



Is Your Child Medically Involved But Not Eligible for Medi-Cal? How The Nursing Facility Waivers Can Help

About The Nursing Facility Waivers

There are two home and community based waivers under Medi-Cal that provide extra services to people who could qualify for nursing facility care because of their health and care needs: 1) the Nursing Facility (NF) A/B Waiver and 2) the Nursing Facility (NF) Sub Acute Waiver.

Children who apply for nursing facility waivers can qualify for Medi-Cal and EPSDT Medi-Cal services because financial eligibility is based on just the child's own income and resources. The parents' income and resources don't count. This is called "institutional deeming."

These waivers authorize case management, extra attendant care (IHSS/Medi-Cal personal care service), home modifications (ramps, widening a door frame) and family training. Most children who already have Medi-Cal do not need these waivers because they qualify for extra services including home nursing under EPSDT Medi-Cal. See Attachment A for more information about these waivers.

Children Helped By the Nursing Facility Waivers

Children not eligible for free Medi-Cal because of the income and resources of their parents. Children covered by Medi-Cal who need home modifications or help with utilities.

Children who are regional center clients but are not eligible for the waiver for regional center clients because their care needs are more than can be handled in an ICF/DD facility.



How Can I Apply For My Child?

Simply fill out the two forms found in Attachment B and send them to In-Home Operations. We have provided an additional copy of each form for your convenience.

Is There A Waiting List?

Yes, a long waiting list. It can take more than a year to get the waiver services you need! Why? Because there are only 1,135 slots or spaces under the waivers for both children and adults. Other waivers have more slots. Although Medi-Cal pays for approximately 80,000 nursing facility beds, Medi-Cal has only set aside 685 slots for people (children and adults) who would otherwise require care in a sub acute nursing facility (mostly people with ventilators) *and only 450 slots for people who would otherwise require care in other kinds of nursing facilities!*

If your child is on the waiting list and you want to know where he/she is on the list, how many there are ahead of your child and how long your child will have to wait, call (916) 552-9105.

Once My Child Is On The Waiting List, What Can I Do So That My Child Does Not Have To Wait So Long?

The State can increase the number of slots in the nursing facility waivers by simply asking the federal government to approve an increase in the number. If you want your child to qualify for services sooner, call, write or e-mail your state representatives: the governor, your state senator, your state assembly member. Ask them to increase the number of slots. Also ask

- Why are there so few slots?
- Why isn't there a special allocation for children?
- Why does a child have to wait so long when a child who can qualify under the waiver for regional center clients does not have to wait?
- What are you doing to help get more slots for these waivers?

Attachment C tells you how to contact the governor and how to use the internet to get the name, phone number and address of your state senator and assembly member. If you do not have access to the internet, you can call Carlos Garcia at (213) 427-8757 ext. 3020 who will give you the name, phone number and address of your state senator and assembly member.

Other Options?

If your child is HIV positive, your child may qualify for the AIDS waiver (3,100 slots). Call (916) 327-6784.

If your child is a client of a regional center, your child may qualify for the waiver for regional center clients (45,000 slots). Talk to your RC counselor.

If you are interested in knowing more about home nursing under the Medi-Cal EPSDT Program, call In-Home Operations at (916) 552-9105.

Disability Rights California
3580 Wilshire Blvd., Suite. 902
Los Angeles, CA 90010-2512
Tel: (213) 427-8747 - Fax: (213) 427-8767
Toll Free/TTY/TDD: 1-800-776-5746

Attachment A

**INFORMATION PROVIDED BY THE DEPARTMENT
OF HEALTH SERVICES ON THE NURSING FACILITY
A/B WAIVER AND SUB-ACUTE WAIVER**

Nursing Facility (NF) A/B Waiver

- Subject to prior authorization.
- Designed for persons who are physically disabled and in the absence of the waiver would be expected to require at least 365 days of nursing facility care. California has multiple levels of service available within the federal nursing facility level of service. This waiver includes NF A (Intermediate Care Facility/ICF) and NF B (SNF) level of care.
- Beneficiary must be Medi-Cal eligible. This can be established in one of two ways:
 - **community deeming** rules/requirements, i.e., the regular financial rules for Medi-Cal eligibility;
 - **institutional deeming** rules/requirements, i.e., the individual is assessed to be Medi-Cal eligible “as if” he/she were in a long-term care facility.
- Authorized services must be **cost-effective** to the Medi-Cal program. This means that the total cost of providing NF A/B waiver services and all other medically necessary Medi-Cal services to the beneficiary must be less than the total cost incurred by the Medi-Cal program for providing care to the beneficiary at the otherwise appropriate nursing facility. The NF A and B levels of care are defined in CCR, Title 22, Division 3, Sections 51120, 51124, 51134 and 51135.
- NF A/B waiver services include: case management, RN or LVN private duty nursing services, home health aide services, shared nursing services, waiver service coordination, minor home modifications such as grab-bar placement or ramps, utility coverage for life-sustaining equipment, personal emergency response systems, family training, personal care services, and respite.
- Implementation of NF A/B waiver services also involves the active participation of the family and/or primary caregiver in the home care program. A family member and/or a primary caregiver should be proficient in the tasks necessary to care for the beneficiary at home to ensure care is not interrupted due to the inability of the provider to render services on a given day or for a certain period of time. This proficiency requirement may be satisfied by training as necessary to safely carry out the plan of treatment and/or by providing direct care to the beneficiary on an ongoing basis. The involvement of the family and/or the primary caregiver helps to ensure a safe home program for the beneficiary.

- Services are authorized through appropriate licensed and certified Medi-Cal providers or waiver specific providers. The provider type may include licensed and certified home health agencies, private duty nursing agencies, individual licensed registered nurses or licensed vocational nurses, and unlicensed caregivers.
- Prescribed by the beneficiary's primary care physician in accordance with regulations outlined in CCR, Title 22, Division 3.
- Provided in the beneficiary's home that has been assessed to be a safe environment. Home may include congregate living health facilities, Type A.

Nursing Facility (NF) Subacute Waiver

- Subject to prior authorization.
- Designed for persons who are physically disabled and in the absence of the waiver would be expected to require at least 180 days or more of nursing facility care. The levels of service under the NF Subacute are the adult subacute and pediatric subacute.
- Beneficiary must be Medi-Cal eligible. This can be established in one of two ways:
 - **community deeming** rules/requirements, i.e., the regular financial rules for Medi-Cal eligibility;
 - **institutional deeming** rules/requirements, i.e., the individual is assessed to be Medi-Cal eligible “as if” he/she were in a long-term care facility.
- Authorized services must be **cost-effective** to the Medi-Cal program. This means that the total cost of providing NF Subacute waiver services and all other medically necessary

Medi-Cal services to the beneficiary must be less than the total cost incurred by the Medi-Cal program for providing care to the beneficiary at the otherwise appropriate nursing facility. The subacute nursing facility levels of care are defined in CCR, Title 22, Division 3, Sections 51124.5, 51124.6, and the Medi-Cal Manual of Criteria.

- NF Subacute waiver services include: case management, RN or LVN private duty nursing services, home health aide services, shared nursing services, waiver service coordination, minor home modifications such as grab-bar placement or ramps, utility coverage for life-sustaining equipment, personal emergency response systems, family training, personal care services, and respite.
- Implementation of NF Subacute waiver services also involves the active participation of the family and/or primary caregiver in the home care program. A family member and/or a primary caregiver should be proficient in the tasks necessary to care for the beneficiary at home to ensure care is not interrupted due to the inability of the provider to render services on a given day or for a certain period of time. This proficiency requirement may be satisfied by training as necessary to safely carry out the plan of treatment and/or by providing direct care to the beneficiary on an ongoing basis. The involvement

of the family and/or the primary caregiver helps to ensure a safe home program for the beneficiary.

- Services are authorized through appropriate licensed and certified Medi-Cal providers or waiver specific providers. The provider type may include licensed and certified home health agencies, private duty nursing agencies, individual licensed registered nurses or licensed vocational nurses, and unlicensed caregivers.
- Prescribed by the beneficiary's primary care physician in accordance with regulations outlined in CCR, Title 22, Division 3.

Provided in the beneficiary's home that has been assessed to be a safe environment. Home may include congregate living health facilities, Type A.

*** All Waiver Services require prior authorization ***

The following are the definitions of the services offered under the NF A/B and NF Subacute Waivers:

CASE MANAGEMENT:

- Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. These services are provided in cooperation with the Department of Health Services (DHS), Medi-Cal Operations Division (MCO), In-Home Operations (IHO).
- The following persons may provide case management services:
 1. A Registered Nurse (RN) employed by a home health agency (HHA) or a Private Duty Nursing Agency (PDNA);
 2. A RN, also known as an Individual Nurse Provider (INP), under the direction of a licensed physician;
 3. An individual who is licensed and certified by the State of California such as Marriage, Family, Child Counselor (MCFF), Clinical Psychologist, or Licensed Clinical Social Worker (LCSW); or
 4. An entity or organization that is licensed and certified by the State of California to provide the services of a MFCC, Clinical Psychologist, or LCSW.
- Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care/plan of treatment (POT) and Menu of Home and Community-Based Services Waiver Service (MOHS) Form.
- The waiver service providers for case management will have responsibility for the ongoing, routine aspects of waiver services being provided in the home. They will have the direct contact with the beneficiary and, as applicable, the assigned nursing staff and the physician; will oversee the implementation and evaluation of all services identified in the POT and offered in the MOHS. Case management responsibilities include assessing, care planning, authorizing, locating,

coordinating and monitoring a package of long- term care services for community-based clients.

- Case management services may begin up to 180 days prior to discharge from an institution. All services provided will be billed against the waiver on the date of discharge. If the beneficiary should decease before discharge, all services provided may be charged to the waiver on the date of death.

PERSONAL CARE SERVICES:

NOTE: The beneficiary must be enrolled in the State Plan Personal Care Services Program in order to access waiver personal care services.

- Services which provide assistance with eating, bathing, dressing, personal hygiene, and activities of daily living; includes hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual and may include skilled or nursing care to the extent permitted by law. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care/plan of treatment, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.
- Personal care companions to provide non-medical care, supervision and socialization provided to a functionally impaired adult. Personal care companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The personal care companion may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.
- To the extent that the waiver participant is willing and able, they will be allowed to manage their personal care services to the extent of their capability.
- Personal care providers may be members of the individual's family. Payment may be made for services furnished to a minor by the child's parent (or stepparent), or to the individual's spouse. Legally responsible

individuals (parents of minors, spouse) may be used in the event there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained. MCOB-IHO may require additional documentation to support requests of this nature.

- Personal Care services may also be provided by Home Health Agency staff or Service Agencies employing personal care providers.
- Supervision of personal care providers may include:
 1. Case managers as described under the Case Management Services, if applicable
 2. The beneficiary or the service agency/applicable county agency employing the unlicensed caregiver
- If a HHA/PDCA participates in the home care plan for the beneficiary, but does not employ the personal care services provider, then the HHA/PDCA nurse is not responsible for the monitoring or supervision of the personal care services provider when the beneficiary is receiving State Plan or Waiver Personal Care Services. However, the HHA/PDCA nurse is responsible for monitoring the health, safety, and welfare of the waiver beneficiary. In this regard, the HHA/PDCA nurse discusses with the beneficiary their health and the care being provided. The HHA/PDCA nurse is required, depending on the circumstances, to report to Adult Protective Services, Child Protective Services or to the beneficiary's physician, any areas of concern regarding a beneficiary's health, safety and welfare, including any sign or symptom requiring professional evaluation or care.
- If an INP participates in the home care plan for the beneficiary, then the INP is not responsible for the monitoring or supervision of the personal care services provider when the beneficiary is receiving State Plan or Waiver Personal Care Services. However, the INP is responsible for monitoring the health, safety, and welfare of the waiver beneficiary. In this regard, the INP discusses with the beneficiary their health and the care being provided. The INP is required, depending on the circumstances, to report to Adult Protective Services, Child Protective Services or to the beneficiary's physician, any areas of concern regarding a beneficiary's health, safety and welfare, including any sign or symptom requiring professional evaluation or care.
- Waiver personal care services shall be rendered by a provider subject to the informed consent of the beneficiary or the authorized representative, and shall be obtained as a part of the order for service, pursuant to W&I

Code sections 12300, et seq. and 14132.95. Training requirements for unlicensed caregivers will be the primary responsibility of the beneficiary with support from the primary care physician and/or medical team, any identified nursing support and appropriate MCOI-IHO staff. As requested, MCOI-IHO staff will work with the beneficiary in assisting them with questions/concerns that may arise regarding hiring, training and supervision of unlicensed caregivers. Referrals will also be made back to the county of residence or other local programs for assistance in this area.

- As part of the eligibility criteria for waiver personal care services only, the beneficiary shall receive periodic case management visits from an identified waiver case management service provider, at prescribed intervals to be determined by the physician to ensure health and safety. As warranted, intermittent nursing services may be authorized through the State Plan benefit.
- Personal care service providers may be paid while the beneficiary is hospitalized up to 7 days per each hospitalization. This payment is necessary to retain the care provider for services when the beneficiary returns home. During these time periods, the personal care services provider will provide written documentation to MCOI/IHO as to the activities performed. Appropriate activities may include care and maintenance of the home environment, running errands for the beneficiary which will facilitate the return home and checking mail.

RESPIRE CARE:

- Intermittent or regularly scheduled temporary medical care and supervision provided in the beneficiary's own home or in an approved out-of-home location to do all of the following:
 1. Assist family members in maintaining the beneficiary at home;
 2. Provide appropriate care and supervision to protect the beneficiary's safety in the absence of family members;
 3. Relieve family members from the constantly demanding responsibility of caring for a beneficiary; and
 4. Attend to the consumer's medical needs and other activities of daily living, which would ordinarily be performed by the service provider or family member.
- Respite care may be provided in the following location(s):
 1. Individual's home or place of residence

2. Medicaid certified NF A or B facility or Subacute (Adult or Pediatric) Facility

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS:

- Those physical adaptations to the home, required by the individual's plan of care/plan of treatment and selected in the MOHS, which are necessary to ensure the health, welfare and safety of the individual; or which enables the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
- Requests for any and all modifications to a residence which is not the property of the waiver recipient, shall be accompanied by written consent from the property owner for the requested modifications. Environmental modification services are payable one time only to a maximum amount of \$5,000.
- The only exceptions to the one time, \$5,000 maximum are if:
 1. The recipient's place of residence changes; or
 2. In the opinion of the DHS-MCOD nurse case manager, and based upon review of appropriate documentation, the waiver beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary; or are necessary to enable the beneficiary to function with greater independence in the home and without which, the recipient would require institutionalization.
- Absent written authorization from the owner, environmental accessibility modifications will not be authorized or be subject to compensation for residential care providers or rental units. To the extent possible, modifications will be made to the residence prior to occupation by the beneficiary. Upon commencement of the modification, all parties will receive written documentation that the modifications are permanent, and

that the State is not responsible for removal of any modification if the beneficiary cease to reside at a residence which is rental property.

- All requests for environmental accessibility modifications submitted by a provider should include the following information:
 1. Physician's order specifying the requested equipment or service;
 2. Physical Therapy evaluation and report to assess the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The Physical Therapy evaluation and report should contain at least the following information:
 - a. An assessment of the beneficiary and the current equipment needs specific to the individual, describing how/why the current equipment does or does not meet the needs of the beneficiary.
 - b. An assessment of the requested equipment or service and description how/why it is necessary for the beneficiary. This should include the ability of the beneficiary and/or the primary caregiver to learn about and appropriately use any requested item.
 - c. Description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the beneficiary and a description of the inadequacy.
 3. Medical Social Worker evaluation and report to assess for other community resources available to provide the requested equipment or service, the availability of the other resources, and any other pertinent recommendations related to the requested equipment or service. This should include the description of the availability of Other Health Care (OHC) coverage to provide for the requested equipment or service.
 4. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the beneficiary, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the beneficiary will still be necessary describing how and why the equipment or service meets the needs of the individual.
 5. If possible, include a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor and applicable warranties. Providers may include Durable Medical

Equipment companies; licensed contractor's or professional organizations

6. The MCOD nurse case manager will take the appropriate action on the TAR after all requested documentation has been received, reviewed, and a home visit has been conducted by appropriate program staff to determine the suitability of any requested equipment or service.

- Because of the maximum allowed cost of \$5,000 for an adaptation, the use of this service may result in a reduction in the amount of other services the beneficiary may receive in the year the adaptation is authorized. Since the waiver must remain cost neutral, it is very important that the fiscal impact of this service be clearly understood by the beneficiary at the time of request for the accessibility adaptation and before the authorization of the modification service.

PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

- PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided as a waiver service to a beneficiary residing in a non-licensed environment. All types of PERS, described below, shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible.

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders
7. Monitoring services
8. Light fixture adaptations (blinking lights, etc.);

9. Telephone adaptive devices not available from the telephone company;
10. Other electronic devices/services designed for emergency assistance.

PRIVATE DUTY NURSING:

- Individual and continuous care (in contrast to part time or intermittent care) provided by a licensed and certified home health agency (HHA), a private duty nursing agency (PDNA), a Congregate Living Health Facility-Type "A" (CLHF-A), a certified home health aide (CHHA) under a HHA, or individual licensed nurses within the scope of State law. These services are provided to an individual at home.

Shared Private Duty Nursing Services

1. "Shared Private Duty Nursing Services" under the waiver are provided by a licensed RN, LVN or CHHA under a HHA, PDNA, an INP or a CLHF-A in accordance with the attending physician's orders, the written plan of care/plan of treatment and the MOHS. Shared nursing is the provision of nursing services for two beneficiaries who live in the same residence and share a nurse amongst themselves, i.e., one nurse for two beneficiaries. This service will only be provided upon request by the beneficiary or his/her authorized representative.

FAMILY TRAINING:

- Training and counseling services for the families of individuals served under the waiver. For purposes of this service "family" is defined as:
 1. The persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws, and
 2. May include other responsible persons who agree to act as an uncompensated caregiver in the absence of a waiver service provider.
- "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care/plan of treatment.
- Family training services shall be rendered by a Registered Nurse. The MCOB/IHO staff will review training and its appropriateness on a case

by case basis and will include follow-up on training for all beneficiaries and their families during scheduled on-site visits to the home.

UTILITY COVERAGE

- Electric services necessary to prevent reinstitutionalization for waiver beneficiaries who are dependent upon medical technology. Utility coverage must be included in the POT and the MOHS.
- There is a minimum monthly amount of \$20.00 that must be reached before this service will be authorized. When the minimum amount has been reached, the waiver will reimburse the beneficiary all charges up to a monthly maximum amount of \$75.00.
- Utility coverage is limited to that portion of the utility bills directly attributable to operation of life-sustaining medical equipment in the beneficiary's place of residence. For purposes of the waiver, "life sustaining medical equipment" is defined as: mechanical ventilation equipment and other respiratory therapy equipment, suction machines, cardiorespiratory monitors, feeding pumps, and infusion equipment. Notwithstanding this definition, in the event a specific medical need is identified in the POT, a consultation between the IHO Nurse Case Manager and the IHO program consultants (medical or nursing) will evaluate requests for and may grant exceptions to this definition.
- Utility coverage is provided through the local utility company. The waiver service provider will submit a request for the authorization of this service. ***Upon receipt of payment for any claim for this service, the waiver service provider will then give the monies to the beneficiary.***
- In order to calculate the cost per unit of time, the authorization for waiver utility services includes consideration of the type of equipment and frequency of use. Cost factors to operate electrical equipment are supplied by utility companies and are based on a consideration of the equipment's size, voltage requirement and amperage requirement. Upon identifying the power requirements of the equipment and the utility rates per kilowatt-hour, MCOB/IHO can estimate the cost of operation of the equipment to within a few cents per unit of time.
- The waiver service provider is responsible for assuring notification to utility providers that services are being provided to an individual dependent upon life sustaining medical equipment. Documentation indicating this notification has been made and, as appropriate, revised shall be kept in the beneficiary's medical record in the provider's files.

WAIVER SERVICE COORDINATION

- This service will include educating the beneficiary and/or caregivers about the different funding sources which could include Medi-Cal related services, California Children's Services for individuals under the age of 21, Regional Center, Department of Rehabilitation, county funded services, Medicare, private insurance; and helping to assist the beneficiary and/or caregivers in understanding the various services he/she is receiving or may receive and the impact, if any, of the services received/requested, based on the source of funding. Waiver Service Coordination will supplement the case management activities authorized under this waiver or through other entities including the state plan benefit of targeted case management.

Service Providers Include:

3. Individuals who meet the same standards as those who provide waiver case management services.
 4. Members of the individual's family.
- This may be the parents of a minor or the spouse of the individual. Legally responsible individuals may be used in the event there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by using this individual. MCOB-IHO may require additional documentation to support requests of this nature.

Justification:

- Criteria for service provider(s) will include written documentation of experience in coordinating such services and how they will coordinate the waiver services with other services received by the beneficiary. This documentation will be included on the plan of treatment and updated as needed. Must include service coordination beyond the use of Medi-Cal linked services and Regional Center services.

INDIVIDUAL NURSE PROVIDERS

5. "Individual nurse provider" means a Registered Nurse or a Licensed Vocational Nurse, who provides individual nurse provider services, as defined in subsection I-III below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization. An individual nurse provider may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual. Legally responsible individuals may be used for this service in the event there are no other available providers, the individual lives in a rural area or

the cost neutrality for waiver services can be established and/or maintained by using this individual. MCOI-IHO may require additional documentation to support requests of this nature.

6. "Private duty nursing services" means services provided by a Registered Nurse or a Licensed Vocational Nurse, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.
7. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the beneficiary such as wound or pain management.
8. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the registered nurse (RN) or the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure/process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the plan of treatment. This evaluation would need to be documented and provided to MCOI-IHO as indicated.

Requirements of the individual Nurse Provider:

I. Registered Nurse (RN) acting as the direct care provider:

The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:

Current license to practice as an RN in the State of California.

Current Basic Life Support (BLS) certification.

Written evidence, in a format acceptable to the Department, of training or experience, which shall include at least one of the following:

A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and plan of treatment. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit; for subacute cases, the 500 hours shall be in an intensive care unit.

A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and plan of treatment.

A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and plan of treatment.

A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of the Department, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and Plan of Treatment.

Detailed plan of treatment that reflects appropriate nursing assessment of the beneficiary, appropriate interventions, and the physician's orders.

The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the beneficiary's medical condition and care need(s).

The plan of treatment shall be signed by the beneficiary, the RN and the beneficiary's physician, and shall contain the dates of service.

Signed release form from the beneficiary's physician, which shall specify both of the following:

The physician has knowledge that the RN providing care to the beneficiary is doing so without the affiliation of a home health agency or other licensed health care agency of record.

The physician is willing to accept responsibility for the care rendered to the beneficiary.

Written home safety evaluation, in a format acceptable to the Department that demonstrates that the beneficiary's home environment supports the health and safety of the individual. This documentation shall include all of the following:

The area where the beneficiary will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

The home is in compliance with local fire, safety, building and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the plan of treatment, are in place and available in working order, or have been ordered and will be in place at the time the beneficiary is placed the home.

Medical information which supports the request for the services. May include nursing notes, facility discharge planning notes or a history and physical completed by the beneficiary's physician

All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

Evidence of renewal of BLS certification and RN licensure prior to expiration.

Written evidence, in a format acceptable to the Department, of ongoing education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

Written evidence, in a format acceptable to the Department, of ongoing contact with the beneficiary's physician for the purpose of informing the physician of the individual's progress, updating or revising of the plan of treatment, and renewal of physician orders.

Updated plan of treatment that reflects ongoing nursing assessment and interventions, and updated physician orders. The updated plan of treatment shall be signed by the beneficiary's physician, the RN, the beneficiary and will contain the dates of service.

II. RN supervisor acting as the supervisor for an individual nurse provider who is a Licensed Vocational Nurse (LVN):

The initial TAR shall be accompanied by all of the following documentation:

Current license to practice as an RN in the State of California.

Current BLS certification.

Written evidence, in a format acceptable to the Department, of training or experience, as specified in section I.A.3 a-d.

Written evidence, in a format acceptable to the Department, of training or experience providing supervision or delegating nursing care tasks to an LVN or other subordinate staff.

Detailed plan of treatment, as specified in section I.A.4 a-b.

Written summary, in a format acceptable to the Department, of nursing care tasks that have been delegated to the LVN.

All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

Evidence of renewal of BLS certification and RN licensing prior to expiration.

Written summary, in a format acceptable to the Department, of all supervisory activities which shall include all of the following:

Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

The training provided to the LVN, as needed, to ensure appropriate care to the beneficiary for whom services have been requested.

Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

Any change in the nursing care tasks delegated to the LVN.

Updated plan of treatment, as specified in section I.A.7d.

III. LVN acting as the direct care provider:

The initial TAR shall be accompanied by all of the following documentation:

Current license to practice as an LVN in the State of California.

Current BLS certification.

Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

Written evidence, in a format acceptable to the Department, of training or experience, as specified in section I.A.3 a-d.

Copy of the detailed plan of treatment that reflects the RN nursing assessment of the beneficiary and the physician's orders. The plan of treatment shall be signed by the supervising RN, the beneficiary's physician, the beneficiary, and the LVN.

Written home safety evaluation, in a format acceptable to the Department, as specified in section I.A.6 a-d.

Medical information, as specified in section I.A.6 e.

All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

Evidence of renewal of BLS certification and LVN licensure prior to expiration.

Written evidence, in a format acceptable to the Department, of ongoing education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

Copy of the updated plan of treatment that reflects ongoing RN nursing assessment and updated physician orders. The plan of treatment shall be signed by the supervising RN, the beneficiary's physician, the beneficiary, and the LVN, and shall contain the dates of service.

IV.A TAR, or similar request must be approved in advance by MCOI-IHO and shall be required for each individual nurse provider service request. Initial authorization shall be granted for a period of up to 90 days, and reauthorization shall be granted for periods of up to 180 days.

V. The individual nurse provider shall agree to notify MCOI-IHO and the beneficiary or his/her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the individual nurse provider intends to terminate individual nurse provider services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the beneficiary, as determined by the MCOI-IHO.

ROLES AND RESPONSIBILITIES OF THE MCOI/IHO CASE MANAGERS:

- MCOI/IHO Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care and MOHS.
- Additional responsibilities will include ensuring the services provided by the waiver service provider are in accordance with State and federal guidelines, the determination of the initial and ongoing Level of Care (LOC), review of the POT, and review of the MOHS; utilization review of authorized State Plan and waiver services as outlined in Title 22, California Code of Regulations (CCR), Section 51003; and routine follow-ups with the waiver service case manager to:
 - Determine whether the authorized waiver services are appropriate and meet the identified needs of the beneficiary;
 - Ensure LOC determinations are accurate;
 - Identify, resolve, or ensure a plan is in place for resolution of issues affecting the beneficiary;
 - Review and authorize requests for waiver services and appropriateness of State Plan services as indicated in the POT/ MOHS;
 - Review the cost neutrality of the program.
- MCOI case management will be accomplished through the use of regular telephone contact with the waiver service case manager; home visits to the beneficiary at least every six months; and yearly, or more frequent as appropriate, provider case conferences.

Attachment B

APPLICATION FOR WAITING LIST FOR THE MEDICAL NURSING FACILITY WAIVERS

Attachment C

HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER QUESTIONNAIRE

Application for Waiting List for the Medi-Cal Nursing Facility Waivers

Date: _____

Mail to: Intake - In Home Operations/Medi-Cal
Home & Community Services Branch
1501 Capitol Avenue, Building 171
Mail Stop 4502
P.O. Box 942732
Sacramento CA 94234-7320

Or fax to (916) 552-9151

My name: _____

Contact Name &
Phone _____

Address: _____

Telephone: _____ SSN: _____

____ I currently receive Medi-Cal personal care services (IHSS).

____ I am married and want to qualify for Medi-Cal through the rules that apply when one spouse is in a nursing facility and the other in the community.

Please put me on the waiting list for Nursing Facility waiver services and let me know where I am on the list (how many people ahead of me). Please also give me your estimate about when you would get to me so I know how long I have to wait.

Signature: _____

Application for Waiting List for the Medi-Cal Nursing Facility Waivers

Date: _____

Mail to: Intake - In Home Operations/Medi-Cal
Home & Community Services Branch
1501 Capitol Avenue, Building 171
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Please put me on the waiting list for Nursing Facility waiver services and let me know where I am on the list (how many people ahead of me). Please also give me your estimate about when you would get to me so I know how long I have to wait.

Signature: _____



Home and Community-Based Services (HCBS) Waiver Questionnaire

- Para recibir esta información en español, por favor llámenos a uno de los números siguientes: (916) 552-9105.

To assist In-Home Operations (IHO) in assessing your medical needs for HCBS waiver services, please complete this two-page form and return by mail to IHO within 10 days upon receipt. You may write additional comments on the back of these pages. If you need help filling out this form, please call IHO at (916) 552-9105.

Beneficiary's Name: _____ SSN: _____ Today's Date: _____

Beneficiary's Date of Birth: _____ Home Phone: () _____ Married: Yes No

Medical Insurance: Medi-Cal Medicare Other _____

_____ () _____

Person completing this form if other than the beneficiary Relationship to the
beneficiary Home or Business Phone

List current medical diagnoses (main illness or injury) below:

Primary _____

Secondary _____

Additional _____

Check the boxes that identify your current medical needs. Use the blank spaces below to write in your specific medical needs that are not listed.

- | | |
|---|--|
| <input type="checkbox"/> Ventilator -Hours Used Per Day (hrs/day) _____ | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Continuous Positive Airway Pressure (CPAP) Device -hrs/day _____ | <input type="checkbox"/> Tracheal Suctioning |
| <input type="checkbox"/> Bi-Level Positive Airway Pressure (BiPAP) Device -hrs/day _____ | <input type="checkbox"/> Oral Suctioning |
| <input type="checkbox"/> Respiratory Treatments - number per day _____ | <input type="checkbox"/> Nasal Suctioning |
| <input type="checkbox"/> Pulse Oximetry , | <input type="checkbox"/> Oxygen as needed |
| <input type="checkbox"/> Continuous Oxygen | |

- | | | |
|--|---|---|
| <input type="checkbox"/> Oral (by mouth) Medications | <input type="checkbox"/> Oral (by mouth) Feedings | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Gastric Tube (GT) Medications | <input type="checkbox"/> Gastric Tube (GT) Feedings | <input type="checkbox"/> Bladder Catheterizations |
| <input type="checkbox"/> Intravenous (IV) Medications | <input type="checkbox"/> Intravenous (IV) Nutrition | <input type="checkbox"/> Bowel Incontinence |
| <input type="checkbox"/> Chronic Pain Treatment | <input type="checkbox"/> Pressure Sores/Open Wounds | <input type="checkbox"/> Routine Bowel Care |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Skin or Wound Treatments | <input type="checkbox"/> Urostomy/Colostomy |

- | | |
|--|--------------------------------|
| <input type="checkbox"/> Some ability to move arms or legs. Needs some help with care needs. | Briefly explain on back. |
| <input type="checkbox"/> No movement of an'r1s or legs. Needs total help with care needs. | Briefly explain on back. |
| <input type="checkbox"/> Special equipment needs. {ex: wheelchair, lift system, ramp) , | Briefly explain on back. |
| <input type="checkbox"/> Other _____ <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
- (write additional comments on back)

HCBS Waiver Questionnaire *continued*

Please identify all of your current providers of service:

In-Home Supportive Services (IHSS) - Hours Authorized Per Month: _____

California Children's Services (CCS) - Please check the CCS services received:

Physical Therapy Occupational Therapy Speech Therapy Medical Social Worker

Regional, Center - Name: _____ Respite Hours Authorized per Quarter: _____

Adult or Pediatric Day Health Care - Name: _____ Days per week: _____

Other: _____

Do you attend school outside of the home? Yes No

If yes, how many days/week do you attend school? _____ How many hours/day? _____

Does the school provide medical assistance for you? (Ex.: attendant worker) Yes No

Please list other agencies or health programs you have contacted to request assistance with home care: (Ex.: Intermittent Home Health Agency services, Outpatient Services, etc.)

Are you aware of the following programs that provide in-home assistance to Medi-Cal eligible individuals?

In-Home Supportive Services (IHSS) Yes No

* Call your local county Department of Social Services office and ask for the IHSS Intake Department for eligibility information.

Program of All-Inclusive Care for the Elderly (PACE) Health Maintenance Organization Yes No

* California has four PACE sites: Los Angeles, Oakland, Sacramento, and San Francisco. If you live in one of those areas, call the local PACE center for eligibility information.

On Lok Senior Health Services	San Francisco	(415) 292-8888
Sutter SeniorCare	Sacramento	(916) 446-3100
AltaMed Senior BuenaCare	Los Angeles	(323) 980-4000
Center for Elders' Independence	Oakland	(510) 433-1150

Senior Care Action Network (SCAN) Health Maintenance Organization Yes No

* SCAN is located in four Southern California counties: Los Angeles, Orange, Riverside, and San Bernardino. Call {800} 915- 7226 for SCAN eligibility information.

In addition to the above resources, the California Department of Aging has a toll-free information and assistance line for senior services. Call {800} 510-2020 to speak with a service provider who can assess your needs and connect you with specific programs and services in your community.

Thank you for taking the time to fill out this form. When you are, finished, please return this form to IHO in the self-addressed and stamped envelope we have provided you.

Contact the Governor (information is from the Governor's webpage)
www.governor.ca.gov/state/govsite/gov_homepage.jsp (click on "contact the governor")

Governor's Office

Governor Gray Davis
State Capitol Building
Sacramento, CA 95814
Phone: 916-445-2841
Fax: 916-445-4633
<mailto:governor@governor.ca.gov>

"To help us keep track of correspondence and to ensure that we are able to respond to California residents, please be sure to include your name and address when you communicate with the Governor's Office. We do not accept e-mail attachments."

Governor's District Offices:

Fresno Office
2550 Mariposa Mall, #3013
Fresno, CA 93721
Phone: 559-445-5295
Fax: 559-445-5328

Los Angeles Office
300 S. Spring St., #16701
Los Angeles, CA 90013
Phone: 213-897-0322
Fax: 213-897-0319

San Diego Office
1350 Front St., #6054
San Diego, CA 92101
Phone: 619-525-4641
Fax: 619-525-4640

San Francisco Office
455 Golden Gate Ave., #14000
San Francisco, CA 94102
Phone: 415-703-2218
Fax: 415-703-2803

Riverside Office
3737 Main St., #201
Riverside, CA 92101
Phone: 909-680-6860
Fax: 909-680-6863

Finding your state senator and state assembly member:

Go to the website for "Official Legislative Information" – www.leginfo.ca.gov. Go to towards the bottom of the page and click on the blue box entitled "your legislature." Counting from your left, it is the 4th box across.

The page that comes up will ask you for your zip code. Enter your zip code and click on "search." The next page that comes up will list the state legislators for your zip code.