

CF OPERATING PROCEDURE
NO. 140-10

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, February 27, 2020

HOME CARE FOR DISABLED ADULTS

This operating procedure provides guidelines for the provision of services through the Department of Children and Families, Adult Services Home Care for Disabled Adults Program and for maintaining and using the statewide Home Care for Disabled Adults waiting list.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

PATRICIA BABCOCK
Deputy Secretary

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

In paragraph 7-4a, changed the phrase “to make semiannual face-to-face” to read “to meet quarterly, face-to-face” in the second sentence, and deleted the phrase “by phone” from the third sentence.

This operating procedure supersedes CFOP 140-10 dated October 28, 2019.

OPR: PDAS

DISTRIBUTION: X: OSGC; PDAS; PDESA; Region Circuit Adult Protective Services staff;
Region/Circuit Economic Self-Sufficiency Services staff.

CONTENTS

Paragraph

Chapter 1 – OVERVIEW

- Purpose..... 1-1
- Goal 1-2
- Authority..... 1-3
- Definitions 1-4
- Forms and Brochures Used in the HCDA Program 1-5

Chapter 2 – HCDA INTAKE AND REFERRAL

- Purpose..... 2-1
- Request for Services..... 2-2
- Referral 2-3
- Screening..... 2-4

Chapter 3 – STATEWIDE HCDA WAIT LIST

- Purpose..... 3-1
- Introduction 3-2
- Purpose of Wait List Policy..... 3-3
- Criteria for Placement on HCDA Wait List 3-4
- Re-Screening 3-5
- Individuals on the Wait List Who Move Within the State 3-6
- Removing Individuals from the Wait List..... 3-7
- Electronic Wait List..... 3-8
- Referring Wait List Individuals for Assessment and Eligibility Determination 3-9

Chapter 4 – APPLICATION AND ASSESSMENTS

- Purpose..... 4-1
- Initial Home Visit 4-2
- HCDA Program Application 4-3
- APS Client Assessment 4-4
- Home Care Provider Agreement 4-5
- APS HCDA Home Care Provider Background Check..... 4-6
- Confidential Information Release..... 4-7
- HCDA Medical Statement..... 4-8
- Client Care Plan 4-9

Chapter 5 – CAREGIVER SCREENING AND RESPONSIBILITIES

- Purpose..... 5-1
- Primary Caregiver 5-2
- Alternate Caregiver 5-3
- Supervision 5-4
- Background Screening 5-5
- Findings 5-6
- Exceptions to Negative Results on a Background Screening 5-7

Chapter 6 – ELIGIBILITY AND APPROVAL

- Purpose..... 6-1
- Financial Eligibility 6-2
- Medical Eligibility..... 6-3
- Finalization of the Application and Eligibility Approval Process..... 6-4

CONTENTS (continued)

Paragraph

Chapter 7 – CASE MANAGEMENT

Purpose..... 7-1
 Services 7-2
 Payment..... 7-3
 Follow Up 7-4
 Case Transfers..... 7-5
 Re-Determination 7-6

Chapter 8 – DOCUMENTATION

Purpose..... 8-1
 Case Record Documentation 8-2
 When to Document 8-3
 Falsification of Case Record Documentation 8-4
 Field Notes and Case Narrative 8-5
 Field Notes: Who, What, When, Where, Why, What’s Next 8-6
 Field Notes: Documentation Requirements 8-7
 Case Narrative 8-8
 Quarterly Narrative 8-9
 Closing Narrative..... 8-10
 Case Record Folders and Contents 8-11
 Retention and Destruction of Case Records..... 8-12

Chapter 9 – TERMINATION OF CASE MANAGEMENT

Purpose..... 9-1
 Termination of Services and Case Closure 9-2
 Procedures for Closing a Case 9-3
 Due Process and Administrative Hearings 9-4

CONTENTS (continued)

Paragraph

Chapter 1

OVERVIEW

1-1. Purpose. This operating procedure is the official document of the Department of Children and Families (Department), Adult Protective Services Program Office (APS) for the implementation of the Home Care for Disabled Adults (HCDA) Program. It describes the intake process, the process for placing and removing a person from the Statewide Wait List and provides guidelines for establishing eligibility of applicants for the HCDA program. This operating procedure will also provide guidelines for assessing and approving HCDA applicants and caregivers, case management, and documentation. It will provide guidance for the provision of home care, authorization of home care subsidy payments, and reimbursement for services (OTE) when funding is available.

1-2. Goal. The goal of the HCDA program is to encourage the provision of care to adults with disabilities in family-type living arrangements in private homes for not more than two unrelated adults with disabilities as an alternative to long term or nursing home placement; to provide, on a non-profit basis, basic support, supervision, maintenance, as well as assistance in arranging for specialized services, purchasing supplies, equipment, and medications. The HCDA program is designed to provide basic monthly subsidy payments to caregivers to defray the home care client's cost of housing, food, clothing, incidentals, supplies, and any other cost or service that aide in the health, safety, and well-being of the HCDA client.

1-3. Authority. Chapter 410, Florida Statutes, provides the legal authority for the HCDA program. Chapter 65C-1, Florida Administrative Code, is the promulgated rule which provides additional direction for the program. The HCDA program is currently funded and operated by general revenue funds that are appropriated by the legislature each fiscal year.

1-4. Definitions. For the purposes of this operating procedure, the following definitions shall apply:

a. Adult with Disabilities. An individual, at least 18 years of age, but under 60, who has one or more permanent physical or mental limitations that restrict his/her ability to perform normal activities of daily living and impede his/her ability to live independently with relatives or friends without the provision of home and community-based services. For the purpose of the HCDA program, an adult with disabilities is currently domiciled in the state of Florida and intends to remain in the state of Florida and is not receiving Vocational Rehabilitation Services.

b. Domicile. The permanent legal residence of the home care client.

c. Home Care Client. An individual who has met all the eligibility requirements of the HCDA program, is enrolled in the program, and who, without the provision of the HCDA program, would require nursing home or other long term placement.

d. Caregiver. An adult who has been approved to provide supervision and care to the home care client on a 24-hour, seven days per week, non-profit basis. The caregiver may be identified as the primary caregiver or the alternate caregiver. The primary caregiver should reside in same residence as the home care client.

e. Statewide Wait List. Wait List maintained within the Electronic Case Management System (ECMS) documenting a prospective applicant's numeric score and date of entry onto the Wait List.

f. Activities of Daily Living (ADL's). Daily self-care activities within an individual's place of residence, in outdoor environments, or both. These include bathing, dressing, eating/feeding, functional mobility, personal hygiene, grooming, and toileting.

g. Instrumental Activities of Daily Living (IADL'S). Activities not necessary for fundamental functioning, but which allow an individual to live independently in the community. These include household chores, taking medication as prescribed, managing money, shopping, use of communication devices, and transportation.

h. Institutional Care Program (ICP). A Medicaid program that helps people in nursing facilities pay for the cost of their care and provides general medical coverage. ICP guidelines establish financial eligibility for the HCDA program. Eligibility is determined by the Department's Office of Economic Self-Sufficiency (ESS) program.

i. Medicaid for the Aged or Disabled (MEDS-AD). A program which entitles certain aged or disabled individuals to receive ongoing Medicaid coverage if their income and resources are within specified limits. Eligibility is determined by the Department's ESS program.

j. Supplemental Security Income (SSI). A federal program paying benefits to disabled adults and children having limited income and resources. Eligibility is determined by the Social Security Administration.

k. Social Security Disability Insurance (SSDI). Pays benefits to individuals with disabilities who have previously worked in jobs covered by Social Security. Recipients must meet Social Security's definition of disability and generally have been unable to work for a year or more.

l. Basic Subsidy. A payment to an approved HCDA caregiver to defray the cost of providing care.

m. One Time Expenditure (OTE). A reimbursement to the caregiver for approved, non-Medicaid, Medicare, or insurance-covered services, supplies, medications, equipment, and care.

n. Case Record. The source documentation maintained by the Counselor for each home care client. It contains all of the information necessary to delineate the provision of subsidies/supplements and describe the provision of services or determination of ineligibility for subsidies/supplements and services. The case record is updated at regular intervals to reflect current and accurate information regarding the home care client's health status and needs, home care provider information, attending physicians, and services, supplies, equipment, medications, and care provided by service providers, vendors, caregivers, the Department, and other agencies. The case record provides a profile of the home care client's health and living situation.

o. Electronic Case Management System (ECMS). The electronic system of record in which Wait List and case management, or investigations, are documented.

p. Office of Economic Self Sufficiency (ESS). The program which determines eligibility for food, cash, and medical assistance for individuals and families. Additionally, the program determines financial eligibility for HCDA clients as needed according to policy.

q. The Florida Medicaid Management Information System (FLMMIS). The information system used to process Florida Medicaid claims and payments, maintain Medicaid eligibility data, and provider enrollment data. This system is owned and maintained by the Agency for Health Care Administration (AHCA).

r. Formal Services. Service(s) and support rendered through established service providers (i.e., ADRC's), religious social service organizations, mental health providers, state agencies and/or charitable organizations.

s. Informal Services. Service(s) and support rendered by family, friends, neighbors, etc.

t. Community Care for Disabled Adults Program (CCDA). The program which assists adults (18 through 59 years of age) who have a permanent physical or mental disability that restricts their ability to perform one or more activities of daily living and impedes their capacity to live independently. Through the provision of, or linkage to, in-home services, CCDA helps these adults with disabilities live dignified and reasonably independent lives in their own homes. Services include, but are not limited to: adult day care; case management; chore service; escort service; homemaker service; and personal care.

1-5. Forms and Brochures Used in the HCDA Program. The following forms and brochures are used in the HCDA program and are also available in DCF Forms:

- a. Adult Services Client Assessment (CF-AA 3019).
- b. Adult Services Screening for Consideration for Community-Based Programs (CF-AA 1022).
- c. Appointment of a Designated Representative (CF-AA 2505).
- d. Care Plan (CF-AA 1025).
- e. Client Progress Notes (CF-AA 1038).
- f. Client Transfer/Termination for Home Care for Disabled Adults and Community Care for Disabled Adults (CF-AA 1122).
- g. Confidential Information Release (CF-AA 1113).
- h. Due Process Rights Pamphlet (CF/PI 140-43).
- i. Financial Information Release (CF-ES 2613).
- j. HIPAA Policy Statement (CF-ES 2320).
- k. Home Care for Disabled Adults Program Application (CF-AA 1020).
- l. Home Care for Disabled Adults Program – Medical Statement (CF-AA 1020A).
- m. Home Care Provider Agreement (CF-AA 1021).
- n. Home Care Provider Background Check (CF-AA 1123).
- o. Notice of Ineligibility or Change in Service Status (CF-AA 1114).
- p. Referral for Protective Supervision, Protective Intervention, CCDA/CCE, or HCDA/HCE Services (CF-AA 1099).
- q. Referral Form (CF-FSP 5065).
- r. Request for Assistance (CF-ES 2337).
- s. Supervisor’s Case Record Review Log (CF-AA 1023).
- t. Adult Services Waiting List Log Revision (CF-AA 1115).
- u. Statewide Community Services Brochure (CF/PI 140-44).

Chapter 2

HCDA INTAKE AND REFERRAL

2-1. Purpose. This chapter identifies the intake and referral process as the first steps to determining home care client eligibility and the time frames associated with these actions. This process includes the initial screening of the potential home care client using the Adult Protective Services Screening for Consideration for Community-Based Programs (form CF-AA 1022). This screening tool will capture general demographic information and information relating to the potential client's physical and mental condition, urgency of need, and support system based on a points system that will result in an overall score. The counselor will make a determination, based on the score, as to whether the HCDA program is appropriate or whether a referral to another APS program, departmental program, or community/service agency is necessary.

2-2. Request for Services. The intake process begins with a request for information and/or services by an adult with disabilities or a representative. The Counselor has three working days to make contact with the person requesting services and document the effort in the case file.

a. A request for services can be made one of four ways:

- (1) Office visit;
- (2) Telephone call;
- (3) Letter/E-mail; or,
- (4) Referral.

b. A Protective Investigator who investigates a case as a result of a referral through the Florida Abuse Hotline may use the Referral for Protective Supervision, Protective Intervention, CCDA/CCE, or HCDA/HCE Services (form CF-AA 1099) in order to request HCDA services on behalf of an adult involved in the case.

2-3. Referral.

a. The Counselor provides general programmatic information to the potential client or representative and determines if the HCDA program is appropriate or whether a referral to another APS program, departmental program, or community/service agency is more appropriate to serve the needs of the adult with disabilities. Refer to CFOP 140-4, Adult Protective Services Protective Intervention, paragraph 2-5 (Information and Referral, No Case Established) for specifics on providing information and referrals for services outside the APS purview.

b. If it is determined that the HCDA program is appropriate, the Counselor begins the screening process using the Adult Protective Services Screening for Consideration for Community-Based Programs (form CF-AA 1022).

2-4. Screening.

a. All three parts of the CF-AA-1022 are completed during the intake process. All efforts should be made to complete the screening with the potential client or current caregiver. The potential HCDA client is not eligible for the program if they are receiving Vocational Rehabilitation Services, have a total score of zero in both the ADLs and IADLs section, or do not have a full time caregiver.

b. Upon completion of the screening tool CF-AA-1022, the Unit Supervisor reviews and approves the potential HCDA client for entry on to the statewide Wait List for services.

c. The potential HCDA client will be notified by mail that they have been placed on the HCDA statewide Wait List and a due process pamphlet will be included with the notification.

d. Staff will enter the demographic and Wait List information into the ECMS within 3 working days of approval by the Unit Supervisor.

e. Annually the potential HCDA client will be contacted and the CF-AA-1022 will be updated, or a new form completed after one update has been made to the original form. The screening tool may be updated at any time the potential client's circumstances have changed.

f. All activity regarding the screening of a potential HCDA client will be noted in the Wait List record. Any referrals made on behalf of the potential client will be documented in the record. In the event the Counselor is needed to perform activities other than the screening tool, a Short Term Case Management may be opened. At no time will the completion of a CF-AA1022 alone result in the opening of a services case.

g. The Counselor should immediately refer applicants making urgent requests for services to other appropriate programs and services.

h. If the Counselor, or any other staff member participating in the intake process, suspects that an adult is in an abusive, neglectful, or exploitive situation, the Counselor or other staff member reports the situation to the Florida Abuse Hotline (1-800-96ABUSE) for a protective investigation.

Chapter 3

STATEWIDE HCDA WAIT LIST

3-1. Purpose. This chapter specifies policy and procedure for the administration of the Statewide HCDA Wait List. It describes the process for screening an individual requesting services, determining eligibility for the Wait List, and Wait List management.

3-2. Introduction. Each fiscal year, the Florida Legislature determines the amount of funding that will be available to the Department for operation of the HCDA Program. As the Department is restricted from spending more than the appropriated amount, it cannot therefore serve all those who may otherwise qualify for the program.

a. Due to limited funding, the Department must maintain a statewide Wait List of all eligible individuals who have requested the HCDA basic monthly subsidy.

b. Eligibility for the Wait List does not guarantee eligibility for the HCDA program; the determination is made when funding becomes available and the individual is pulled from the Wait List and referred for an assessment.

c. The policy for selecting individuals from the Wait List for an eligibility determination must be fair and equitable. The Wait List policy must ensure that adults with disabilities are served according to the urgency of their needs, as determined by their scores and the date they were placed on the Wait List.

d. An individual may be simultaneously placed on both the HCDA and CCDA Wait Lists.

3-3. Purpose of Wait List Policy. The purpose of the APS Statewide Wait List Policy for the HCDA program is to:

a. Maintain statewide consistency in the development and management of the HCDA Wait List.

b. Establish criteria for placement on the Wait List.

c. Provide a process for referring individuals for face-to-face eligibility determination when funding becomes available.

d. Provide process for ranking individuals' placement of the Wait List.

3-4. Criteria for Placement on the HCDA Wait List. The APS Screening for Consideration for Community-Based Programs (form CF-AA 1022), hereinafter referred to as CF-AA 1022, assists the Counselor in establishing demographic information, acquiring information pertaining to the individual's medical situation and level of functioning, determining the degree to which the individual receives support or assistance, and evaluating the individual's risk of long-term or nursing home placement. Obtaining the aforementioned information through completion of CF-AA 1022 allows the screener to assign a Wait List score to the individual.

a. Must be between 18-59 years of age with a permanent disability.

b. Must reside in the community.

c. Must be a Florida resident at the time of the request for placement on the Wait List.

d. Must have a 24-hour caregiver who should reside in the home with the individual.

e. Must not currently receive services funded by the Division of Vocational Rehabilitation of the Department of Education.

f. Individuals with a cumulative score of zero (0) in both the ADLS and IADLS section of the CF-AA 1022 will not be placed on the Wait List.

g. Individuals who are active Statewide Medicaid Managed Care Long-Term Care Program (SMCC-LTC) [administered by the Department of Elder Affairs (DOEA) and the Agency for Health Care Administration (AHCA)] recipients or who are on the Wait List for Managed Care may be added to the HCDA Wait List. If an individual appears to be eligible for services from a Waiver program, such as the Developmental Disabilities (DD) Waiver administered by the Agency for Persons with Disabilities (APD) or the Traumatic Brain and Spinal Cord Injury Waiver (TBSCI) administered by the Department of Health, they may be added to the HCDA Wait List, but shall be referred to the appropriate agency for screening for that Wait List.

3-5. Re-Screening. All individuals on the Wait List are re-screened at least annually. The purpose of the annual re-screening is to determine if the individual still desires HCDA services and remains eligible for placement on the Wait List, and to record any changes to the individual's health and needs.

a. An individual may contact the APS office for a re-screening whenever their situation changes. If the changes are not the result of an annual rescreening, the counselor completes the Adult Services Waiting List Log Revision (CF AA 1115).

b. Re-screenings may result in the score increasing or decreasing, changing the individual's ranking on the statewide Wait List. The information in the ECMS must be updated to reflect the new score within three working days of the rescreening.

c. A re-screening does not change the "First Contact Date" in the ECMS.

d. Re-screening requires the completion of a new CF-AA 1022 which is then reviewed by the unit supervisor and forwarded to the Region/Circuit designee so that updates can be made to the ECMS. A new form will be completed after one update has been made to the original form.

e. For annual re-screenings, if the Counselor is unable to contact the individual by phone, a letter is mailed giving the applicant 10 calendar days to make contact with the Counselor or the Wait List file will be closed.

3-6. Individuals on the Wait List Who Move Within the State. The HCDA Wait List is a statewide Wait List; individuals on the Wait List may move from one county to another county within the state of Florida without affecting their ranking on the Wait List.

a. The move may require transferring Wait List management to another APS office. An individual who relocates within the State of Florida is **not** considered a new referral, but must be re-screened by the counselor in the receiving unit. The date of "First Contact" (Initial Contact) does **not** change.

b. Transfer Process.

(1) The Counselor from the originating unit shall contact the receiving Program Office for information on where to transfer the case record and a contact name and phone number to provide to the Wait List individual.

(2) The Counselor in the originating unit shall provide the individual on the statewide Wait List with the telephone number and contact name in the receiving unit, and instruct the Wait List individual to follow-up with the contact as soon as the move is completed.

(3) All documentation pertaining to the individual is sent from the originating unit to the receiving unit or Program Office where the individual is moving and the CF-AA 1022 is updated as necessary.

(4) The originating unit shall keep a copy of the file until they verify the receiving unit received it and has updated the ECMS.

(5) The receiving county/Region is responsible for ensuring that the ECMS is updated within three working days from receipt of case file.

3-7. Removing Individuals from the Wait List. Situations will occur in which individuals are no longer considered appropriate for HCDA services or the individual requests to be removed from the Wait List.

a. Individuals will be removed from the Wait List under the following situations:

(1) Individual is in long-term placement and not expected to return to the community.

(2) Individual requests to be removed from the Wait List.

(3) Inability to locate the applicant for annual re-screening.

(4) Relocation out of state.

(5) Individual no longer has a 24-hour caregiver.

(6) Aged out.

(7) Acceptance of Vocational Rehabilitation services. **(If enrolled in CCDA at any time while on the HCDA Wait List, an individual must be promptly re-screened after a CCDA care plan is in effect and the HCDA Wait List score adjusted accordingly.)**

(8) Died.

b. APS staff complete and send the Notice of Action for HCDA and CCDA Program Requests (CF-AA 1016) and the Due Process Pamphlet (CF/PI 140-43), unless the reason for removal is that the individual could not be located or is deceased.

c. The Counselor shall document in the individual's case file that this information was provided to the individual and/or the reason for removing the individual from the Wait List. A copy of the Notice of Action for HCDA and CCDA Program Requests (CF-AA 1016) is kept in the individual's case file, if applicable.

d. The Waiting list Log Revision form (CF-AA 1115) is used to notify the designated person in the Region / Circuit to remove the individual from the Wait List.

e. The ECMS shall be updated within three working days of the decision to remove the individual from the Wait List.

f. If an individual contacts the Department at a later date requesting to be added back to the Wait List, the individual is considered a new referral and a new CF-AA 1022 is completed. The date of the new request for services becomes the new date of "First Contact" in the ECMS.

3-8. Electronic Wait List. Upon completing PARTs I, II, III and scoring the CF-AA 1022, the name and other required information specific to the individual requesting services is added to the Statewide HCDA Wait List.

a. Within three business days of completing the CF-AA 1022, the information must be entered into the ECMS.

(1) The Counselor submits the CF-AA 1022 to the unit supervisor for review and approval.

(2) The unit supervisor reviews and approves the completed CF-AA 1022.

(3) The designated person in the Region/Circuit creates a Wait List record in the ECMS.

b. Unit supervisors are responsible for ensuring that there is a designated backup person.

c. Information regarding individuals on the Statewide HCDA Wait List is confidential and will not be shared with anyone other than APS staff, as needed, to maintain the Wait List and/or to move an individual on or off the Wait List.

3-9. Referring Wait List Individuals for Assessment and Eligibility Determination. Once funding is available, Headquarters uses the Statewide HCDA Wait List to refer individuals in priority order for a face-to-face assessment and programmatic eligibility determination for the HCDA program. The priority is by score and then by the date of initial or first contact. Headquarters sends the list of individuals from the Wait List for assessment to the local APS Program Offices for dissemination to Operations staff.

a. There are times when face-to-face assessment of an individual who has been pulled from the Wait List will result in a lower score. When this occurs, the unit staff will notify the local Program Office of the new score.

(1) If the new score and date of "First Contact" results in the Wait List placement remaining within the group that was pulled from the Wait List, the assessment/eligibility process shall continue.

(2) If the new score and date of "First Contact" results in the Wait List placement dropping out of the group that was pulled, the individual shall be placed back on the Wait List. The Notice of Action for HCDA and CCDA Program Requests (form CF-AA 1016) will be mailed along with the Due Process Rights pamphlet (CF/PI 140-43).

b. In the event of a hearing proceeding involving the highest scoring individual on the Statewide HCDA Wait List, all actions relating to moving that individual off the Wait List are suspended until the hearing officer provides a final order.

Chapter 4

APPLICATION AND ASSESSMENTS

4-1. Purpose. This chapter will discuss the designated forms and tasks that are required for the initial home visit. Each form and task associated with the initial home visit will be outlined as well as timeframes associated with each task.

4-2. Initial Home Visit. Within three working days of taking assignment, the Counselor makes contact with the applicant to schedule a home visit with the applicant and the potential caregiver to continue the process of determining programmatic eligibility. All forms detailed below should be completed and documented within 45 days of the actual home visit.

a. During the initial home visit, together with the applicant and caregiver, the Counselor will:

- (1) Complete the Home Care for Disabled Adults Program Application;
- (2) Complete the Home Care Provider Agreement;
- (3) Initiate APS Home Care Provider Background Check (form CF AA-1123);
- (4) Complete the APS Client Assessment;
- (5) Complete the Client Care Plan;
- (6) Provide the HIPAA and Due Process forms.

(7) Obtain the information necessary to verify the home care applicant's medical eligibility; and,

(8) Obtain the information necessary to verify the home care applicant's financial eligibility. Complete the ESS Application if income is over ICP limits. Otherwise, verification of SSI/Medicaid, MEDS-AD, or other qualifying Medicaid is required.

b. Notify the applicant/caregiver of the fixed annual care plan and the amount of monthly subsidy payments.

c. Notify the applicant/caregiver to the possibility of and process for reimbursement through an OTE.

4-3. Home Care for Disabled Adults Program Application (form CF-AA 1020). All applicants for the HCDA Program must complete the Home Care for Disabled Adults Program Application. The application captures basic demographic information, consent for caregiver clearance, sources of income, health care coverage, and general condition of the home itself. This form is completed initially and then annually.

4-4. APS Client Assessment (form CF-AA 3019). The APS Client Assessment is comprised of eight sections that will capture information specific to the applicant's overall health, nutrition, activities of daily living, instrumental activities of daily living, support system, home environment, cognitive abilities (including any mental health or substance abuse problems), and the person(s) identified as the primary and alternate caregiver. A score will be calculated at the conclusion of the assessment. After conducting the Client Assessment, the Counselor will determine if the applicant is appropriate for further eligibility determination or if the applicant should be placed back on the Statewide Wait List or if a referral to another program is necessary.

4-5. Home Care Provider Agreement (form CF-AA-1021). The Counselor will have the potential primary caregiver sign and date the Home Care Provider Agreement that states they are willing and capable of providing the basic maintenance and supervision of the home care client and performing related duties in support of the home care client. Alternate caregiver(s) are formally identified at this time. Alternate caregivers will provide supervision for the home care client when the primary caregiver is away from the client for two hours or more during a 24-hour period.

4-6. APS HCDA Home Care Provider Background Check (form CF-AA 1123). Refer to Chapter 6 of this operating procedure.

4-7. Confidential Information Release (form CF-AA 1113). During the initial home visit, the APS Counselor obtains a signed, initialed, and dated Confidential Information Release (form CF-AA 1113) from the home care applicant (or legal representative, if appropriate). This will allow the APS Counselor to obtain financial, medical, and/or psychiatric information, and share medical and psychiatric information relative to the home care client's receipt of subsidies and services.

4-8. HCDA Medical Statement (CF-AA 1020A). Refer to Chapter 6 of this operating procedure.

4-9. Client Care Plan (form CF-AA 1025).

a. The Care Plan will document the need for HCDA services as well as any other services that may be appropriate, and the monthly subsidy amount. The applicant/caregiver's signature on the Care Plan will attest that the terms of and services provided through the HCDA Program have been accepted with the goal of preventing long-term care placement. The APS Counselor will have 14 calendar days from the date of the client assessment to complete the Care Plan.

b. If any of the above criteria are not met and the home care applicant or potential caregiver does not intend to satisfy unmet criteria, within five working days, the APS Counselor will complete the Notice of Ineligibility or Change in Services Status (CF-AA 1114) and provide it to the home care applicant. This notice provides the applicant with information on his/her rights to an administrative hearing.

Chapter 5

CAREGIVER SCREENING AND RESPONSIBILITIES

5-1. Purpose. The HCDA Program does not have statutory authority to conduct criminal background screenings on potential primary and/or alternate caregivers. The purpose of this chapter is to outline the roles and responsibilities of those identified as primary and alternate caregivers, and to discuss the background screening process using the ECMS for Investigations.

5-2. Primary Caregiver.

a. Is an adult (18 years or older) who is willing and capable of accepting responsibility for the social, physical, and emotional needs of the home care client, and with whom the home care client has made an arrangement for the provision of supervision, care, and services for the home care client;

b. Resides in the home with the home care client and / or is physically present in the home to provide care, supervision, and assist with arranging services for the home care client and purchase needed supplies, equipment, and medications;

c. Is responsible for maintaining the residential dwelling free of conditions that may pose a threat to the life, safety, health, or well-being of the home care client;

d. Is not presenting him/herself to the public as an adult family care home, residential group home, half-way house, assisted living facility, or other similar facility offering room, board, and personal care services. The primary caregiver does not intend to convert his/her home-style living environment into one of these living arrangements;

e. Authorizes the APS Counselor, by signing the HCDA Provider Background Check (form CF-AA 1123), to conduct annual background checks through the department's Electronic Case Management System for Investigations, for possible findings of abuse, neglect, or exploitation of a vulnerable adult or child.

5-3. Alternate Caregiver. Is an adult (18 years or older) who is willing and capable of accepting responsibility for the social, physical, and emotional needs of the home care client. Alternate caregiver(s) must be available to supervise the home care client in the absence of the primary caregiver. Supervision must be consistent with the home care client's level of functional dependency. The alternate caregiver is not required to live in the home with the home care client but must be physically present in the home when serving as the alternate caregiver. If the primary caregiver's absence does not exceed two hours, the alternate caregiver is required to make face-to-face contact with the home care client at least once during the two-hour period.

5-4. Supervision.

a. Supervision provided by the primary caregiver must be consistent with the home care client's functional status and level of dependency, but not less frequently than once every two waking hours. The critical factor to consider is the potential for harm that could occur should the home care client not be adequately supervised.

b. The APS Counselor will approve and document in the case record the primary caregiver's arrangements for supervising the home care client when they are not in the home.

(1) When absences exceeding two hours in duration are of a daily or routine nature (i.e., the primary caregiver has part-time employment), the APS Counselor requests a schedule of the

primary caregiver's routine absences and the name of the approved alternate caregiver for the case record.

(2) Using multiple alternate caregivers should be avoided if possible. However, there are families who will share the responsibility of providing care and supervision to the home care client. In these situations, flexibility is provided; however, all adult family members serving as a caregiver (primary or alternate) must meet the same background requirements as the primary caregiver.

(3) The primary caregiver may hire other caregivers, sitters, or companions who are employed and paid by home care agencies to serve as alternate caregivers. The employee hired must meet the department's caregiver requirements. The primary caregiver will receive the monthly subsidy payment.

c. A home care client may engage in a day program outside of his/her home if supervision as described above is provided. However, the Counselor verifies and documents in the case record that the program is legitimate, licensed, or certified. These programs include, but are not limited to:

- (1) Sheltered workshops;
- (2) Adult day health care programs;
- (3) Mental health day treatment programs;
- (4) Faith-based initiative programs; and,
- (5) Veterans' Administration programs.

d. Counselors will verify that an agency is licensed by the appropriate regulatory agency and that the license is current.

5-5. Background Screening.

a. All potential primary caregivers and alternate caregivers are screened, at least annually, through the Electronic Case Management System for Investigations to verify that the potential primary caregiver or alternate caregiver **has not** been identified as a verified perpetrator of abuse, neglect, or exploitation of a vulnerable adult or a child.

b. The APS Counselor will conduct the primary and alternate caregiver approval and screening process every time a new primary caregiver or alternate caregiver is identified.

5-6. Findings.

a. The Counselor will send the Home Care Provider Background Check (form CF-AA 1123) to the Regional screening staff responsible for completing background screenings through the Electronic Case Management System for Investigations.

(1) The findings of whether a potential caregiver was identified as a perpetrator or possible responsible person in an abuse, neglect, exploitation, or abandonment report, are indicated on the Home Care Provider Background Check (form CF-AA 1123).

(2) Regional screening staff will return the Home Care Provider Background Check (form CF-AA 1123) to the APS Counselor with copies of applicable report(s); and,

(3) The Counselor includes the Home Care Provider Background Check (form CF-AA 1123) in the case record; however, information printed from the Electronic Case Management System for Investigations is **not** included in the HCDA case record.

b. If an investigation involving the potential primary or alternate caregiver is pending completion by a Protective Investigator, the potential primary or alternate caregiver will not be approved until a staffing is completed and a preliminary determination is made to the satisfaction of both Services and Investigations staff.

c. If the potential primary or alternate caregiver does not pass the background screening, the Counselor informs the home care applicant that the potential caregiver did not pass the background screening. Details of the screening are not provided. **Specific information viewed and documents printed from the Electronic Case Management System for Investigations are confidential and not shared with the potential caregiver or client.**

d. Failure to report true or accurate information will disqualify the primary or alternate caregiver from serving in this role.

e. The home care applicant may identify another potential primary or alternate caregiver if any of the above criteria are not met by the applicant's original primary caregiver selection. The newly selected potential caregiver is screened and must meet the above criteria.

5-7. Exceptions to Negative Results on a Background Screening.

a. An exception to the above listed disqualifications pertaining to the information found in the Electronic Case Management System for Investigations may be granted if there is clear and convincing evidence that the potential home care agency staff, day program staff, or primary/alternate caregivers are of the character which justifies the exception. This type of exception is reviewed and approved on a case-by-case basis with APS Program Office staff. An exception cannot be made for the intentional falsification of information on the Home Care Provider Background Check (form CF-AA 1123).

b. In order to grant an exception to the above stated background screening criteria, the Counselor must:

(1) Conduct a home visit to determine that the potential caregiver has no reluctance to discuss the report of abuse, neglect, or exploitation.

(2) Determine if there is sufficient evidence of rehabilitation and good character since the incident which led to the report of abuse, neglect, or exploitation. The evidence includes, but is not limited to:

- (a) The circumstances surrounding the incident;
- (b) The length of time that has elapsed since the incident;
- (c) The nature of the harm inflicted upon the victim; and,
- (d) The history of the potential caregiver since the incident;

c. Obtain a **written statement** from the potential caregiver that allows the APS Counselor to discuss the incident which led to the report of abuse, neglect, or exploitation with the home care client. **(CAUTION: Specific information viewed and documentation printed from the Electronic Case Management System for Investigations is confidential and is not shared with the potential home care provider or client.)**

d. Determine if the home care client is satisfied with the potential caregiver and that the potential caregiver does not pose a threat to the home care client's safety and well-being.

e. Develop a conclusive written summary with a recommendation which addresses the above steps and submit the summary to the Unit Supervisor and the **next level of supervision** in the Region/Circuit for final approval or disapproval.

f. Document in the case record the clear and convincing evidence, facts and information obtained, and any recommendations made.

Chapter 6

ELIGIBILITY AND APPROVAL

6-1. Purpose.

a. This chapter will discuss the final steps and criteria that will determine the applicant's eligibility and approval for the HCDA Program. The specific methods of determining financial and medical eligibility will be discussed in detail.

b. Information captured on the Home Care for Disabled Adult Program Application may require verification by one or more additional programs / entities before final eligibility and approval can be determined. The entire process for approving or denying the home care applicant's eligibility for the HCDA program is typically completed within 45 calendar days from the date the Counselor completes the Home Care for Disabled Adults Program Application form (CF-AA 1020). This is a flexible time frame, however, since a portion of the process may involve ESS, whose time frames may not coincide with this operating procedure. If the approval process extends past 30 calendar days, the Counselor will contact ESS for a status update and document the status in the case record.

6-2. Financial Eligibility. Financial eligibility is based solely on the home care applicant's total annual income and assets. A home care applicant is determined to be financially eligible for the HCDA program by one of the following methods:

a. Meets standards for Supplemental Security Income (SSI). Prior to the initial home visit, the Counselor researches whether the home care applicant has Medicaid coverage through SSI. Individuals receiving SSI meet the aged, blind, or disability standards of Title XVI of the Social Security Act. If the individual receives a SSI payment from the Social Security Administration, they are also eligible for assistance under the Florida Medicaid program. The SSI recipient automatically meets the financial and assets eligibility requirements for the HCDA program, but the Counselor must verify and document this in the case record.

(1) The Counselor must obtain up-to-date verification of financial eligibility. The Counselor may also check FLMMIS for up-to-date verification of the applicant's Medicaid coverage through SSI. Beginning April 2014, applicants may provide verification via the "MySSA" website. Resources available are current SSA benefit award letter, the FLORIDA System, or bank statement clearly stating SSI as a direct deposit.

(2) If the home care applicant's income and assets appear to be close to the SSI eligibility standards, the Counselor refers the applicant to the Social Security Administration for SSI eligibility determination. The home care applicant is required to attempt to establish SSI eligibility through the Social Security Administration's final appeals process. Failure to seek SSI through the final appeals process will disqualify the applicant from further eligibility determination. The entire process must be documented in the case record.

(3) If the home care applicant is receiving Medicaid through SSI, the Counselor adds these documents to the case record. The Counselor will not forward the application to the ESS office for financial and assets eligibility determination, since financial eligibility has already been established.

b. Meets Standards for the MEDS-AD Program.

(1) An applicant receiving Medicaid coverage through the MEDS-AD program automatically meets the financial eligibility requirements for the HCDA program, but the Counselor must verify and document this and place in the case record along with the Home Care for Disabled Adults Program Application. Prior to the initial home visit, the Counselor checks FLMMIS to verify whether the

disabled adult has Medicaid coverage through MEDS-AD. The Counselor must obtain up-to-date verification of financial eligibility through FLMMIS. The Counselor will not forward the application to the ESS office for eligibility determination, since financial eligibility has already been established.

(2) If the home care applicant's income and assets suggest that they may be eligible for the MEDS-AD program and they are not receiving Medicaid through MEDS-AD, the Counselor will submit the Request for Assistance (form CF-ES 2337 or on-line application) along with the completed Home Care for Disabled Adults Program Application (form CF-AA 1020) to the ESS office to verify MEDS-AD eligibility.

(3) Eligibility is not established until ESS takes action on the Request for Assistance (form CF-ES 2337).

(4) If the home care applicant is receiving Medicaid through MEDS-AD, the Counselor adds these documents to the case record. The Counselor will not forward the application to ESS for financial and assets eligibility determination, since financial eligibility has already been established.

c. Meets Income Criteria Set by the Institutional Care Program (ICP) / Medicare Buy-In Programs. If the client is currently opened under ICP eligibility then further determination is not necessary; FLMMIS documentation needs to be placed in the case record.

(1) If the Counselor ascertains the home care applicant does not qualify for SSI, the MEDS-AD program, or Medicaid buy-in programs, then ICP eligibility is pursued. ESS must determine whether the home care applicant meets financial eligibility via the ICP method, regardless of the income (or lack of income) reported by the home care applicant.

(2) The ICP income ceiling is the upper limit of financial eligibility for home care clients. The ICP limit increases yearly based on Federal cost of living increases, which affects the upper income limit for determining SSI and ICP. The Counselor can check current ICP criteria on the ESS website at the end of the calendar year for projected Federal cost of living increases.

(3) If ICP eligibility has not been established, the Counselor will forward the completed and signed Home Care for Disabled Adults Program Application (form CF-AA 1020) to ESS along with the Request for Assistance (form CF-ES 2337) for eligibility determination. In addition, the Counselor will forward any verified income and asset information to ESS in order to expedite the financial eligibility determination process. Resources available are current SSA benefit award letter, FLORIDA System, and bank statements from the 3 most recent months.

(4) ESS will notify the Counselor of the home care applicant's eligibility status by completing the "Final Review and Case Disposition" section of the Home Care for Disabled Adults Program Application (form CF-AA 1020) and returning the application to the Counselor.

d. Copies of all documents exchanged during this process should be placed in the case record.

6-3. Medical Eligibility.

a. In order to meet medical eligibility for the HCDA program, the home care applicant must possess permanent limitations in performing at least one ADL and/or IADL. This is documented on the Adult Services Client Assessment (form CF-AA 3019). In addition, the home care applicant must be at risk of nursing home or other long term care placement. The home care applicant's primary licensed physician (medical doctor, psychiatrist, or doctor of osteopathic medicine), primary licensed registered nurse, primary licensed psychiatric registered nurse or, in the absence of a primary care physician, a Registered Nurse Specialist (RNS) from the APS Program Office may complete the Home Care for

Disabled Adults Program Medical Statement (form CF-AA 1020A) verifying the applicant's medical need.

b. The Home Care for Disabled Adults Program Medical Statement (form CF-AA 1020A) will include the following:

- (1) A detail of the applicant's disabilities and limitations.
- (2) A statement verifying that services provided by the HCDA program are appropriate for the well-being of the applicant.
- (3) That the home care applicant could require nursing home or other long term care if in-home care subsidies and services are not provided.

c. Completion of the CF-AA 1020A is required before HCDA subsidies can begin. The counselor can assist the applicant in obtaining the completed medical statement by mailing it to the medical professional along with the Confidential Information Release (form CF-AA 1113) signed by the applicant or caregiver. However, ultimate responsibility for obtaining the required documentation falls on the applicant.

d. If the medical professional does not return the completed Home Care for Disabled Adults Program - Medical Statement (form CF-AA 1020A) within 10 business days, the Counselor will contact the medical professional and request an estimated date of return. Subsidy payments and services cannot begin until the medical professional returns the completed Home Care for Disabled Adults Program - Medical Statement (form CF-AA 1020A).

6-4. Finalization of the Application and Eligibility Approval Process.

a. Once the application and eligibility process has been completed, the Counselor forwards the case record to the Unit Supervisor for review and approval before the issuance of subsidy payments. The supervisor uses the Supervisor's Case Record Review Log (form CF-AA 1023) to insure:

- (1) The Counselor verified financial eligibility or ESS has determined financial eligibility and verification is stated on the Home Care for Disabled Adults Program Application (form CF-AA 1020);
- (2) Medical eligibility is established based on the completed Adult Services Client Assessment (form CF-AA 3019) and the Home Care for Disabled Adults Program – Medical Statement (form CF-AA 1020A);
- (3) The primary caregiver and all alternate caregivers meet the screening criteria as indicated on the Home Care Provider Background Check (form CF-AA 1123) and have signed and submitted a completed Home Care Provider Agreement (form CF AA-1021).
- (4) Within three working days of receipt of the case for final approval by the Counselor, the Unit Supervisor will also document any corrective action that may be required by the Counselor regarding his/her performance on the case. The Counselor must complete any corrective action within 30 calendar days of the record review date and document it in the Supervisor's Case Review Log., which will be filed in the case record.
- (5) Upon supervisor approval of the HCDA case, the HSC will submit form CF-AA 1115, Waiting List Log Revision, to the APSPO.
- (6) Once approval from APSPO HSC has three working to input into the current ECMS.

b. If any of the above criteria are not met and the home care applicant or potential home care provider does not make revisions in order to satisfy the unmet criteria, within five working days of the determination the counselor will staff the case with the supervisor. If any conditions are identified or observed during the evaluation process that indicate potential abuse, neglect or exploitation the counselor will make a report to the hotline.

c. If the decision is made to deny the application for HCDA the Counselor will complete the Notice of Ineligibility or Change in Services Status (form CF-AA 1114) and provide it to the home care applicant. This notice provides the applicant with information on his/her rights to an administrative hearing. The Counselor will indicate financial, medical, and/or provider ineligibility on the form by checking the appropriate box.

d. If the home care applicant has not received the Adult Services Due Process Rights pamphlet (CF/PI 140-43), the Counselor will provide one at this time.

e. If the Counselor feels there is hazardous environment it must be reported to the hotline.

Chapter 7

CASE MANAGEMENT

7-1. Purpose. This chapter describes case management and the specific role, responsibilities, and obligations of the Counselor as a case manager, including mandatory reporting of abuse, neglect, and exploitation, client confidentiality, and ethical considerations. The arrangement and delivery of services, supplies, medications, equipment, and care from service providers/vendors are described, as well as the Counselor's role in securing the services, items, and care. Referring home care clients to other programs and departments is also discussed in this chapter. The process for transferring a home care client's case from one area of the state to another is described. Finally, the process for completing the annual re-assessment and eligibility re-determination is discussed.

7-2. Services. The Counselor assists the caregiver with locating necessary items, service providers and licensed caregivers, arranging for the delivery of items, services, and care, and ensuring that the items, services, and care are provided. The Counselor makes sure that the services provided meet expectations and produce expected results.

a. All case management activities relating to support services, supplies, medications, equipment, and care should be consistent with the home care client's established Care Plan (form CF-AA 1025) and should be documented in the case record. Documentation of case management activities should include:

(1) Identification of items, formal and informal supports, and caregivers related to the home care client's provision of care.

(2) The dates, frequency, and duration of items, vendors, service providers, and care to be delivered.

(3) Any circumstances that may prevent the delivery of items, services, or care.

b. A service provider or caregiver may be a neighbor (i.e., the neighbor who constructs a wheelchair ramp for the home care client), friend, relative, as well as a professional.

c. If the Counselor makes a referral to a professional service provider or caregiver, the Counselor will contact the service provider or caregiver on behalf of the home care client.

d. If the service provider or caregiver is able to accommodate the home care client, the Counselor completes the referral process and documents the referral in the case file.

e. When a Counselor arranges for or makes a referral for items, services, or care to be delivered, the Counselor completes at least one follow-up with the home care client and or the primary caregiver (face-to-face or telephone) within 30 calendar days to assure that the item, service, or care was delivered appropriately. The Counselor will address any problems that may have occurred with the delivery of services with the service provider or caregiver. Documentation of the follow-up contact and resolution of problems encountered is added to the case record.

f. If the client or caregiver does not receive the requested services within 30 calendar days of the initial referral, the Counselor contacts the service provider to obtain a status report on the delivery of the services. The Counselor documents the follow-up contact in the case record.

g. The primary caregiver will obtain documentation for expenditures made for any item, service, or care. Expenditures must be supported by dated invoices, receipts, or statements marked "Paid" for possible future reimbursement.

7-3. Payment.

a. Payments for new enrollees can be made retroactive to the date ~~when~~ the client signed the HCDA Program application (CF-AA 1020). A one-time expenditure (OTE) may be authorized only for purchases made during the current fiscal year, with accompanying documentation of the service(s) rendered (i.e., invoice, receipt), and may only be authorized for items that are not available for payment by other programmatic funding (e.g., HCDA clients also enrolled in SMMC or APD services must rely on their primary funding stream for services, equipment, etc.). OTE's are reimbursements and payments are not made to providers/vendors. It may be difficult for the primary caregiver to pay up front for a service, supply, medication, equipment, or care, or for co-payments, even though pre-approval for reimbursement has been made. Therefore, a copy of a credit card statement or loan agreement is acceptable documentation with a paid invoice/receipt.

b. The caregiver must contact the counselor/family support worker by the fifth of each month (face to face or telephone) to confirm the care is still being provided to the client and the client remains in the home. If no contact has been made with the Counselor by the sixth of the month, the counselor / family support worker will contact the caregiver (face to face or telephone) prior to authorizing monthly payment. This contact certifies that supervision and services were provided during the month in which payment is being requested. Noncompliance with this requirement is grounds for termination from the HCDA program.

c. The caregiver is responsible for submitting all paid invoices, receipts, or statements for services, supplies, medication, equipment, care, and reimbursement requests to ensure appropriateness. Receipts are reviewed to ensure that prior authorization (prior to purchase) was provided.

d. Reimbursement of items, services, and care are provided directly to the primary caregiver. The Counselor or other departmental staff will not pay a service provider, vendor, or licensed caregiver directly for medical or support items, services, or care.

7-4. Follow Up.

a. The Counselor is in frequent contact, either face-to-face or by telephone, with the home care client and the home care provider. At a minimum, the Counselor is required to meet quarterly, face-to-face with the home care client. At least quarterly, the Counselor will complete an interview to re-assess the Care Plan (form CF-AA 1025) and modify it to meet documented changes in the status or needs of the home care client.

b. For example, the Counselor may:

(1) Discuss with co-workers, supervisors, and other departmental staff resources and items that may be available in the Circuit/Region for distribution to clients of the department.

(2) Find local programs which may provide needed services, items, or care to individuals in need for free or at a reduced price. These types of programs include local non-profits, churches, advocacy groups, or other federal or state run programs.

(3) Discuss with the home care provider the possibility of religious organizations assisting with purchases and repaying these organizations once the subsidy reimbursement is received.

(4) Counsel the primary caregiver in negotiating with a service provider, vendor, or caregiver.

(5) Advise the primary caregiver in obtaining information on a no-interest loan (i.e., from a bank, person, or government entity) that can be used to purchase the service, item, or care. The primary caregiver can re-pay the loan once the subsidy is received. **CAUTION: The Counselor never provides a financial loan to the home care provider or client.**

7-5. Case Transfers.

a. Home care clients in the HCDA program who relocates from one Circuit/Region to another can continue to receive subsidies from the HCDA program. This is contingent on the home care client remaining financially eligible, having an approved caregiver, and moving into a home that meets the home standards.

b. The Counselor's goal is to assist the home care client with the transfer so that they continue to receive appropriate subsidies and services in a seamless manner. In order to accomplish this, the Counselor located in the Circuit / Region where the home care client currently lives contacts their Supervisor in the Circuit / Region where the home care client is moving prior to the client's move. The early communication will allow the Supervisor in the new location to perform the background screening on any new caregivers. Problems can potentially be addressed prior to the move or the move can be reconsidered if problems are insurmountable.

c. The APS Office from the originating location will:

(1) Provide both the APS Program Office and the unit who will be receiving the client with the name, date of birth, telephone number(s), the date the home care client is moving, and all necessary demographic information.

(2) Forward the home care client's record to the APS Circuit/Region location in the receiving location. A follow-up email will be sent to the receiving Circuit/Region location and upon receipt an e-mail will be sent to the sending Circuit/Region and APS Program Office.

(3) The APS Program Office will provide the information to APS Headquarters.

(4) Once programmatic requirements have been met in the new Circuit / Region, the Counselor in the originating location completes the Client Transfer / Termination for Home Care for Disabled Adults or Community Care for Disabled Adults Program (form CF-AA 1122) and immediately emails the form to APS Headquarters Program Office staff and to the Circuit / Region where the home care client moved.

d. The APS Office in the receiving location will:

(1) Contact the home care client within three working days of receiving the client's record and schedule a home visit to occur within 10 working days from that contact. Upon receipt of the case record an e-mail will be sent to the sending Circuit/Region and APS Program Office.

(2) Review the financial information and complete/update the Home Care for Disabled Adults Program Application (form CF-AA 1020). The application should be forwarded to ESS, if there has been a substantial change in the home care client's financial situation since the move.

(3) Complete or update the home care provider agreement (form CF-AA 1021).

(4) Complete the background screening on any new potential caregivers.

(5) Provide electronic feedback to staff in the APS Program Office and staff from the originating Circuit/Region regarding continuation of eligibility or eligibility problems.

(6) If necessary, the Counselor will document financial, medical, and caregiver ineligibility on the Notice of Ineligibility or Change in Services Status (form CF-AA 1114) form by checking the appropriate box, and providing the form to the home care client.

(a) The Counselor in the Circuit / Region where the ineligibility determination was made is responsible for terminating the case in the ECMS using the appropriate disposition code.

(b) The case record of a terminated case remains in the Circuit/Region where the case was terminated and is not returned to the originating location.

(c) The Counselor documents in the case record all activities relating the transfer.

(7) Complete the transfer/reassignment in the ECMS.

7-6. Re-Determination.

a. An annual re-determination is required for all home care clients-

b. The Annual re-determination of eligibility process consists of the following:

(1) Completing a new Home Care for Disabled Adults Program Application (form CF-AA 1020) and verifying SSI, MEDS-AD, ICP eligibility, or Medicare Buy-In programs. If the client is not receiving SSI, MEDS-AD or ICP, the application is forwarded to ESS for eligibility determination.

(2) Obtaining an updated Home Care for Disabled Adults Program medical statement (form CF-AA 1020A), **if and when** there is a sufficient improvement in the client's functional ability.

(3) The process of obtaining an updated Home Care for Disabled Adults Program – Medical Statement (form CF-AA 1020A) is completed annually as needed if and when there is a sufficient improvement in the client functional ability to reflect the home care client's current health status and attest to the appropriateness of the client's continuation in the program.

(4) Complete a home care provider background screening using the Home Care for Disabled Adults Home Care Provider Background Check (form CF-AA 1123).

(5) Completing the Home Care Provider Agreement (form CF-AA 1021).

(6) Complete a new Care Plan (form CF-AA 1025).

(7) Complete / update Adult Services Client Assessment (form CF-AA 3019).

(8) Complete / update Confidential Information Release (form CF-AA 1113).

c. The Counselor completes all necessary actions and forwards file to the supervisor for review. Within three working days of supervisor approval the counselor updates ECMS to reflect the redetermination is complete.

d. If the home care client or primary caregiver is determined ineligible at the annual re-determination, and fails to comply with eligibility criteria within ten calendar days, the home care client's case is terminated. The Counselor will document financial, medical, and caregiver ineligibility on the Notice of Ineligibility or Change in Services Status (form CF-AA 1114) form by checking the appropriate box.

e. The Counselor documents all re-determination activities, includes all relevant paperwork in the case record, and updates the ECMS to reflect the case termination using the appropriate disposition code. The Client Transfer/Termination for Home Care for Disabled Adults and Community Care for Disabled Adults (form CF-AA 1122) is emailed to the APS Program Office.

Chapter 8

DOCUMENTATION

8-1. Purpose. This chapter provides generalities about gathering and documenting information for case records. It also provides specifics on what and when to document in the case record. Specifics on field notes, case narratives, case record folders, case record organization and contents are described. Retention and destruction of case records are also discussed.

8-2. Case Record Documentation. Documentation is an essential part of a client's case record. It should be clear, legible, thorough, accurate, and concise. If abbreviations or acronyms are used, the Counselor should refer to the APS Acronyms and Abbreviations key available on the Adult Protective Services Intranet page, filed under Best Practices > Documentation Best Practices (<http://eww/aps/BestPractice.shtml>). It is considered best practice to maintain up-to-date and complete documentation of case activities. The Counselor will document a short but complete summary of everything they do for a home care client beginning with the intake process through placement into HCDA services.

a. The Counselor dates and documents all contacts, subsidies, and services provided in the chronological field note (on the Client Progress Notes [form CF-AA 1038]) or narrative section of the home care client's case record.

b. The written documentation in the chronological section for non-required visits can be brief. If, during the visit, the Counselor did not identify any problems with the home care client, home care provider, services, items, or care.

c. It is not necessary to repeat all that is written on the APS Client Assessment (form CF-AA 3019) and Care Plan form (CF-AA 1025), but the Counselor makes reference to these documents, as appropriate, in the field notes and/or narrative.

d. The Counselor documents all visits made to the home care client's place of residence in the case record. The notation includes the date of the visit, name of individual(s) contacted, purpose of the visit, a brief summary of the outcome of the visit, and subsequent planned follow-up contacts.

e. The Counselor documents all incoming and outgoing telephone contacts with the home care client, caregiver, service providers, vendors, family members, or other individuals regarding the HCDA case in the case record. The notation includes the date of the telephone contact, name of the individual contacted, and a brief summary of the content and outcome of the conversation.

f. The Counselor documents activities related to processing and providing subsidies payments to the caregiver. This includes the pre-approval of services, supplies, equipment, medications, and care, communications with APS Headquarters staff regarding costly services and items, requests for estimates for costly services and items, overpayment of subsidies, and recoupment of subsidies if necessary.

g. The Counselor documents submission of forms to obtain services or determine eligibility for services or programs. All face-to-face or telephone contacts with service providers, vendors, and caregivers are noted in the case record. The notation includes the date, type of contact (for example, field visit, office visit, or telephone call), name of the individual(s) and agency contacted, and a brief description of the content and outcome of the conversation. In addition, the Counselor documents in the case record the home care client's refusal of services or care, barriers or problems in the delivery of services or care, and other similar situations.

h. The Counselor documents in the case record any case staffing during which the home care client is discussed. The notation includes the date of the case staffing, names of individuals attending the staffing, and a brief summary of the discussion and outcome of the staffing.

i. The Counselor documents any other contact made concerning the home care client in the case record. Delivering goods (food, medical items, or donations) to a home care client, contacting family members and friends of the home care client, and contacting medical professionals, staff from other agencies, or other individuals are examples.

j. The Counselor places a copy of all notices and forms given/mailed to the home care client and home care provider in the case record. If it is not possible to place a copy of a form in a case record, the Counselor documents in the field notes/narrative forms that were given to the home care client/provider or on behalf of the home care client.

8-3. When To Document. When to document is just as important as what to document. The Counselor documents as soon as possible after the activity is conducted. The Counselor completes the field notes immediately following the activity, but this may not always be possible. Therefore, all documentation must be completed within 3 working days of the performed activity.

8-4. Falsification of Case Record Documentation. Knowingly falsifying a client's record is a criminal offense. In 2002, Chapter 839, Florida Statutes, was revised to enact criminal penalties against state employees, agents of the department, or departmental contractors who knowingly falsify client records. These criminal penalties include:

a. Any employee of the department (or agent of or contractor) who knowingly falsifies by altering, destroying, defacing, overwriting, removing, or discarding an official record relating to an individual in the care of the department commits a third degree felony, punishable as provided in sections 775.082, 775.083, or 775.084, Florida Statutes, if the act has the potential to detrimentally affect the health, safety, or welfare of that individual.

b. Any employee of the department (or agent of or contractor) who commits a violation described above in paragraph a. which contributes to great bodily harm to or the death of an individual in the care of the department commits a second degree felony, punishable as provided in the Florida Statute sections cited in paragraph a. above.

c. Any employee of the department (or agent of or contractor) who knowingly falsifies by altering, destroying, defacing, overwriting, removing, or discarding an official record relating to an individual in the care of the department, with the intent to conceal a fact material to the case, commits a third degree felony, punishable as provided in the Florida Statute sections cited in paragraph a. above.

d. Paragraphs a., b., and c. above do not apply to the disposing or archiving of records as provided by Florida Statutes (see Chapter 9, paragraph 9-7 of this operating procedure). This also does not prohibit any employee (or agent of or contractor) from correcting or updating records.

8-5. Field Notes and Case Narrative. During the time of an event or soon thereafter, field notes are typically written on the Client Progress Notes (form CF-AA 1038) and included in the case record. If field notes provide a comprehensive description of a situation, are typewritten on a computer or typewriter, or legibly handwritten, and follow the specified guidelines, they may stand alone without a narrative. If used exclusively in the case record, the field notes must include the specifics described below in the case narrative section, as well as additional information described in the following field notes section. A narrative may be completed in the office and may be developed from field notes, if the notes are not comprehensive enough to stand alone in the case record. In that case, both field notes and narrative become part of the case record.

8-6. Field Notes – Who, What, When, Where, Why, What’s Next. The Counselor files all field notes in the case record. Field notes answer the questions, “who, what, when, where, why, and what’s next” as described below.

a. Who. Who are you calling or contacting? Identify the person, agency, program, or other entity being contacted. If someone has contacted you, who is the person? What is this person’s relationship to the home care client? Provide enough information so that the reader can easily understand who or what they are reading about.

b. What. What is occurring that makes this contact necessary? What is happening in the home care client’s life and what information needs to be conveyed? Identify the purpose and any concerns, needs, or other relevant information. How does the particular activity relate to the implementation of the Care Plan (form CF-AA 1025)?

c. When. When are you making the contact or when did you receive the contact? The written date is recorded for each. When will follow-up activities occur? Include the time of day that the activity occurred or if that information makes the sequence of events easier to follow.

d. Where. Where did the contact or case management activity take place? Note if the contact was an office visit, home visit, or telephone contact.

e. Why. Why are you contacting this person or why has the person contacted you? It is important to document as much information as possible so everyone understands the information and its relationship to the Care Plan (form CF-AA 1025).

f. What’s Next. If the situation merits, indicate what will happen next and who is responsible. What specific follow-up is needed? What case management activities will occur and who will do them?

8-7. Field Notes – Documentation Requirements. The Counselor follows the documentation requirements below when writing field notes for all HCDA cases:

a. Adult Protective Services case management field notes may be handwritten, typed, submitted on a computer printout, or entered into the ECMS. If handwritten, the notes must be clear and legible. Pencil-written field notes are inappropriate and unacceptable.

b. Field notes are written at the time the activity is undertaken (such as a home visit) or immediately after the activity is completed. The Counselor files all completed and original entries in the home care client’s case record within 3 working days of the documented activity. If entries are entered into a computer, a copy is printed, dated, and signed or initialed by the Counselor and placed in the case record.

c. Field notes are filed in reverse chronological order, with the most recently recorded information on top.

d. The first field note entry is followed by the Counselor’s full signature at the end of the entry. Thereafter, that same Counselor can initial the entries as they continue to document case management activities. If another individual (such as the Unit Supervisor) documents activities in the home care client’s field note portion of the case record, the full signature of the other individual is required to document the entry. After the first entry, the initials of the other individual can be used thereafter.

e. Use quotation marks when indicating a direct quote by someone and include the name of the person who is speaking.

f. Do not use correction fluid or correction tape to correct any entry in the field notes. If an error is made, the Counselor strikes through the mistake with a single line, dates, and initials the change.

g. Field notes contain non-judgmental observations and statements of what occurred, or will occur, as well as any pertinent case management actions, details, or other information. Observations made by the Counselor, home care provider, family members, or other people who know the home care client (collateral contacts/providers) are essential in order to present a complete picture of the home care client's situation. Accuracy is very important. The Counselor's signature or initials at the end of each entry in the field notes attests to the accuracy of the information recorded in the home care client's case record.

h. Field notes are continuous and sequential on each page. No extra lines are left blank between entries. This is to prevent additional information from being added to an entry at a later date. If a page is not filled with notes, mark the empty space with a large "X" so no other entries can be made on the page.

i. In the event that an entry is made out of sequence, it is noted as a late entry such as "5/3/14 late entry...On 4/29/14 received a phone call from..."

j. The Counselor enters every case management activity into the field notes as a separate entry. It is possible to combine multiple contacts into a single entry if the contacts relate to the same activity or service.

8-8. Case Narrative.

a. Case narrative describes ongoing occurrences and events in the case and reflects activities that relate either directly or indirectly to the Care Plan (form CF-AA 1025).

(1) Upon review of the case narrative, the reader is able to ascertain if the Care Plan (form CF-AA 1025) is valid and subsequent services and care are appropriate and necessary to meet the home care client's needs.

(2) Changes in the client's situation, unmet needs, or reasons for variances from the Care Plan (form CF-AA 1025) are described.

(3) Information included in the narrative describes the home care client's progress toward accomplishing the overall goals, outcomes, and pertinent information relating to the client's overall situation. This includes notations specific to follow-up activities, problems encountered in service delivery, or unique circumstances which could affect the client.

(4) The narrative is typed, filed in reverse chronological order, and each entry is signed or initialed by the writer (the writer's first entry is signed, follow-up entries can be initialed).

b. Case narrative entries consist of:

(1) General Information. Date of the contact, type of contact, and source of contact.

(2) Opening / Annual Narrative. The initial entry includes the following:

(a) Reasons and circumstances necessitating HCDA;

(b) Results of the staffing held with the Protective Investigator if the referral is as a result of suspected abuse, neglect, or exploitation, risk level of the client, and the plan for reducing or eliminating any further occurrences of abuse, neglect, or exploitation;

(c) The client's current situation, including living arrangements, home care provider situation, financial status, family, and other information pertinent to the case;

(d) Results of the application process including financial eligibility, medical eligibility, home care provider screenings, and home standards compliance;

(e) Subsidy/supplement amounts provided and an indication of when the subsidies will begin;

(f) Available resources explored, reasons for selecting specific vendors, service providers, and caregivers as indicated in the Care Plan (form CF-AA 1025), and involvement of the home care provider, family, or significant others;

(g) That the service provider, equipment or supply vendor, and caregiver of arranged or referred services were advised of the client's needs;

(h) Follow-up activities to be completed within 30 calendar days from the date of the purchase or referral; and,

(i) Additional information not covered in the AS Client Assessment (form CF-AA 3019) or Care Plan (form CF-AA 1025), or that will be helpful or necessary during the provision of subsidies/supplement, services, and care to the home care client.

8-9. Quarterly Narrative. The Counselor documents all ongoing activities performed on behalf of the client in the ongoing narrative. Ongoing activities include telephone contacts with clients, home care providers, family members, service providers, vendors, or caregivers, home visits, office visits, and staff meetings pertaining to home care clients. The ongoing narrative relates to the Care Plan (form CF-AA 1025) and the initial narrative summary by continuously evaluating the progress or lack of progress in reaching the client's goals and outcomes. Ongoing narrative reflects:

a. Dates of contacts, subsidies, activities, services, supplies, equipment, medications, and care provided (an entry can be written after the date of the contact if the counselor indicates in the narrative the actual date of the contact or service (see paragraph 9-5b(9) of this operating procedure));

b. Changes in the client's status;

c. That services, supplies, equipment, medications, and care provided are consistent with the Care Plan (form CF-AA 1025);

d. Variances from the Care Plan (CF-AA 1025), as well as the reason for change; and,

e. Any other information pertinent to the client's situation.

8-10. Closing Narrative. The Counselor completes a brief closing summary upon closure of the case. The summary includes the reasons and circumstances for the closure, status of the completion of the goals and outcomes, evaluation of the results of services and care provided, and the home care client's present level of risk and future risk for institutionalization and the occurrence of abuse, neglect, or exploitation. The closing summary also documents that the client was informed of his/her right to appeal the action (see Chapter 9, paragraph 9-4 of this operating procedure) and that the Due Process Rights pamphlet was given and explained to the client.

8-11. Case Record Folders and Contents. Individual offices organize their record folders in the manner that proves to be most efficient and most practical within their Region. All case records are

established and organized in a manner that protects the basic confidentiality of record contents. There are basic guidelines that are adhered to with all case records. These are listed below:

- a. The assigned Counselor is responsible for creating a separate case record folder for each home care client.
- b. Each case record is assembled in a folder.
- c. The folder label is typed and placed on the folder in a position where it can be easily viewed at a time when the folder is stored in a filing cabinet. This label includes the following information:

- (1) Home care client's name (last name, first name, and middle initial) recorded on the first line;

- (2) Home care client's social security number recorded on the first line after the home care client's name; and,

- (3) Service program type (HCDA) is recorded on the second line.

EXAMPLE: Stewart, Mary G. 123-45-6789
HCDA

- d. A client's case record folder contains only information that is pertinent to the client. The Counselor or Unit Supervisor immediately removes any information from the case record that is not relevant to the home care client's case. **At no time should a report alleging abuse, neglect, or exploitation, or any notes from that report be filed in the HCDA case record.**

- e. The Counselor files information and documents according to the date, in reverse chronological order, upward, beginning with the earliest information and ending with the latest information. The Counselor date stamps any undated case documents according to the date on which the document was obtained.

- f. Information in the case record file folder is updated, as appropriate. When reviewing documents, the Counselor ensures that all necessary signatures are obtained.

- g. The Counselor ensures that documentation in the case record provides a current profile of the home care client's status, subsidy/supplement amounts, and the delivery of services, equipment, supplies, and care.

- h. Contents of the case record are securely fastened to the file folder using file fasteners. Loose paper in the case record is unacceptable.

- i. All case records are filed in alphabetical order, in filing cabinets, and in a secure location.

- j. The Counselor ensures that case records are not left open on desks or exposed in a way that might compromise the client's confidentiality.

8-12. Retention and Destruction of Case Records. The case record is prepared for retention when the case is closed. Records are destroyed when the retention period has ended or when records are determined as not being subject to retention. Any records authorized for disposal that contain confidential information are disposed of in a manner that will render them unreadable. Refer to CFP 15-7, Records Retention Schedules Used by the DCF (located on the APS Program's Intranet site, or Department's Internet site) for specifics on retention of case records, specifics on conditions under which records can be destroyed, and the sanctioned methods of record destruction.

Chapter 9

TERMINATION OF CASE MANAGEMENT

9-1. Purpose. This chapter provides guidelines for the termination of the HCDA basic subsidy, OTE, services, and case closures. The chapter outlines the reasons for closure and describes the procedures for closing a case. The chapter also describes the due process and the Administrative Hearings process.

9-2. Termination of Services and Case Closure. A client is terminated from enrollment in the HCDA program when one or more of the following conditions exist:

- a. The home care client dies.
- b. The home care client turns 60 years of age (a referral is made to the DOEA, through the local Aging and Disabled Resource Center; three months prior to the client turning 60 years of age).
- c. The home care client leaves the state for more than 60 consecutive days without notification and prior departmental approval, or permanently leaves the state.
- d. The home care client is hospitalized for more than 60 consecutive days, if it appears that upon release from the hospital the home care client will not return home. If the home care client is expected to return home, the subsidy payment is not provided while hospitalized, but the case remains open until they return home, and subsidy payments are restored at that time.
- e. The home care client is placed in a nursing home, other institutional setting, Assisted Living Facility, or Adult Family Care Home, with no anticipated discharge date.
- f. The home care client no longer meets financial eligibility for the HCDA program.
- g. The home care client no longer meets medical eligibility for the HCDA program.
- h. The home care client no longer has an approved home care provider.
- i. The home care client fails to comply with the HCDA program criteria (i.e., providing information necessary to ensure eligibility, submitting necessary documentation, meeting with the Counselor quarterly).
- j. The home care provider fails to comply with the responsibilities associated with the HCDA program, which includes making required monthly telephone contact with the Counselor/APS staff, or fails to cooperate with the Counselor's attempts to arrange quarterly (or other) visits or annual re-assessments and re-determinations; or fails to meet the identified needs of the client.
- k. Subsidies and services are no longer needed or appropriate.
- l. The home care client no longer requests services.
- m. The home care client moves and leaves no forwarding address with the Counselor, home care provider, guardian, family, friends, primary physician, service providers, caregivers, post office, or other individuals. The Counselor is unable to locate the home care client.

9-3. Procedures for Closing a Case.

a. If the Counselor determines that any of the conditions listed in paragraph 9-2 exist, the following steps are completed:

(1) A closing narrative is completed.

(2) The Counselor discusses the case closure with the home care client and the home care provider, and gives the home care client the Notice of Ineligibility or Change in Service Status (form CF-AA 1114) explaining the reason for closure. A copy of the notice is placed in the case record.

(a) The Notice of Ineligibility or Change in Service Status (form CF-AA 1114) is required for all closures except in the event of home care client's death or if the Counselor is unable to locate the home care client.

(b) If the Notice of Ineligibility or Change in Service Status (form CF-AA 1114) is hand delivered and the Counselor anticipates a problem with the case being closed, the Counselor has the home care client sign a statement acknowledging receipt of the notice. If the home care client does not sign for receipt of the notice, the Counselor indicates this on the notice and documents it in the case record.

(c) If the Notice of Ineligibility or Change in Service Status (form CF-AA 1114) is sent by certified mail, return receipt requested, the return receipt is placed in the case record.

(3) The Counselor advises the home care provider to submit documentation of any outstanding bills paid by the home care provider which the department may reimburse if funds are available. The Counselor informs the home care provider when the last HCDA warrant will be received.

(4) If the home care client has moved and their new address and telephone number are not known, the Counselor makes every effort to locate the home care client. This includes checking with the home care provider, family members, guardian, service providers, caregivers, other agencies/programs providing services to this home care client, telephone information, and the post office for a forwarding mailing address. If the home care client cannot be located, all efforts to locate the new address/telephone number are documented in the case record. The Notice of Ineligibility or Change in Service Status (form CF-AA 1114) is not required.

(5) The Counselor informs the home care client of their right to appeal the action being taken, provides the home care client with the Due Process Rights Pamphlet (CF/PI 140-43), and documents in the case record that this information was provided to the home care client.

(6) The Counselor or other APS staff completes the Client Transfer/Termination for Home Care for Disabled Adults and Community Care for Disabled Adults Programs form (form CF-AA 1122) and sends it to the Regional APS Program Office. This completed form informs Headquarters of the termination and the freed dollars which can be used to pull an individual off the Statewide HCDA waiting list. A copy of the completed form is added to the case record.

(7) Within three working days of receiving the case file from the Counselor, the Unit Supervisor signs and dates the Supervisor's Case Record Review Log (form CF-AA 1023) to document agreement with case closure.

(8) The ECMS is updated and a screen shot of the closed HCDA case is printed and filed in the case record.

b. Home care clients remain eligible for HCDA subsidies and services through the last day of the month in which the Notice of Ineligibility or Change in Service Status (CF-AA 1114) is dated. The Counselor is mindful of closing the case and completing the notice immediately upon learning that closure is appropriate. This ensures that payments are not made after eligibility has been terminated.

9-4. Due Process and Administrative Hearings. An individual has the right to due process if they do not agree with the actions taken by the Department in respect to their case.

a. An administrative hearing is the method by which an individual requesting services, a home care applicant, or a home care client challenges decisions made by the department concerning the Statewide Wait List, program eligibility, or receipt of subsidies and services. An administrative hearing is an appeal of the Department's action involving programs funded through state general revenue dollars.

b. An individual requesting services, home care applicant, or client wishing to appeal their placement on or removal from the Statewide Wait List, a subsidy or service denial, termination, suspension, or reduction may do so by contacting the department within 21 days after receiving notice from the Department. Written or oral requests made by an individual requesting services, home care applicant, or home care client or their legal representative are acceptable requests for a hearing. If an administrative hearing is not requested within 21 days of receipt of the notice, the individual requesting services, home care applicant, or home care client waives their right to request an administrative hearing.

c. The hearing may be informal or formal in nature. Hearings that do not involve disputed issues of material fact are informal and are conducted by a Hearing Officer assigned to hear the case by the Department's Agency Clerk. Hearings involving disputed issues of material fact are formal hearings and are referred to the Division of Administrative Hearings to be heard by an Administrative Law Judge. Regional Legal Counsel is notified immediately of any hearing request and files the hearing request with the Agency Clerk. The Agency Clerk assigns the matter for an informal hearing or refers the case to the Division of Administrative Hearings for a formal hearing.

d. The termination of subsidies and services during administrative actions is inappropriate. If it appears that the case must be terminated prior to the final order, the Region's legal services staff are consulted for advice.

e. In the event of a hearing request, the Counselor documents specifics regarding the request and the final decision in the waiting list file folder and the ECMS.