual physical examination including a TB skin test. All providers must submit to a background check before providing services to any waiver beneficiary.

Adult Day Care

Adult day care services must be provided by an established, qualified facility/agency. It is not appropriate for an individual to apply for a DOM provider number for the sole purpose of providing care to friends/family members.

Each adult day care service must meet the following requirements:

- The facility must be compliant with applicable state and local building restrictions as well as all zoning, fire, and health codes/ordinances.
- The facility must meet the requirements of the American Disabilities Act of 1990.
- The facility must have a governing body with full legal authority and judiciary responsibility for the overall operation of the program in accordance with applicable state and federal requirements.
- The facility must have an advisory committee, and the committee must be representative of the community and participant population.

- The facility must have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.

- The facility must have a qualified administrator (chief executive officer or president) responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the adult day care services program. The administrator must have master's degree and one (1) year supervisory experience (full-time or equivalent) in a social or health service setting; **or** a bachelor's degree and three (3) years supervisory experience (full-time or equivalent) in a social or health service setting; **or** comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.

- The facility must have a program director (center manager, site manager, center coordinator) responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program in accordance with the participant's needs and any mandatory requirements. The program director must have a bachelor's degree in health, social services, or a related field and one (1) year supervisory experience (full-time or equivalent) **or** comparable technical and human services training with demonstrated competence and experience as a manage in a health or human services setting. The program director must be under the direction of the administrator.

- The facility must have a qualified social service staff person. The staff person must have a master's degree in social work and at least one (1) year of professional work experience (full-time or equivalent) in a human services setting; **or** a bachelor's degree in social work and two (2) years of professional work experience (full-time or equivalent) in a human services setting; **or** a bachelor's degree in a health or social services related field and two (2) years experience (full-time or equivalent) in a human services field. Social Workers must comply with all licensure requirements set by the Mississippi State Board of Examiners for Social Workers and Marriage & Family Therapists. In lieu of a licensed social worker, the functions may be carried out by other health service professionals such as certified rehabilitation counselors, licensed gerontologists, licensed professional counselors, or licensed/certified mental health workers.

- If the facility offers nursing services, there must be a registered nurse (RN). The RN must have a valid state license and a minimum of one (1) year applicable experience (full-time or equivalent). It is preferable for the RN to have a bachelor's degree, that all or part of the RN's experience has been in a community setting, and that the RN's experience has involved working with the aging adults and adults with chronic impairments.

- The facility must have an activities coordinator. The coordinator must have a bachelor's degree and at least one (1) year of experience (full-time or equivalent) in developing and conducting activities for the type population to be served **or** an associate's degree in a related field and at least two (2) years of appropriate experience (full-time or equivalent). An educational degree with a major in recreation, occupational therapy, arts, humanities, social services or health services is preferred. Experience that includes therapeutic recreation for older adults and those with disabilities is preferred.

- The facility must have a program assistant. The assistant must have a high school diploma or the equivalent and at least one (1) year experience (full-time or equivalent) in working with adults in a health care or social service setting. The program assistant must receive training in working with older adults and conducting activities for the population served. Responsibilities of the program assistant should include providing personal care assistance to participants and working with other staff as required for the implementation of services/activities. The program assistant may assist with transporting and escorting participants to, from, and within the facility.

- If the facility prepares food on site, there must be a food service director. The food service

director must be a registered dietician (RD), dietetic technician registered (DTR), RD eligible, DTR eligible, or a four (4) year graduate of a baccalaureate program in nutrition/dietetics/food service. In addition, the food service director must have a minimum of one (1) year experience (full-time or equivalent) in working with adults in a health care or social service setting. **If the food is not prepared on site, the facility must contract with a reputable food service provider/caterer.**

- The facility must have a secretary/bookkeeper. The secretary/bookkeeper must at a minimum have a high school diploma or equivalent and the skills and training to carry out the responsibilities of the position. A bachelor's degree in accounting or high school diploma with five (5) years experience (full-time or equivalent) in accounting is preferred.

- The facility must have a driver. The driver must have a valid state driver license, a safe driving record, and training in first aid and cardiopulmonary resuscitation (CPR). The driver must maintain compliance with all state requirements for licensure/certification. The driver should be aware of basic transfer techniques and safe ambulation. Experience in assisting older adults and adults with impairments are preferred. Successful completion of a defensive driving course, training in sensitivity to the needs of older adults, and passenger assistance training is preferred. If qualified, the driver may also serve as the program assistant.

- If the facility uses volunteers there must be a record of the volunteer's hours and activities. Volunteers must be individuals or groups who desire to work with adult day service participants. Volunteers must successfully complete an orientation/training program. The responsibilities of volunteers must be mutually determined by the volunteers and staff. Duties must be performed under the supervision of facility staff members. Duties should either supplement staff in established activities or provide additional services for which the volunteer has special talent/training. **The facility may not use volunteers in place of required staff and should use volunteers only on a periodic/temporary basis.**

Homemaker Services

DOM requires that an agency seeking approval as a Medicaid Home and Community-Based Waiver provider for the Elderly & Disabled Waiver be established and in business for a minimum of one (1) year. It is not appropriate for an individual to apply for a DOM provider number for the sole purpose of providing care to friends/family members.

To be approved/certified by DOM as a provider of homemaker services, the agency must provide written documentation of the following:

- DOM provider agreement that includes the agency's agreement to the waiver requirements

- Governing structure for assuring responsibility and for requiring accountability for performance

- Fiscal management

- Personnel Management including personnel policies, job descriptions, and the process for recruitment, selection, retention and termination of homemakers

- Roster of qualified homemaker staff

- Criteria/procedure for the provision of services including procedures for dealing with emergency service requests

Each homemaker agency must have qualified homemakers and supervisors.

- Homemaker supervisor

  The homemaker supervisor must have a bachelor's degree in social work, home economics, or a related field and at least one (1) year experience (full-time or equivalent) working directly with aged and disabled individuals; **or** licensure as a registered nurse (RN) or licensed practical nurse (LPN) and one (1) year experience (full-time or equivalent) working directly with aged and disabled individuals; **or** a high school diploma and four (4) years experience (full-time or equivalent) working with aged and disabled individuals. In addition, all homemaker supervisors must have at least two (2) years supervisory experience (full-time or equivalent) preferably in a setting with aged and disabled individuals.

  The homemaker supervisor may not supervise more than twenty (20) full-time homemakers. Responsibilities include, but are not limited to:

  - Making home visits with the homemaker to observe and evaluate job performance
  - Submitting supervisor reports and monthly activity sheets
  - Reviewing/approving service plans
  - Processing requests for service
  - Interpreting agency policy and procedure, maintaining appropriate records and reports
  - Planning and documenting in-service training for homemaker staff
  - Maintaining accessibility to homemakers for emergencies, case reviews, conferences, and problem solving.

  The homemaker supervisor must report directly to the agency director.

- Homemakers

  Requirements for homemakers are as follows:

  - Eighteen (18) years of age or older
  - High school diploma, General Educational Development (GED) Test, or must demonstrate the ability to read the written homemaker assignment and write well enough to complete required forms and reports
  - Successful completion and passing score on a forty (40) hour Homemaker Curriculum Training Course or the equivalent (e.g., Certified Nursing Assistant)
  - Valid Mississippi driver license and access to reliable transportation
  - Ability to function independently without constant supervision/observation
  - Physical ability to perform tasks required
  - Absence of communicable diseases as verified by a physician

- Interest in, and empathy for, individuals who are ill, elderly, and/or disabled
- Emotional maturity and ability to respond to individuals and situations in a responsible manner
- Good communication and interpersonal skills; ability to deal effectively, assertively and cooperatively with a variety of people
- Absence of any criminal convictions related to violent crime and/or crime substantially related to the dependent population

Experience in caring for aged and disabled individuals is preferable but not required.

In-Home Respite

DOM requires that an agency seeking approval as a Medicaid Home and Community-Based Waiver provider for the Elderly & Disabled Waiver be established and in business for a minimum of one (1) year. It is not appropriate for an individual to apply for a DOM provider number for the sole purpose of providing care to beneficiaries who are friends/family members.

DOM requires all providers of in-home respite services to submit written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into a provider agreement.

Each in-home respite agency must have qualified in-home respite providers and supervisors.

- In-home respite provider supervisor

  The in-home respite supervisor must meet the following requirements; bachelor's degree in social work or related profession, at least one (1) year experience (full-time or equivalent) working with aged and disabled clients, and two (2) years supervisory experience (full-time or equivalent); **or** licensure as a RN or LPN, one (1) year experience (full-time or equivalent) working directly with aged and disabled individuals, and two (2) years supervisory experience (full-time or equivalent); **or** a high school diploma, four (4) years experience (full-time or equivalent) working directly with aged and disabled individuals, and two (2) years supervisory experience (full-time or equivalent).

- In-home respite provider

  Requirements for in-home respite providers are as follows:

  - Eighteen (18) years of age or older
  - High school diploma/GED, and at least for (4) years (full-time or equivalent) experience as a direct care provider to the aged or disabled
  - Certification in CPR and first aid
  - Valid Mississippi driver license and access to reliable transportation
  - Ability to function independently without constant supervision/observation
  - Physical ability to perform tasks required

- Ability to recognize signs of abuse, neglect, and/or exploitation; ability to follow procedures required in the Vulnerable Adult Act
- Knowledge of how to prevent burns, falls, and fires; knowledge of emergency numbers for contacting emergency personnel if required
- Absence of communicable diseases as verified by a physician
- Interest in, and empathy for, individuals who are ill, elderly, and/or disabled
- Emotional maturity and ability to respond to individuals and situations in a responsible manner
- Good communication and interpersonal skills; ability to deal effectively, assertively and cooperatively with a variety of people
- Absence of any criminal convictions related to violent crime and/or crime substantially related to the dependent population

Escorted Transportation

Qualifications

All escorted transportation (ET) providers must, at a minimum, meet the qualifications and standards set forth for participation in the state Medicaid program as a non-emergency transportation provider. Refer to Provider Policy Manual Section 12.08 for Driver Requirements policy and Section 12.09 for Vehicle Requirements policy. All ET providers must be certified by and enter into a provider agreement with DOM. The ET provider must not have more than two (2) traffic violations and no driving under the influence (DUI) violations. Providers must submit to DOM an official copy of their driving record provided by the Mississippi Department of Public Safety. The provider must obtain this documentation on all drivers employed by the agency.

Service Documentation

Written documentation must be kept for all ET services. Each instance of service delivery must include, but is not limited to, the following:

- Date of service
- Time of departure from the beneficiary's residence
- Time of arrival at destination
- Number of miles traveled to destination
- Time of departure from this location
- Time of return arrival at the beneficiary's residence
- Return mileage driven to the beneficiary's residence

- Name and signature of the individual providing the ET service
- Beneficiary's signature verifying the accuracy of the documentation
- Beneficiary's Medicaid identification number

General Terms and Conditions

1. Provider agrees to deliver services and the Division agrees to pay for services as set forth in their agreement.

2. Provider agrees to make available to appropriate state and federal personnel, during regular business hours, all necessary records relating to services performed. Provider agrees to maintain such records for a period of five (5) years.

3. Provider agrees to submit claims for reimbursement in accordance with instructions from the Division or its fiscal agent. Provider is responsible for the validity and accuracy of claims submitted.

4. Provider agrees to provide transportation services without regard to race, color, religion, sex, national origin, or handicap.

5. Provider agrees to abide by federal and state laws and regulations affecting delivery of services, including use of safety belts.

6. Provider agrees to accept as payment in full the amount paid by Medicaid for claims submitted for payment under that program.

7. Provider understands that payment of claims will be from federal and state funds and any falsification or concealment of material fact may be prosecuted under federal and State laws.

8. Provider will take no action that would circumvent or deny freedom of choice to Medicaid beneficiaries under the Medicaid program.

9. Provider agrees to bill only those claims to Medicaid that have been administered by the provider to an eligible Medicaid HCBS E&D Waiver beneficiary.

10. Provider will refrain from offering or purporting to give any reimbursement, premium, or other free merchandise as a trade inducement to a Medicaid beneficiary.

11. Provider is an independent provider and Medicaid has no liability for negligent acts or omissions of the provider.

12. Provider agrees to have a legal driver's license and have a current inspection sticker, current license plate and current liability insurance on the vehicle. The provider agrees that if a beneficiary is in the provider's vehicle when an accident occurs, the provider must notify DOM within twenty-four (24) hours after the accident.

13. Provider agrees to notify the Division verbally and in writing within the first working day after the loss of inspection sticker, license plate, or liability insurance. The provider's agreement is automatically terminated in the event of such loss, expiration, or non-renewal.

14. Payment may be withheld because of irregularity for whatever cause until such irregularity can be adjusted.

15. The provider's agreement is subject to availability of state and federal funds, the cessation or reduction of which, will constitute the voidance of this Agreement.

16. The provider's agreement is not transferrable or assignable by the provider and may be terminated by thirty (30) days written notice by either party, with the exception of Paragraph 13.

17. In the event funds have been overpaid or disallowed, the provider shall repay to the Division the full amount of the overpayment or disallowance on terms mutually agreeable to the Division and the provider.

18. Provider will not disclose any Medicaid beneficiary information except in connection with providing transportation services or submitting a claim for providing such services, or as otherwise authorized by the Division.

19. The provider agrees to conduct a criminal background check and obtain a motor vehicle report (MVR) on all drivers at least yearly along with a check of the Mississippi Sex Offenders registry. The provider must obtain this documentation on all drivers employed by the agency. Records must be retained in the employee personnel file.

To bill for an hour of ET service, the ET provider must provide at least forty-five (45) minutes of services.

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain approval the waiver provider must complete and submit current DOM approved forms as follows:

- Pre-Admission Screening (PAS) Tool
- Plan of Care Form
- Admitted and Discharged Form

Pre-Admission Screening (PAS) Tool

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm which will generate a numerical score. The score will be compared to a set numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. **The PAS will generate a Summary and Physician Certification page that must be signed by the physician.**

After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS score, the application along with the Plan of Care (POC), which includes all of the service needs of the applicant, will be forwarded electronically.

Refer to Provider Policy Manual Section 64.0 for Long Term Care/Pre-Admission Screening (PAS) policy.

Plan of Care

The Plan of Care form is completed by the case manager. This form, in conjunction with the Pre-Admission Screening (PAS) Tool, contains objectives, types of services to be furnished, and frequency of services. The form must be submitted to the Division of Medicaid, Division of LTC/HCBS.

Admitted and Discharged Form

The Admitted and Discharged form is used to admit and discharge a beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and anytime there is a change in the beneficiary's status.

DOM HCBS staff will review/process the documents. If approved, an enrollment date will be established. The Pre-Admission Screening (PAS) Tool and the Plan of Care will be returned to the case management provider to retain as part of the case record.

A beneficiary may be locked into only one program at a time. Any request to add or increase skilled services listed on the approved plan of care requires prior approval.

The following services are provided through the Elderly and Disabled Waiver:

- Case Management
- Homemaker
- Adult Day Care
- Institutional or In-Home Respite
- Home Delivered Meals
- Escorted Transportation
- Extended Home Health Visits
- Transition Assistance

Providers must meet all provider specifications for the respective service as outlined in the CMS approved waiver.

Beneficiaries who choose to reside in a licensed/unlicensed Personal Care Home may not receive personal care services through the waiver.

Case Management

Case management services assist beneficiaries in accessing needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services. Case management services for the E&D Waiver program are provided through the Mississippi Planning and Development Districts/Area Agencies on Aging (PDD/AAA). Each PDD/AAA providing case management services must be approved by the Division of Medicaid and must enter into a provider agreement.

Case management services are rendered by teams. Each team is composed of two (2) case managers. One case manager is a Registered Nurse and the other is a Licensed Social Worker. Each team must have an assigned case management supervisor. The case management supervisor should not carry an active caseload of clients.

A case management team comprised of a registered nurse and a social worker will maintain an average caseload of one hundred (100) active cases with up to five (5) cases pending approval by DOM. Priority will be given to beneficiaries electing to transition from nursing home to a home/community-based setting. If a case manager leaves a team, the remaining case manager will become a single CM team until the vacant position is filled. The remaining case manager will continue to maintain the caseload. Beneficiaries should not be discharged down to fifty (50) nor should new beneficiaries be added until the team member is replaced. Any exceptions must be approved by DOM. The Case Management Supervisor must document all efforts made to find/hire a new team member.

If a team has a social worker and a nurse, **both** are expected to make each visit. If one member is out on a prolonged leave/absence, the other team member may conduct the monthly visits, quarterly visits, readmits, and recertification visits alone. Single (one member) case management teams may also conduct monthly visits, quarterly visits, readmits, and recertification visits alone.

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 protective 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 (cost is included in the rate paid to providers)
- 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.

To receive Medicaid reimbursement the beneficiary must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the beneficiary to and from the facility.

Institutional or In-Home Respite Services

Respite Care provides assistance to beneficiaries unable to care for themselves. Respite service is non-medical care and supervision is provided to the beneficiary in the absence of the beneficiary's primary

full-time, live-in caregiver(s) on a short-term basis. Services are provided to assist the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the beneficiary.

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**

   In-Home Respite services are limited to no more than sixty (60) hours per month. Respite services in excess of sixteen (16) continuous hours must be prior approved by the case management team.

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 has no responsible caregiver in the home. 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.

Escorted Transportation

Escorted transportation is a service offered to the frail population served in the E&D Waiver. These services are offered in addition to medical transportation required under 42 CFR 431.53 and transportation services offered under the State Plan, defined in 42 CFR 440.170 (a) (if applicable). Escorted transportation is provided when the State Plan non-emergency transportation is either not available or inadequate to accommodate the needs of the beneficiary. Whenever possible, family, friends, or community agencies will be utilized in lieu of escorted transportation. In no case will family members be reimbursed for the provision of escorted transportation under this waiver. Escorted transportation may be used for trips to doctors' appointments and trips to the pharmacy to pick up medications. The escorted transportation provider is expected to assist the beneficiary into and out of their home, to the vehicle safely, into the doctor's office/pharmacy, remain with the beneficiary throughout the time they are in the doctor's office/pharmacy, and assist them back to the vehicle. **At no time will the beneficiary be left alone or dropped off unattended. The escorted transportation provider may not**

at any time use the beneficiary's personal vehicle to provide services. 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.

Extended Home Health Services

Beneficiaries may receive twenty-five (25) home health visits each fiscal year through the regular Medicaid program. 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 twenty-five (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. Exceptions must be approved by DOM. 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

All transition services must be essential to (1) ensuring that the individual is able to transition from the current nursing facility, and (2) removing an identified barrier or risk to the success of the transition to a more independent living situation.

3. Exclusions

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