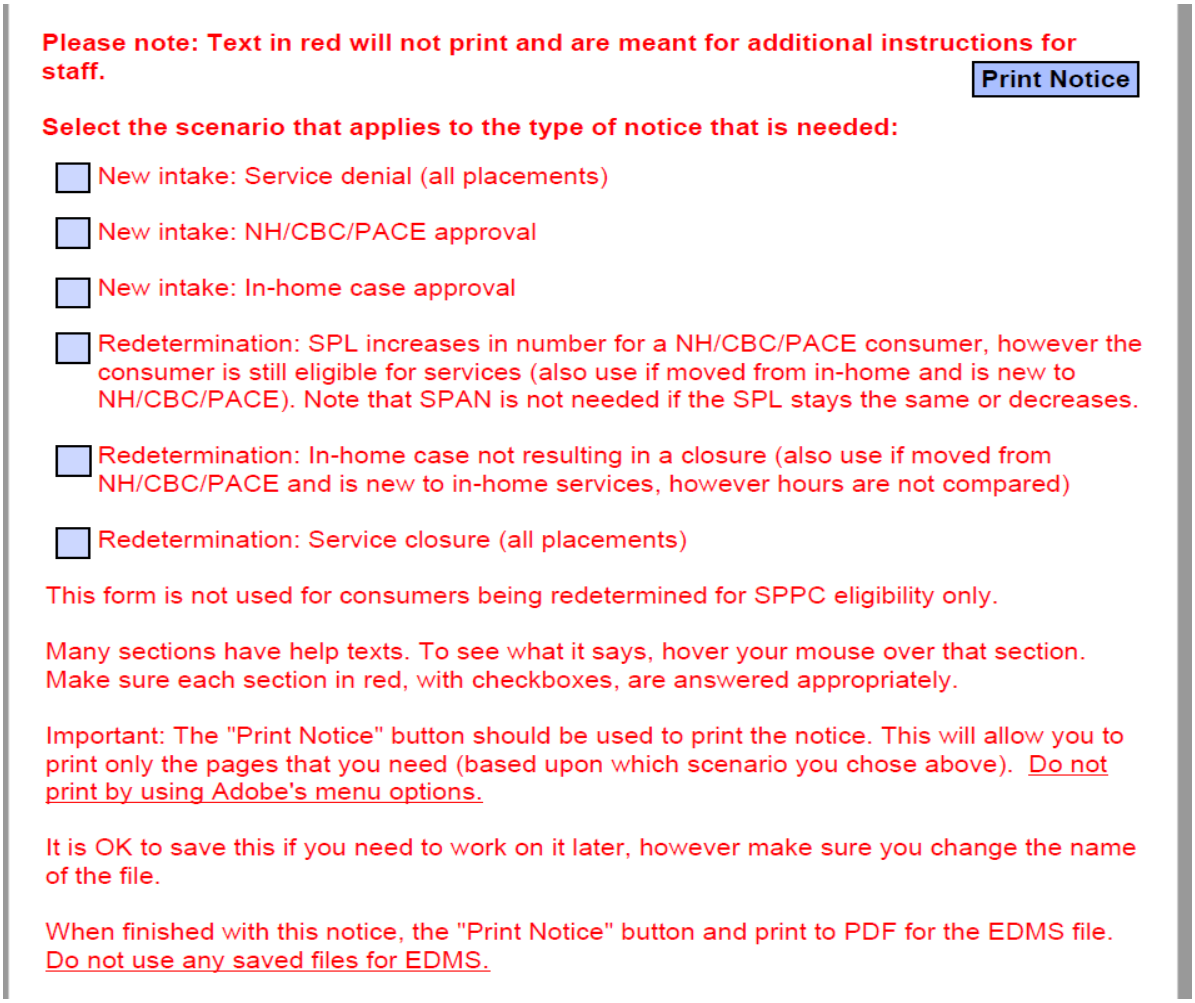
New Decision Notice Information and Instructions Guide

Updated with the New Service Plan and Notice (SPAN)

Provided by the:
Department of Human Services
Aging and People with Disabilities
Medicaid Services and Supports Unit
Revised August 2018

Selection Page



Please note: Text in red will not print and are meant for additional instructions for staff.

Print Notice

Select the scenario that applies to the type of notice that is needed:

- ☐ New intake: Service denial (all placements)
- ☐ New intake: NH/CBC/PACE approval
- ☐ New intake: In-home case approval
- ☐ Redetermination: SPL increases in number for a NH/CBC/PACE consumer, however the consumer is still eligible for services (also use if moved from in-home and is new to NH/CBC/PACE). Note that SPAN is not needed if the SPL stays the same or decreases.
- ☐ Redetermination: In-home case not resulting in a closure (also use if moved from NH/CBC/PACE and is new to in-home services, however hours are not compared)
- ☐ Redetermination: Service closure (all placements)

This form is not used for consumers being redetermined for SPPC eligibility only.

Many sections have help texts. To see what it says, hover your mouse over that section. Make sure each section in red, with checkboxes, are answered appropriately.

Important: The "Print Notice" button should be used to print the notice. This will allow you to print only the pages that you need (based upon which scenario you chose above). Do not print by using Adobe's menu options.

It is OK to save this if you need to work on it later, however make sure you change the name of the file.

When finished with this notice, the "Print Notice" button and print to PDF for the EDMS file. Do not use any saved files for EDMS.

The Selection page allows the CM to select the specific situation for each consumer. It is important to remember:

- Sections in red will not print.
- To review any instructions provided and check the appropriate boxes.
- The notice will generate depending on the selections made.
- That notices should be printed by using the “Print Notice” button.
- The “Print Notice” button generates only the pages needed by the consumer.
    - When saving to EDMS, use the “Print Notice” button and use a Print to PDF option.
    - Notices should not be printed or saved to EDMS by any other method.

Copy of Page 2

Service Plan and Notice — Print Notice

DHS Oregon Department of Human Services

Branch:	Prime:	Prgm:	DOB:
1	2	3	4
Case Name: 5			Date of Notice: 6
Worker Name: 7			Phone Number: 8

9 10 11 12 13 14

15 On 7/2/18 , you were assessed for Medicaid Long Term Services and Supports.

This assessment found you to be - 16

17 **Therefore, you are eligible for services.**

18 Previously, on 6/1/17 , you were assessed at - 19

APD serves individuals who are assessed as Service Priority Level (SPL) 1 through 13 per OAR 411-015-0015. APD is responsible for these programs based on ORS 410.070.

20 Per the assessment on 7/2/18 ,you are authorized to receive a total of 14 hours in each two week service period. Of this amount, you are authorized to receive exceptional hours. 21 22

Per the previous assessment on 6/1/17 , 23

you were authorized to receive 17 hours each two week service period.

25 This is a new service plan authorization. 24

If you disagree with this decision or you do not think your assessment is correct, you may file an appeal by completing and submitting form MSC 443 or by contacting your Case Manager. Your Assessment Summary is attached as part of this notice. Your hearing rights are also attached to this notice.

This change is effective: **You will receive another notice explaining any other change(s) to your benefits.** 26

Here is a summary of your care needs that determine your eligibility for our program:

27

Critical

Instructions for Page 2

Demographic information must be typed in. The form is not yet loaded as an OA form. Please remember that all the consumer-specific information must be filled in completely. This includes:

1. Branch #
2. Consumer's Prime
3. Program Code
4. Date of Birth
5. Consumer's name
6. Date the notice is mailed
7. Case manager's name (Please note: this should be the name of the CM who completed the assessment)
8. Case manager's phone number (DO NOT LEAVE BLANK)
9. Consumer's or Representative's Name (First, Middle Initial and Last Name)
10. Mailing Address (Line 1)
11. Mailing Address (Line 2)
12. City
13. State
14. Zip Code

Page 1 will load the specific information for NF/CBC/PACE or in-home consumers. The example above shows an in-home consumer that is being re-determined for eligibility. For both types of cases you must:

15. Enter the date of the assessment – type the date or select from calendar
16. Select SPL level from drop down. Please note - no SPL 99
17. Select eligibility status:
    - Therefore, you are eligible for services.
    - Therefore, you are not eligible for services.
18. Enter or select previous assessment date (if it is a redetermination).
19. Select previous SPL level from drop down (if it is a redetermination).

For in-home consumers you will need to complete the following:

20. The date will autofill when the mouse points to the field.
21. The total hours will autofill as the form is completed.
22. Enter the number of exception hours authorized for the consumer, if any.
23. The date of the previous assessment will autofill when the mouse points to the field.
24. The total hours will autofill as the form is completed.
25. Select from the dropdown box the best option that describes the consumer's specific situation. Options include:
    - This is a new service plan authorization;

Instructions for Page 2, continued

- This is an increase in the total hours authorized from your last service plan.
- This is a decrease in the total hours authorized from your last service plan.
- The total hours authorized in your service plan have remained the same.

26. Enter the effective date of the notice. This must be at least 10-days from the date the notice will be postmarked if it is a reduction.
    - For in-home cases, align the effective date with the service period.
      - First day of the service period for reductions and changes.
      - Last day of the service period for closures.
    - For NF and CBC, make the effective date the last day of the appropriate month.
27. **This is one of the MOST important boxes in the entire notice. This is where you summarize why the consumer was assessed at the level they were**. You must use consumer-friendly language and not use jargon or rule language. Each notice must be specific to the consumer.
    - Clearly explain the reason for the SPL.
    - Only address the ADL(s) that drive the eligibility
    - Clearly explain the difference if there is any change in SPL

Copy of Page 3

Service Plan and Notice Print Notice

The assessment included the Case Manager's (CM) observations, information from you, and from the following:

1

Oregon Administrative Rules (OAR) 411-015-0006 and 0007 list each ADL/IADL component as well as the specific criteria to determine your assistance level. Mobility, Eating, Elimination and Cognition are the ADLs used to determine your eligibility for Long Term Care Services. The criteria in each ADL specifies the tasks, the types of assistance and the required frequency. You can find information regarding ADLs/IADLs in this notice. For more information, ask for the brochure called "Assessing Individuals for Medicaid Long Term Care." Your Assessment Summary is attached as part of this notice.

Instrumental Activity of Daily Living (IADL) are set out in Oregon Administrative Rule (OAR) 411-030-0070(2) and (3). Hours may also be reduced for documented reasons per OAR 411-030-0070(2)(c), OAR 411-030-0070(3)(c), and OAR 411-030-0070(3)(e).
You may request additional hours or an exception to the maximum number of hours (per OAR 411-030-0071; OAR 411-027-0050; OAR 41-027-0020) authorized in any ADL or IADL. You will also receive a notice of, and have hearing rights if, your request for additional hours is not approved.

2

☐ Community Based Care Facility Payment per OAR 461-160-0610 and 461-160-0620
You must pay the following payment each month (see attached 0450):

First Month	Ongoing Months	
$	$	Liability
+	+	Room and Board
$ 0.00	$ 0.00	Total monthly payment to facility

☐ Nursing Facility Payment per OAR 461-160-0610 and 461-160-0620
If checked, you must pay a liability payment each month for nursing facility services (see attached form 458A).

Instructions for Page 3

1. On page 3 there is a free text box. In this box you need to:
   Document who was at the assessment
   - Be specific – include names and relationship. As examples:
     - You, your daughter Sylvia, and I were at your assessment.
     - You, Fred Smith (your homecare worker), your friend Nancy Smith and I were at your assessment.

   Include any collateral information that was used to make your assessment.
   - Again, be specific. As examples:
     - We reviewed the Care Plan provided by Happy Home Assisted Living Facility.
     - We discussed the service provided with the Director of Nursing at the Nursing Facility.
     - We reviewed medical records provided by Doctor Smith dated 12/2016 through 4/2018.
   - Use all collateral information that you have available to you.

2. If this consumer is eligible for services and is living or will be living in a CBC, NF, or receiving services through PACE, this information will display and will need to be completed.

Copy of Page 4

Extended Waiver Eligibility Decision Print Notice

For individuals who are reassessed and found to be meet SPL 14 through 17, the Department can continue to pay your provider in limited circumstances, called "Extended Waiver Eligibility" (EWE).

We reviewed your eligibility for EWE per OAR 411-015-0030 and have determined that you are not eligible. To meet criteria for EWE you must meet criteria for SPL 14 through 17. OAR 411-015-0030(1).

Here is why you are not eligible for EWE:

Case Manager: Choose one of the following: (Please complete free text above if ineligible)

- ☐ Consumer is SPL Eligible
- ☐ Consumer is EWE eligible (send a separate notice)
- ☐ Consumer is ineligible for EWE as consumer was not already receiving services.
- ☐ Consumer is ineligible for EWE as their SPL is higher than 17.
- ☐ Consumer is ineligible for EWE as consumer has adequate access to shelter and support.
- ☐ Consumer is ineligible for EWE as consumer didn't take steps to mitigate identified risks.

Your eligibility for the Medicare Savings Program and the Oregon Health Plan has been reviewed. If there is a change, you will receive a separate notice regarding your eligibility. Please note that per OAR 411-014-0010, Service Priority Level eligibility for Long Term Care services is primarily determined by the level of assistance needed in Mobility, Eating, Elimination and Cognition. Assistance needs for Bathing, Personal Hygiene and Grooming currently only impact SPL 14 through 17 and Extended Waiver Eligibility (EWE). More details are in OAR 411-015-0010.

Instructions for Page 4

Page 4 is for Extended Waiver Eligibility (EWE).

Please remember that the red text will not print.

1. Select the appropriate box for the consumer's specific situation. The page will generate the appropriate information for the consumer's notice.
2. If the consumer is not SPL or EWE eligible, you MUST enter information in the free text area that explains why they are not eligible. Use plain language, free of jargon.

   Here are some examples:

   - You are not eligible for Extended Waiver Eligibility services because you live in your own home and have no history of evictions or abuse before you came onto services.
   - You are not eligible for Extended Waiver Eligibility services because you did not follow through with what you agreed to do for your transition plan.
   - You are not eligible for Extended Waiver Eligibility services because you are going to live with your daughter which is a safe place for you to live.

Copy of Page 5

Print Notice

State Plan Personal Care Eligibility

State Plan Personal Care, authorized through OAR 411-034, is a program that allows for a provider to work up to ten hours per pay period. Additional hours may be requested and considered through an exception requested through your case manager. This service also pays for a nurse to manage health support needs and delegated nursing tasks. This program does not pay for services that include shopping or being transported.

Case Manager: Please choose one of the following:

- ☐ Not applicable since the consumer is eligible for Long Term Services and Supports.
- ☑ Eligible for SPPC.
- ☐ Not eligible for SPPC due to living in a facility.
- ☐ Not eligible for SPPC due to not meeting Medicaid requirements.
- ☐ Not eligible for SPPC due to not meeting personal care criteria.
- ☐ Not eligible for SPPC due to natural supports.

You have been determine eligible for State Plan Personal Care. You are authorized to receive hours per service period, effective:

Instructions for Page 5

Page 5 is about State Plan Personal Care Services.

Select the appropriate option to meet the consumer's specific situation. The red text will not print, but it will allow you to complete the information later in the notice.

1. If you select option 2
    a. You will be able to inform the consumer how many hours they will get each service period.
    b. You will also need to fill in or select the effective date.
2. If you select options 3, 4, 5, or 6, see the next two pages.

Please note that the 540 and 541 are only required when doing a redetermination for SPPC, in which case the SPAN form is not used. In all other cases, the SPAN replaces the 540/541.

Copy of Page 5, continued

Print Notice

State Plan Personal Care Eligibility

State Plan Personal Care, authorized through OAR 411-034, is a program that allows for a provider to work up to ten hours per pay period. Additional hours may be requested and considered through an exception requested through your case manager. This service also pays for a nurse to manage health support needs and delegated nursing tasks. This program does not pay for services that include shopping or being transported.

Case Manager: Please choose one of the following:

- ☐ Not applicable since the consumer is eligible for Long Term Services and Supports.
- ☐ Eligible for SPPC.
- ☑ Not eligible for SPPC due to living in a facility.
- ☐ Not eligible for SPPC due to not meeting Medicaid requirements.
- ☐ Not eligible for SPPC due to not meeting personal care criteria.
- ☐ Not eligible for SPPC due to natural supports.

You are not eligible for State Plan Personal Care Services (SPPC) because you are receiving assistance with Activities of Daily Living (ADLs, which is described in OAR 411-015-0006) from a licensed 24-hour residential services program (such as an Adult Foster Home, Assisted Living Facility, Group Home, or Residential Care Facility) or you are in a prison, hospital, sub-acute care facility, nursing facility, or other medical institution. OAR 411-034-0030(2)(a)and(b). If you move into a different setting, you may qualify for SPPC.

Here is why you are not eligible for State Plan Personal Care:

Instructions for Page 5, continued

Page 5 is about State Plan Personal Care Services.

3. Select the appropriate option to meet the consumer's specific situation. The red text will not print but it will allow you to complete the information later in the notice.
4. A free text box will display if boxes 3, 4, 5, or 6 are checked.
5. If this occurs, explain in plain language why the consumer is not eligible for SPPC.

Copy of Page 6

Service Plan and Notice Print Notice

☐ If checked, you have a pay-in (liability) that must be paid to the department by the 10th of each month. OAR 411-015-0015(7), 461-160-0610, 461-160-0620, 461-185-0050. The amount owed each month is as follows:

Ongoing Months:

☐ If checked, you have decided to receive services through the Independent Choices Program. See attached 546IC. OAR 411-015-0015(7), 461-160-0610, 461-160-0620, 461-185-0050. The monthly benefit amount is as follows:

Ongoing Months:

Shift Services:
Shift Services is an hourly in-home service option that authorizes 16 hours of paid in-home care each day. The specific program requirements are found in OAR 411-030-0068(2).

CM: Eligible for Shift Services: Yes ☐ No ☑ Make sure this and the following section have the appropriate box checked.

You have been evaluated for the Shift Service option.

You are not eligible for shift services for the following reason(s):

There is a more cost effective way to meet your needs per OAR 411-030-0050(2)(B)(vi)

-

-

-

CM: Eligible for Spousal Pay: Yes ☐ No ☑ Add rule and reason below if consumer applied and is denied. Otherwise leave blank.

Below is a summary of your level of assistance in each ADL and IADL (per OAR 411-030-0070 (1)(a)-(c)) and the hours you are authorized to receive. If you previously received Medicaid in-home services, also provided is information on how you were previously assessed. NOTE: If your previously assessed hours were monthly, they were converted to the two week pay period in order to compare to your newly assessed hours.

Instructions for Page 6

Note: This page will be blank if the consumer is ineligible for services or the consumer is receiving services in a CBC/NF setting.

There are three parts to page 6

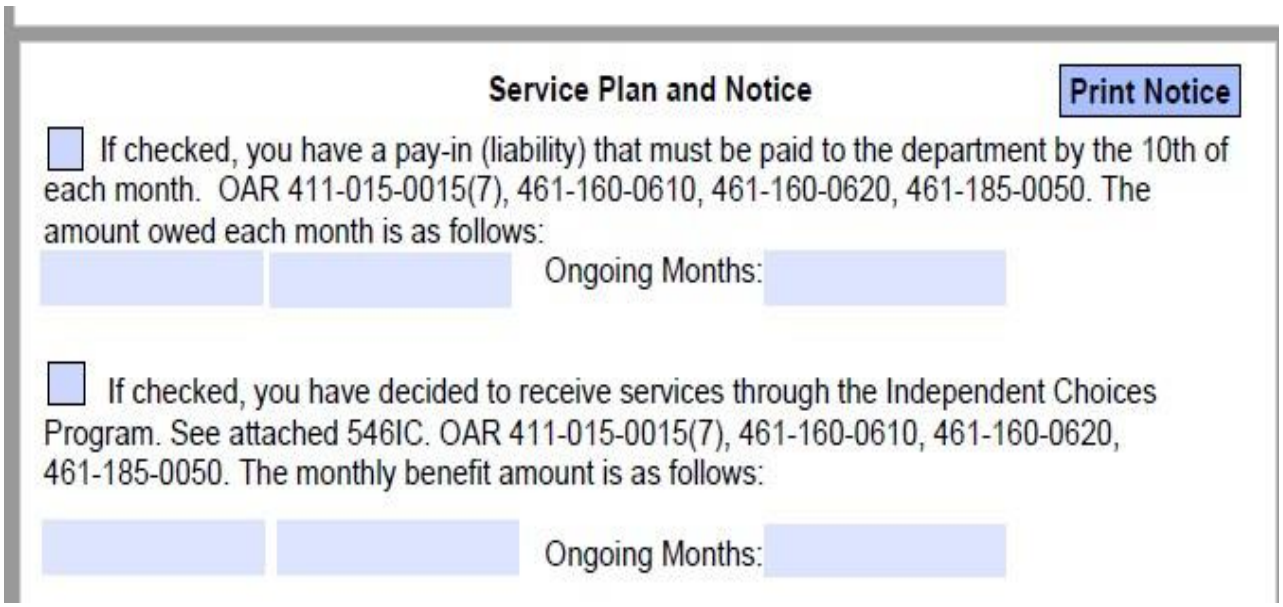
- Pay-In & Independent Choices Program
- Shift Services
- Spousal Pay

Pay-In and ICP Services

If the consumer has a pay-in, check the box and enter in the amount owed for the initial and ongoing months. Please make sure the pay-in worksheet is included.

If the consumer is receiving services through ICP, check the box and enter in the benefit amount for the initial and ongoing months. Please make sure the 546IC-two week is also provided.

The 541N is not required for service eligibility.



Copy of Page 6, continued

Shift Services

Approval

Shift Services:
Shift Services is an hourly in-home service option that authorizes 16 hours of paid in-home care each day. The specific program requirements are found in OAR 411-030-0068(2).

CM: Eligible for Shift Services: Yes ☑ No ☐ Make sure this and the following section have the appropriate box checked.

You have been evaluated for the Shift Service option.

You are eligible for shift services, which authorizes 16 hours of paid in-home care each day or 224 hours for a 14 day pay period. Please note that any homecare workers working for you are subject to a weekly hourly cap of either 40 or 50 hours per week. See OAR 411-030-0070(5)(b). If you believe that you need more than 16 hours per day or have your homecare worker(s) allowed to work above their weekly hourly cap, an exception may be requested per OAR 411-030-0071 and OAR 411-030-0072.

Denial

Shift Services:
Shift Services is an hourly in-home service option that authorizes 16 hours of paid in-home care each day. The specific program requirements are found in OAR 411-030-0068(2).

CM: Eligible for Shift Services: Yes ☐ No ☑ Make sure this and the following section have the appropriate box checked.

You have been evaluated for the Shift Service option.

You are not eligible for shift services for the following reason(s):

- There is a more cost effective way to meet your needs per OAR 411-030-0050(2)(B)(vi)
- You do not need help with an ADL/IADL task each waking hour (OAR 411-030-0068(2)(a)).
- You are not a Full Assist in Mobility, Elimination, or Cognition per OAR 411-015-0006
- You do not have a qualifying debilitating medical condition per OAR 411-030-0068(A)-(C)

Instructions for Page 6, continued

Shift Services

Check the appropriate boxes for the consumer's eligibility for Shift Services. This must be completed for every in-home consumer.

YOU MUST ASSESS ALL IN-HOME CONSUMERS FOR SHIFT SERVICES.

If the consumer is not eligible for shift services, select **all** of the appropriate dropdown selections for Shift Services. Remember to only select the ones that apply to the consumer. Drop downs include:

- There is a more cost effective way to meet your needs per OAR 411-030-0050(2)(B)(vi).
- You do not need help with an ADL/IADL task each waking hour (OAR 411-030-0068(2)(a)).
- You are not a Full Assist in Mobility, Elimination, or Cognition per OAR 411-015-0006.
- You do not have a qualifying debilitating medical condition per OAR 411-030-0068(A)-(C).

Copy of Page 6, continued

Spousal Pay

Approval

CM: Eligible for Spousal Pay: Yes ☑ No ☐ Add rule and reason below if consumer applied and is denied. Otherwise leave blank.

You are eligible for the Spousal Pay Program per OAR 411-030-0080(2). Please note that per OAR 411-030-0080(3)(b), the spousal pay provider's hours must consist of the one-half of the assessed hours for IADLs and all of the hours for specific ADLs based on the service needs of the individual.

Below is a summary of your level of assistance in each ADL and IADL (per OAR 411-030-0070 (1)(a)-(c)) and the hours you are authorized to receive. If you previously received Medicaid in-home services, also provided is information on how you were previously assessed. NOTE: If your previously assessed hours were monthly, they were converted to the two week pay period in order to compare to your newly assessed hours.

Denial

CM: Eligible for Spousal Pay: Yes ☐ No ☑ Add rule and reason below if consumer applied and is denied. Otherwise leave blank.

Below is a summary of your level of assistance in each ADL and IADL (per OAR 411-030-0070 (1)(a)-(c)) and the hours you are authorized to receive. If you previously received Medicaid in-home services, also provided is information on how you were previously assessed. NOTE: If your previously assessed hours were monthly, they were converted to the two week pay period in order to compare to your newly assessed hours.

Instructions for Page 6, continued

Spousal Pay

If the consumer applied for Spousal Pay and is **approved**, check “Yes.”

If the consumer applied for Spousal Pay and is **denied**, check “No” and use the free text box to enter the appropriate reason and rule from the APD worker guide.

If the consumer did not apply for Spousal Pay, check “No” and leave the box blank.

Copy of Pages 7 through 14

Assessment

Service Plan and Notice

Print Notice

Mobility: Ambulation 411-015-0006(7)(a), (b), (c) and (d)

6/8/17	Minimal Assist OAR 411-015-0006(9)(d)(A) - former rule
7/2/18	Independent OAR 411-015-0005 (26)
Reason:	According to your provider, you do not need assistance in this area that meets rule.

You are no longer needing help with walking in your home.

Mobility: Transfer 411-015-0006(7)(a), (b), (c) and (d)

6/8/17	Assist OAR 411-015-0006(9)(e)(A) - former rule
7/2/18	Assist OAR 411-015-0006(7)(e)(A)
Reason:	Your care needs are similar to your last assessment.

You are still needing help getting up from your bed each morning.

Mobility (Ambulation and Transfer) Hours

		Hours
6/8/17	Substantial Assist - 7 Max Hours (former 411-030-0070(2)(a)(D)(ii))	7
7/2/18	Substantial Assist - 7 Max Hours (411-030-0070(2)(a)(D)(ii))	0

Reason: Your care needs are similar to your last assessment.

Reason if less than maximum hours are authorized: ☑ Check if less than maximum hours are authorized

411-030-0070(2)(c)(D) - Natural supports.

Your provider let us know that she has not been helping you get out of bed in the morning. Your daughter is helping you instead and is not a paid provider.

Instructions for Pages 7 through 14

For each ADL and IADL component from the assessment:

1. Select the appropriate need level as assessed in the previous assessment where the consumer has been receiving benefits. This section will not display for consumers who are not currently receiving services. It is important to select the "former" rule option if the consumer was assessed prior to 10/1/17.
2. Select the appropriate need level of the current assessment.
3. Select the most appropriate reason from the following:
    a. The amount of care you need is indicated below.
    b. Your care needs are similar to your last assessment.
    c. Other information supports lower needs than requested or reported.
    d. You need more help in this area since the last assessment.
    e. You need less help in this area since the last assessment.
    f. You need less help now because your condition has improved.
    g. You need less help now because of a home modification or medical equipment.
    h. You told us you do not need assistance at least one day per week.
    i. You told us that you do not need assistance each time you perform this task.
    j. Although you may need assistance, the type of assistance needed does not qualify.
    k. According to your provider, you do not need assistance in this area that meets rule.
4. In the free text box, in plain language, explain the reason the person is assessed at the specific need level. Discuss any changes that have occurred since the last assessment. The free text boxes MUST not be left blank. Do not copy from the 002N comments.
    a. Use consumer-friendly language. For example:
        i. Your physical therapy allowed you to gain enough strength to help you walk again without any help.
        ii. You can walk in your home by yourself.
        iii. Your bathroom was changed allowing you to get up from the toilet without any help.
        iv. You have since recovered from your X medical condition and no longer need any help.
        v. You let us know that due to your medical needs, you are now needing help with dressing and undressing every time.
        vi. Although you prefer someone in your home while you take a shower, that is not a need we cover.

"Not Previously Assessed" is a dropdown option.

Select this **only** if:

For Cognition, the previous assessment was prior to 10/1/17.

or

The previous assessment was a 4 ADL assessment only (i.e. living in a NF)

Instructions for Pages 7 through 14, con't.

Hours Section

This section will not generate for:

- NF/CBC/PACE consumers;
- If the consumer was closed; or
- If the consumer was denied.

For in-home consumers, do the following for each ADL and IADL (note that line for previous hours will not be available if the consumer is not currently receiving services):

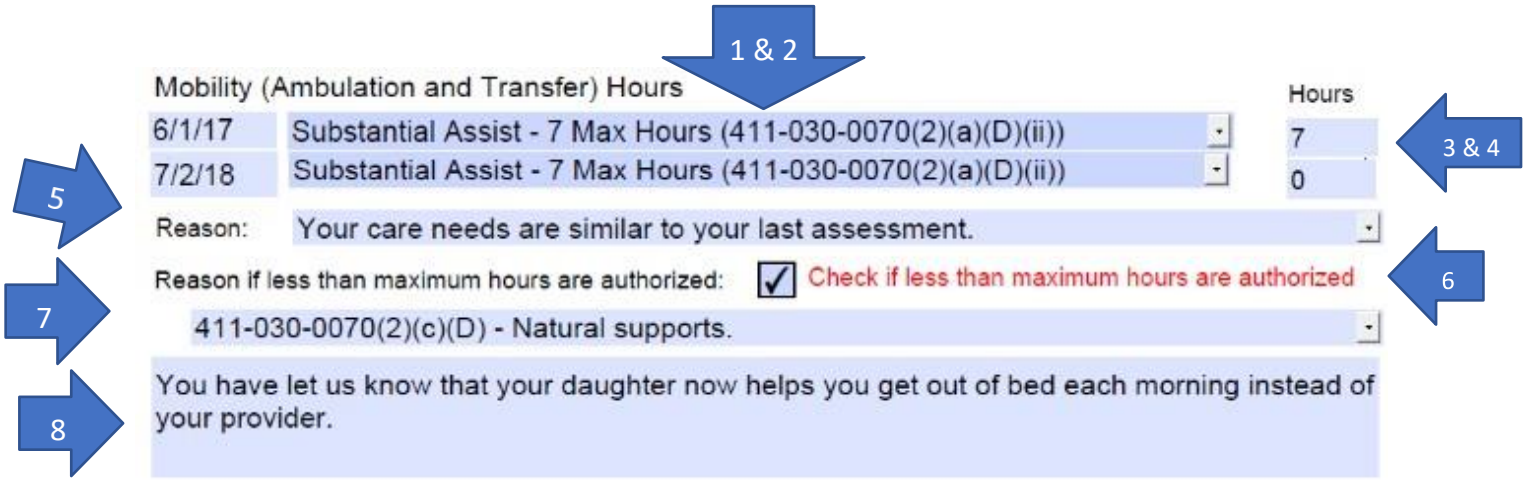
1. Select the appropriate need level that was assessed in the previous service plan NOT the assessment. It is important to select the "former" rule option if the consumer was assessed prior to 10/1/17.
    a. General options are:
        i. Independent;
        ii. Minimal Assist;
        iii. Substantial Assist; or
        iv. Full Assist.
2. Select the appropriate need level from the current service plan.
    a. General options are:
        i. Independent;
        ii. Minimal Assist;
        iii. Substantial Assist; or
        iv. Full Assist.
3. Enter in the total number of hours the consumer was authorized in the previous service plan.
    a. This includes any exception hours.
    b. If the previous plan is under the monthly format, it will need to be converted to the two-week format.
4. Enter in the total number of hours the consumer is authorized in the new service plan.
    a. This includes any exception hours.
5. Select the most appropriate reason (most options include why the need level has changed).
    a. Your hours were determined by rule and how much help you need from others.

Instructions for Pages 7 through 14, con't.

b. Your care needs are similar to your last assessment.
c. Other information supports lower needs than requested or reported.
d. You have been approved exceptional hours based upon your care needs.
e. The tasks that comprise this activity have changed.
f. Per your provider, you don't have a need in this area that meets rule.
g. No hours have been authorized in this activity because you are independent.
h. You need less help in this area since the last assessment.
i. You had a condition during your last assessment that has improved.
j. You reported you no longer need assistance that was previously being provided.
k. You now have medical equipment that decreased your need for assistance.
l. A modification done to your home has decreased your need for assistance.
m. You need more help in this area since the last assessment.

6. If less than the maximum hours are being assigned,
    a. Check the box provided.
7. Select from the dropdown list, *even when box is not checked*;
    a. The maximum allowed hours were authorized.
    b. You have been assessed as independent, no hours are authorized.
    c. If the box was checked use one of these dropdowns:
        i. 411-030-0070(2)(c)(A) - Reduced frequency and duration
        ii. 411-030-0070(2)(c)(B) - Durable medical equipment or home modification reduces need.
        iii. 411-030-0070(2)(c)(C) - Individual preference.
        iv. 411-030-0070(2)(c)(D) - Natural supports.
        v. 411-030-0070(2)(c)(E) - Provided or funded by another agency.
8. In the free text box that is provided, explain in plain language why the hours were not fully assigned.
    a. The free text box is not used if the max hours are assigned.

Copy & Instructions for Pages 7 - 14, con't.



Examples of Free Text When Authorizing Less than the Maximum Hours

- Rules have changed and fewer hours are now allowed for this task.
- You do not need as much help in this area.
- You son John helps you with this task.
- This task doesn't happen as often or is not taking as long as it did last year.
- You do not want this task done by a paid caregiver.

Copy of Page 15

Exception Decision for , **Date of Notice:**

Exception to the Homecare Worker Cap CM: Please skip this page for CBC/NH consumers **Print Notice**

1

Per OAR 411-030-0070(5)(b)and (c), homecare workers (HCWs) may not work above their weekly hourly cap (most HCWs may not work more 40 hours per week). An exception to this rule may be requested per OAR 411-030-0072(2) if you feel that you qualify for it. You must meet at least one of the criteria for an exception, outlined in OAR 411-030-0072(5).

☑ You have requested an exception to the hourly cap for one or more HCW(s). Below is the decision:

HCW	Exception Decision	Hourly Cap	Effective Date	End Date
Joe Smith	Approved	50	7/15/18	7/13/19
Emma Winchester	Denied	40	7/15/18	7/13/19

2

APD has determined that you needs can be met by one of your HCWs working additional hours. You may choose to hire additional HCWs or arrange for an IHCA for your other hours.

3

Exceptional Service Hours Decision "Total Hours Approved" auto-fills from the notice.

4

☐ This does not apply as you have not requested an exception or you are not receiving in-home services. **Print Exception Decision Only**

☑ You have requested an exception to the maximum allowed hours. This request was **partially denied** by **Central Office** .Effective: 08/05/2018 Ends: 08/03/2019

5

ADL/IADL	Max Hours	Requested Exceptional Hours	Approved Exceptional Hours	Total Hours Approved
Mobility	12	8	8	20
Eating				0
Elimination	14	28	10	24
Cognition				0
Bathing and Personal Hygiene				0
Dressing and Grooming				0
Housekeeping/Laundry				0
Breakfast				0
Lunch				0
Dinner/Supper				0
Med Management				0
Shopping				0
Transportation				0

6

Exception hours are evaluated per OAR 411-030-0071

You let us know that you need about 3 hours a day (42 hours a pay period) to manage your toileting needs. However, based upon the needs you reported, it has been determined that your needs can be met in about 2 hours a day (24 hours a pay period).

7

Instructions for Page 15, continued

Skip this page for consumers who are in a NF or CBC.

This page includes hourly exceptions and weekly cap exceptions.

You can print just this portion if:

1. The consumer has requested an exception during a current assessment period and you are not doing a new assessment.
2. The exception took longer than the rest of the process and you have already authorized the maximum hours available without an exception.
3. A new exception decision was made after a service plan has been provided.

HCW Cap Instructions

If the consumer has asked for an exception to the weekly HCW cap.

1. Mark the box.
2. Complete the table for each HCW the cap was requested for:
    a. Enter HCW's name in HCW column
    b. Enter decision (Approved or Denied) in Exception Decision
    c. Enter new weekly cap in the Hourly Cap
    d. Enter Effective Date
    e. Enter End Date
3. In consumer-friendly language, enter the reason the decision was made.

Instructions for Page 15, continued

In-Home Exceptions

4. Check the appropriate box
5. Complete this line once a decision has been made:
    a. Enter the decision
        i. denied
        ii. approved
        iii. partially denied
    b. Select who made the decision
        i. Central Office
        ii. the Local Office
    c. Enter the Effective date in Effective space
        i. Type in date or use calendar option
    d. Enter the End date in End space
        i. Type in date or use calendar option
6. You only need to complete the sections for ADLs the consumer requested an exception for.
    a. Enter max hours per the rule in Max Hours column
    b. Enter the number of EXCEPTION hours the consumer is requesting
    c. Enter the number of EXCEPTION hours that were approved
    d. The hours will auto fill in the Total Hours Approved by pulling the hours from the hours entered in from pages 7-14.
7. In the free text box, using consumer-friendly language, explain the reason the decision was made.

Copy of Page 16

Service Plan and Notice

Summary of Activities and Instrumental Activities of Daily Living (ADL and IADL)

Below are DHS' summaries for your convenience. Please see the precise, technical rule wording in OAR 411-015-0006 and 0007. During the assessment, we determine your ability to do everyday tasks called Activities of Daily Living and Instrumental Activities of Daily Living. Each ADL, except cognition, requires that you need assistance at least one day per week. Individuals with less frequent needs may be ineligible for assistance in that ADL or IADL. Services and supports are determined by assessing your level of need in:

Mobility: considers your ability to get around inside or outside your home, to get in and out of bed and chairs or the toilet. Your need for assistance must be hands-on from another person;
Eating: considers your need for hands on or cueing assistance from another person to get food into your mouth, chew and swallow and/or use assistive devices;

Elimination: considers your need for hands-on assistance from another person to: do tasks such as catheter or ostomy care, digital stimulation, enemas, suppository insertion, cleansing after toileting, change soiled incontinence supplies or clothing, adjust clothing or your need for cueing to prevent incontinence;

Cognition: considers your ability to use information, make decisions, and ensure your daily needs are being met in such a way that your health and safety needs are met.
The frequency in cognition is a need one time each day;
Dressing and grooming: considers your ability to dress and undress as well as your ability to care for your hair and nails and the need for hands-on, cueing or stand-by assistance of another person;
Bathing and personal hygiene: considers your ability to get in and out of a shower or bath and to wash yourself, as well as your ability to care for your mouth, shave or menstruation care (when applicable) and the need for hands-on, cueing or stand-by assistance of another person;

Housekeeping: considers your ability to wash and wipe surfaces, clean floors, make the bed, clean dishes and take out garbage;
Laundry: considers your ability to gather clothing, use a washing machine and dryer and to fold or hang clothing and put it away;
Meal Prep: considers your ability to prepare meals each day, including one large meal;
Medication management: considers your ability to manage the ordering, organizing and taking of medication as prescribed;
Shopping: considers your ability to go to a store and purchase food, medication, or clothing;
Transportation: considers your ability to arrange rides, get in and out of vehicles and the need for assistance (cognitive or physical) while in vehicles.
See the OARs (rules) at the links below, or you may ask your Case Manager for a copy.

411-015 Service Eligibility (Current Rules):

https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1751

411-015 Service Eligibility (Former Rules):
https://www.dhs.state.or.us/policy/spd/numeric.htm

Copy of Page 17

Service Plan Agreement

Print Service Plan Only

Print Notice

CM: Skip this page if the consumer is ineligible

1

Consumer: **Prime:**

Based upon our discussion, you have been given the choice and agree to receive monthly ADL and IADL services and supports from the following:

CM: Select "Waivered Case Management Services" unless the consumer is in a NH, on PACE, or is MAGI eligible.

2

- ☐ Waivered Case Management Services
- ☐ Independent Choices Program
- ☐ Homecare Worker*
- ☐ In-Home Care Agency*
- ☐ Home Delivered Meals
- ☐ Adult Day Services
- ☐ Specialized Living
- ☐ Nursing Home
- ☐ PACE Program
- ☐ Natural Support
- ☐ Long-Term Care Community Nursing
- ☐ Emergency Response System
- ☐ Community Based Care Enter type of CBC below

3

4

☐

*Your provider may be authorized additional and reasonable mileage reimbursement if they need to take their own vehicle to shop on your behalf.

The service plan is intended to address your needs identified in the assessment including how much assistance is needed and the type of provider(s) you have selected. If you think the service plan does not meet your needs, please discuss with your case manager. You have the right to appeal if you continue to disagree with the assessment or service plan.

Signing your service plan means you have received and reviewed the provided information. It is important for you to sign this page and return it to the case manager as soon as possible.

5

☐ Please check this box if you believe this service plan does **not** meet your needs or you disagree with the assessment or service plan.

_____

Consumer Signature Date

_____

Consumer Representative Signature Date

_____

Provider Signature Date

_____

Case Manager Signature Date

Instructions for Page 17

The Service Plan Agreement replaces the use of forms 001N and 914. Leave this form blank if the consumer is ineligible.

1. Name and Prime will autofill.
2. Select “Case Management Services” unless the consumer is on MAGI or in a NF/PACE setting.
3. Select the services the consumer has agreed to receive
4. If the consumer is in a CBC setting: in the field below it, enter in the type of placement (i.e. Assisted Living, Adult Foster Home, etc.)
5. The consumer may check the box if they disagree with the assessment or service plan; however, they still need to sign.

- The consumer or representative and the case manager must sign the form.
- The provider must sign if the consumer lives in a CBC or NF setting.
- A new signed agreement needs to be on file after the completion of each assessment in which the consumer is determined eligible.