

# 4

## LONG-TERM CARE SERVICES

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# 4

## LONG-TERM CARE SERVICES

### 4.1 Introduction

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It is the responsibility of the service worker working with the adult and/or his or her representative to determine the most appropriate method of service delivery such as direct services, purchased services, or referral to another agency. This chapter identifies the primary services provided by local Adult Services programs and describes the responsibilities of the local department of social services (LDSS) in relation to other agencies.

### 4.2 Home-Based Care Services to adults

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#### 4.2.1 Home-Based Care Services defined

Home-Based Care Services consist of three components: Companion, Chore, and Homemaker services.

Each local board shall provide for the delivery of at least one of these services to the extent that federal and/or state matching funds are made available. The local board shall determine which of the three services is offered (§§ 63.2-1600 and 51.5-146 of the Code of Virginia).

The local board shall develop a home-based care policy including criteria for receiving home-based services, financial eligibility criteria, which home-based service(s) will be provided, and how an assessment will be conducted to determine the number of approved hours. The policy shall be reviewed by an Adult Protective Services (APS) Division Regional Consultant prior to board approval.

#### 4.2.2 Purpose of Home-Based Care Services

Home-Based Care Services are used for the following purposes:

- To provide protection to adults or prevent abuse, neglect, or exploitation.

- To assist adults in attaining or retaining self-care, self-sufficiency, and independence.
- To prevent inappropriate institutionalization.

### **4.2.3 Eligibility for Home-Based Care Services**

#### **4.2.3.1 Financial eligibility**

Eligible individuals are adults who meet financial eligibility criteria contained in Chapter 3, Adult Services Case Management and local board policy, and who are assessed to need the service.

#### **4.2.3.2 Living arrangements**

An adult is eligible to receive Home-Based Care Services if one of the following conditions is met:

- The home is owned in full or in part by the adult; or
- The rent or mortgage and utilities, etc. are paid in the adult's name; or
- The rent or mortgage, utilities, household expenses, etc., are shared between the adult and others; or
- The adult lives in the home of a relative, friend, roommate, or other housing situation; or
- The adult does not live in a residential care setting such as a nursing facility, assisted living facility, or a hospital.

#### **4.2.3.3 Prioritizing need for Home-Based Services/waiting lists**

When funds are inadequate to maintain the level of services or to increase service delivery as needed, the LDSS shall develop criteria for prioritizing need and/or establish a waiting list. The LDSS shall apply waiting list criteria uniformly to all adults requesting the service. The LDSS should review and update waiting lists at least annually.

#### **4.2.3.4 Temporary reduction or termination of SSI**

In cases where the Social Security Administration (SSA) or the LDSS has made an error that requires a temporary reduction or temporary termination of an individual's SSI payment due to an overpayment, the adult may continue to be eligible for service as an SSI recipient. The case record shall identify error(s)

resulting in overpayment, who was responsible for the error(s), and what affect the error(s) had on the adult's SSI benefits.

#### **4.2.4 Criteria for Companion Services**

##### **4.2.4.1 Definition**

Companion Services are performed by an individual or an agency provider who assists adults unable to care for themselves without assistance and where there is no one available to provide the needed services without cost. Individuals must meet the eligibility requirements in Section 4.2.3. Companion activities include, but are not limited to:

- Bathing.
- Dressing.
- Toileting.
- Eating/feeding.
- Transportation.
- Meal preparation.
- Shopping.
- Supervision.
- Light housekeeping.
- Companionship.
- Household/financial management.

##### **4.2.4.2 Provision of Companion Services**

- A parent, spouse, or other relative of an eligible adult may be approved as a companion provider if the written documentation shows that:
  - He or she is the most available and/or qualified person to provide the service.
  - He or she is unable or unwilling to provide these services free of charge.

- In the professional judgment of the worker, this would be the best plan of care for the adult.
- An LDSS shall not establish policy that prohibits the utilization of a relative as a companion provider.

#### **4.2.5 Criteria for Chore Services**

##### **4.2.5.1 Definition**

Chore Services are the performance of non-routine, heavy home maintenance for adults unable to perform such tasks. Chore Services are provided to adults living in an independent situation who are responsible for maintenance of their residence and have no one available to provide this service without cost. Chore activities include but are not limited to:

- Performing minor repair work on furniture and appliances in the home.
- Carrying coal, wood, and water.
- Chopping wood.
- Removing snow.
- Yard maintenance.
- Painting.

##### **4.2.5.2 Eligible persons - Chore Services**

To qualify for Chore Services, the following information shall be documented in the case record:

- The adult is living in an independent situation and is responsible for maintenance of his or her residence.
- The adult is unable to perform the necessary heavy home maintenance task(s).

##### **4.2.5.3 Provision of Chore Services**

Chore Services shall not be purchased from a relative who is a member of the household; however, chore services may be purchased from a relative who is not a member of the household.

## **4.2.6 Criteria for Homemaker Services**

### **4.2.6.1 Definition**

Homemaker Services are performed by an individual or an agency provider who provides instruction in (or, where appropriate, performs) activities to maintain a household. The activities include:

- Personal care.
- Home management.
- Household maintenance.
- Nutrition.
- Consumer education.
- Hygiene education.

### **4.2.6.2 Provision of Homemaker Services**

- Homemaker Services may be provided directly by staff of the LDSS.
- Services provided by all homemaker providers shall be supervised and monitored by the service worker or supervisor.
- The adult receiving care shall meet the requirements of Section 4.2.3.

## **4.2.7 Assessment required for Home-Based Care Services**

### **4.2.7.1 Use of Virginia Uniform Assessment Instrument**

The LDSS shall use the Virginia Uniform Assessment Instrument (UAI) to assess the need for home-based services. The UAI shall be completed in PeerPlace.

### **4.2.7.2 Assessment procedure**

Each LDSS shall establish a procedure for conducting a home-based care assessment to determine the required number of service hours for each adult. The method used to determine the amount of services to be provided shall be approved by the local board and uniformly applied within each LDSS. Services should not be authorized prior to the date of assessed need. Any change in authorized hours shall be documented on an assessment form. The home-based care assessment shall be completed as needed, but at least annually for each adult receiving home-based services.

#### **4.2.7.3 Types of services**

As part of the assessment, informal services (e.g., family, friends, community groups) and formal services shall be explored that could help meet the adult's needs. Home-based services may be used to complement informal and/or formal service providers, or they may be the only service provided to the individual.

#### **4.2.7.4 Duplication of service activities**

An adult receiving home-based services may be assessed by the screening team for nursing facility admission or community-based care when he or she is at risk of institutionalization. Although an adult may receive services from both home-based services and a Medicaid waiver simultaneously in order to meet his or her needs, duplication of service activities shall be avoided. The service plan should document services provided by the LDSS and other providers. Service plans should be developed in coordination with other providers when possible.

### **4.2.8 Service delivery – Home-Based Care Services**

#### **4.2.8.1 Maximum hours**

Each LDSS shall establish local board policy to specify the maximum number of hours of home-based services that may be provided per adult per week.

#### **4.2.8.2 Provider pay rate**

Each LDSS shall establish local board policy to specify the rate of pay for providers. Home-based providers shall be paid at least minimum wage.

#### **4.2.8.3 Methods of service delivery**

Services are provided directly, by referral, or by purchase as required to ensure appropriate service delivery and resource utilization necessary for the implementation of the service plan.

#### **4.2.8.4 LDSS responsibility**

When home-based services are contracted out to other agencies (i.e., not managed directly by the LDSS), the LDSS continues to be responsible for ensuring that the UAI and any needed reassessments are completed as well as ensuring compliance with other requirements noted in this section.

#### **4.2.8.5 Licensing standards**

Home-based services shall be purchased from providers who are approved as meeting the standards in 22 VAC 30-120 and Chapter 5 Adult Services Approved

Providers or by demonstration of appropriate licensure through a licensing authority.

#### **4.2.8.6 Minimal safety standards**

If the adult's living situation does not meet minimal standards of safety (such as is required for the provision of Medicaid-funded long-term care services and supports), the LDSS cannot deny services to the adult. However, the situation may preclude a provider from entering the home.

#### **4.2.9 Receiving Home-Based Care Services and Medicaid Waiver Services**

Eligibility for home-based care does not necessarily preclude an adult's eligibility for another services through a Medicaid waiver.

The LDSS shall not deny or terminate home-based services solely because the adult is eligible for or receiving a Medicaid waiver. Before an LDSS terminates home-based services, the LDSS shall ensure that the individual will receive the Medicaid waiver hours necessary to meet the individual's needs. The LDSS may terminate home-based services if the combination of support systems and Medicaid waiver can meet the adult's assessed needs.

The LDSS cannot deny home-based services based on the home-based services provider's level of training, education, or professional credentials as long as the provider can meet the needs of the adult and meets standards established in 22 VAC 30-120 and Chapter 5.

If an adult is eligible for other services (such as a Medicaid waiver), but cannot afford the co-payment or chooses home-based services in lieu of Medicaid waiver, the LDSS cannot deny services to that adult if he or she meets eligibility requirements for the requested service(s) and funding for services is available.

#### **4.2.10 The LDSS as the adult's fiscal agent**

See Chapter 5 for information on the relationship between local department-approved providers of home-based services and the adult receiving care. Neither the state nor the LDSS is the provider's employer.

### **4.3 Adult Day Services**

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#### **4.3.1 Definition – Adult Day Services**

Adult Day Services is the purchase of day services from approved providers or licensed providers for a portion of a 24-hour day. Adult Day Services include personal supervision of the adult and promotion of social, physical, and emotional well-being through companionship, self-education, and leisure activities.

#### **4.3.2 Eligible individuals - Adult Day Services**

Eligible individuals are those adults who meet financial eligibility criteria contained in Chapter 3 and local board policy, and who fall within all of the following categories:

- The adult has been assessed using the Virginia UAI as needing assistance with ADLs, IADLs, and/or supervision.
- The adult is in a family situation where the people normally responsible for his or her care are not available to provide such care.
- The adult does not live in an assisted living facility, nursing facility, hospital, or other institution.

#### **4.3.3 Purchase components - Adult Day Services**

The following are purchase components for Adult Day Services:

- Registration required by facilities when not a part of unit cost.
- Transportation to and from center or home.
- Day services provided by a licensed or an approved provider.

#### **4.3.4 Providers - Adult Day Services**

Adult Day Services providers are either:

- Licensed by VDSS, Division of Licensing Programs; or
- Approved by the LDSS. The provider and home shall meet the standards found in Chapter 5, Adult Services Providers.

#### **4.3.5 Rates of payment - Adult Day Services**

Rates of payment for services shall be negotiated by the LDSS on an individual basis with each vendor according to guidance regarding governing purchase of services or by the rate-setting process for department-approved providers by the local board.

#### **4.3.6 Service requirements - Adult Day Services**

The entire UAI shall be completed to begin this service and shall be updated at least annually.

## **4.4 Adult Foster Care (AFC)**

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### **4.4.1 Definition – AFC**

AFC is an optional local program that provides room and board, supervision, and special services to an adult who has a physical or mental health need (§ 63.2-1601 of the Code of Virginia). The adult shall be assessed prior to AFC admission using the Virginia UAI. The adult shall meet residential level of care criteria at a minimum. AFC may be provided for up to three adults by any one provider. Care provided for more than three adults requires licensure by VDSS as an assisted living facility.

The provision of an AFC program shall be approved by the local board of social services before services can be provided. There shall be local board policy addressing the provision of AFC when this option is chosen. A facility cannot be referred to as an AFC home unless it has been approved by the LDSS. Approved AFC providers are bound by the department-approved provider standards located in Chapter 5 and regulations (22 VAC 30-120).

The LDSS shall only approve AFC homes in which it will make placements. The LDSS may not approve AFC homes for placements by other agencies. LDSS may collaborate with community services boards (CSB) regarding the provision of AFC. See Section 4.4.7 for additional information.

### **4.4.2 Eligible individuals/payment sources - AFC**

#### **4.4.2.1 Local-only funding eligibility**

Eligible individuals are those adults who meet financial eligibility criteria contained in Chapter 3 and local board policy, and who are assessed to need the service.

#### **4.4.2.2 Auxiliary Grant (AG) eligibility**

Eligible individuals are those adults who meet the criteria for a payment under the AG Program (to be determined by the eligibility worker), and local board policy, and who are assessed to need the service.

#### **4.4.2.3 Private pay**

Eligible individuals are those adults who are incapable of independent living or unable to remain safely in their own homes and have the resources to pay for a private placement in an approved AFC home. This option should be outlined in the LDSS's AFC local policy and approved by the local board of social services.

### **4.4.3 LDSS services - AFC**

Services that the LDSS shall provide as part of AFC are:

#### **4.4.3.1 Recruitment, screening, and approval of AFC homes**

The intent of the AFC program is to keep the adult in his or her own community. The recruitment of AFC homes and the placement of adults are limited to bordering city/county jurisdictions, so long as the adult's specified needs can be met in the AFC home.

Prior to the recruitment and approval of AFC homes and the placement of an adult in another bordering jurisdiction, there shall be a written agreement between the placing and receiving jurisdictions. A sample "Interagency Agreement" is available on FUSION.

Refer to Chapter 5 for additional information on recruitment, screening, and approval.

#### **4.4.3.2 Assessment using the UAI**

The service worker conducting the assessment shall follow ALF assessment guidance for conducting the AFC assessment. The assessment shall be updated at least annually. The worker shall evaluate the adult's ability to perform activities of daily living, instrumental activities of daily living, manage medications, the adult's behavior pattern and orientation, and assess the availability of the informal support systems (e.g., family, friends, neighbors, community groups, etc.) to assist in meeting the adult's needs. Based on the results of the UAI assessment, the LDSS will determine if the adult's needs:

- Can be met by independent living with supportive services;
- Can be met by an AFC provider; or
- Require a higher level of care such as nursing facility.

#### **4.4.3.3 Facilitating the admission**

LDSS shall consider the following prior to the individual's admission to an AFC home:

- The adult's assessed need(s).
- Compatibility with the provider and other individuals residing in the AFC home.

- Ability of the AFC provider to provide any needed special services as identified by the assessment.

The LDSS shall arrange for any needed services from other community agencies prior to the individual's admission to the AFC home.

#### **4.4.3.4 AFC Provider Monitoring**

The LDSS shall monitor the services that are provided to the adult and the provider for ongoing compliance. LDSS staff shall visit the home of the provider as often as necessary, but at least every six (6) months. The purpose of the monitoring visit is to determine the provider's compliance with applicable requirements and the progress and well-being of the adult. The provider monitoring visits shall be documented on the "Compliance Form for Department Approved Providers," which is available on FUSION.

The LDSS will reapprove the provider prior to the end of the 24-month approval period if the provider continues to meet requirements. The LDSS shall determine and document that the provider is qualified to provide the special services required by the adult. For example, if the healthcare provider has instructed the provider on the correct procedure for dressing changes or medication management, and the provider is able to and does provide the services, then this is to be documented in the provider's record. See Chapter 5 Adult Services Providers for additional information.

#### **4.4.3.5 Ongoing contact**

The placing LDSS will maintain contact with the adult residing in AFC and the provider at least on a quarterly basis. The placing LDSS maintains responsibility for the provision of direct services, case management, ongoing supervision of the adult, and monitoring of services provided in the AFC home. The adult's case shall remain open as long as services are provided, and the service plan shall be evaluated and updated in accordance with Chapter 3, Adult Services Case Management.

#### **4.4.3.6 LDSS responsible for determining AG eligibility**

The LDSS where an individual resided prior to entering an institution or AFC is responsible for determining the individual's eligibility for AG and issuing the AG payment.

#### **4.4.3.7 AG and Medicaid waivers**

Pursuant to 12 VAC 30-120-920, individuals who are receiving AG are not eligible for Medicaid waiver services.

#### **4.4.4 Medical examination - AFC**

Each adult in an AFC home shall submit a medical statement from a licensed physician, a local health department, licensed nurse practitioner or licensed physician assistant that contains the following information:

- Date of last physical examination (must have been within 60 days of admission in AFC).
- Diagnoses of significant problems.
- Documentation that the adult is believed to be free from tuberculosis in a communicable form.
- Recommendation for care including medication, diet, and therapy(ies).

#### **4.4.5 Monthly AG Rate- AFC**

The following services are included in the AG rate paid to the AFC provider:

##### **4.4.5.1 Room and board**

- Provision of a furnished room in a home that meets applicable zoning, building, and fire safety codes.
- Housekeeping services based on the needs of the adult.
- Meals and snacks, including extra portions and special diets.
- Clean bed linens and towels as needed and at least weekly.

##### **4.4.5.2 Maintenance and care**

- Assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.
- Medication monitoring.
- Provision of generic personal toiletries including soap and toilet paper.
- Assistance with the following: care of personal possessions; care of personal funds if requested by the adult and the home's policy permits it; use of telephone; arranging transportation; obtaining necessary personal

items and clothing; making and keeping appointments; and correspondence.

- Securing health care and transportation when needed for medical treatment.
- Providing social and recreational activities as required by provider standards.
- General supervision for safety.

#### **4.4.6 AG - Adult Foster Care**

##### **4.4.6.1 Maximum rate to be paid to AFC providers**

Individuals eligible for an AG payment and approved for AFC shall pay the provider a rate not to exceed the established AG rate.

The AFC home may not request or require the receipt of any money, gift, donation, or other consideration from or on behalf of an adult as a condition of admission or continued stay. AG checks shall be provided directly to the adult or his responsible party who then pays the provider. The AFC home is required to provide each adult residing in the home, a monthly statement or itemized receipt of the adult's expenses not covered by the AG payment. Unless a guardian or conservator has been appointed by the court, the adult is free to manage his or her personal finances.

##### **4.4.6.2 Third-party payments on behalf of individuals receiving AG**

An AFC provider may accept payment by a third party for services provided to an individual receiving AG. These payments are not to be counted as income when determining eligibility for AG.

Pursuant to § 51.5-160 of the Code of Virginia, third-party payments shall be made:

- Directly to the AFC provider by the third party on behalf of the individual receiving AG;
- Voluntarily by the third party, and not in satisfaction of a condition of admission, stay, or provision of proper care and services to the individual receiving AG; and
- For specific goods and services provided to the individual receiving AG other than food, shelter, or specific goods or services required to be

provided by the AFC provider as a condition of participation in the AG program.

The AFC provider shall document all third-party payments received on behalf of an individual receiving AG, including the source and amount of the payment and the goods and services for which these payments are to be used.

Documentation shall be provided to the Department upon request. AFC providers shall provide each individual receiving AG with a written list of goods and services that are covered by the grant and a statement that the AFC provider may not charge an individual receiving AG or the individual's family additional amounts for goods or services included on such list.

#### **4.4.6.3 Room, board, supervision, and special services**

An agreement stating the amount to be paid by the adult shall be reduced to writing and fully explained to the adult. The service worker, AFC provider, and the adult residing in AFC shall sign this agreement. A sample "Agreement for AFC" is available on the VDSS internal website.

Any modifications in the amount to be paid shall be indicated on the signed agreement and initialed and dated by the service worker, the AFC provider, and the adult residing in AFC. Appropriate notification to the eligibility worker shall be made.

The adult shall retain a personal needs allowance for personal use. The amount retained shall not be less than what is allowable under the AG program.

#### **4.4.6.4 Coordinating the adult's eligibility for AG**

For an adult to be eligible for an AG payment, the following shall occur:

- Both the service worker and the eligibility worker shall coordinate efforts to determine the adult's eligibility to reside in AFC. Whoever has contact with the adult first shall refer the adult to the other.
- The service and financial eligibility determination processes shall occur simultaneously when possible. The service worker shall assess the adult's needs and arrange for the potential admission. The eligibility worker shall determine financial eligibility and shall notify the service worker of the adult's eligibility for AG.
- Upon notification that the adult is eligible for AG, the service worker shall assist with the adult's admission to the AFC. The service worker shall provide verification of the adult's admission to the eligibility worker. The

eligibility worker shall approve the case and determine the amount of the AG payment.

- See Section 4.4.3.7 for information about AG and Medicaid waiver eligibility.

#### **4.4.7 Coordination with local Community Services Boards (CSB) – AFC**

LDSS are encouraged to coordinate with CSBs in the provision of AFC to adults with mental illness and/or intellectual disability. Prior to assisting individuals who receive services from the local CSB, the LDSS shall enter into an administrative support agreement with the local CSB concerning AFC. This agreement should specify which agency will be responsible for assessment, monitoring of services, placement, and discharge services provided to an adult with mental illness and/or intellectual disability in the AFC home.

The LDSS is responsible for approving the AFC home and following the requirements of this chapter when the adult's assessment and residence in AFC is funded by the LDSS.

The LDSS has no responsibility for approving AFC homes when placement and services are provided and funded by the CSB or any other agency.

#### **4.4.8 AFC option as an option for youth transitioning from child foster care**

LDSS often struggle arranging service for foster care youth who will continue to need support as they transition out of child foster care (CFC). Locating an appropriate living arrangement for a young adult with special needs may be difficult, as most adult long-term care facilities focus on the elderly individuals with significant medical and nursing needs. An AFC program may be an appropriate option to meet the needs of these foster youth in transition.

Section 63.2-905.1 of the Code of Virginia, allows for independent living services as part of the foster care services to be provided to any child 14 years of age or older. Though permanency is the goal for youth in foster care, planning needs to occur for youth who may not achieve permanency. If an AFC setting is being explored, developing an appropriate post foster care plan for a youth includes collaboration among CFC workers, eligibility workers, and adult services social workers to coordinate an individual's seamless transition from CFC services to an AFC setting. In some situations, the youth may be in need of legal representation such as guardianship. The CFC worker should assess the need for legal representation early in the youth transition planning and begin consultation with the AS worker in obtaining it. CFC workers would need to assess the youth's interest in living in an AFC home and consult the youth's family members as to their opinion regarding the suitability of an AFC setting for the youth. A review of the youth's appropriateness for AFC would

include an evaluation of the youth's potential eligibility for SSI and/or Social Security Disability Insurance (SSDI), AG eligibility and the extent to which the youth needs assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

For additional information on AFC for youth aging out of CFC, see Appendix B.

## **4.5 Assisted Living Facility (ALF) assessment**

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### **4.5.1 Introduction to ALF assessment**

The following is a brief overview of the assessment process for individuals residing in an ALF. Please refer to the Assisted Living Facility Assessment Manual located on FUSION for complete information.

For information on assessment of private pay individuals, see the Assisted Living Facility Private Pay Assessment Manual on FUSION.

### **4.5.2 Definition of ALFs**

ALFs are licensed by the VDSS Division of Licensing Programs to provide care and maintenance to four or more adults. ALF placement is appropriate when the adult is assessed to need assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), administration of medication, and/or supervision due to behavioral conditions, but does not require the level of care provided in a nursing facility.

### **4.5.3 Persons to be assessed in ALFs**

Individuals applying to reside in or residing in ALFs, regardless of payment status or anticipated length of stay, shall be assessed using the Virginia UAI to determine the individual's need for residential or assisted living. Except in the case of a documented emergency, no one can be admitted to an ALF prior to an assessment.

### **4.5.4 Assessors for public pay (AG) individuals in ALFs**

Employees of the following entities can conduct ALF assessments:

- LDSS.
- Area agencies on aging.
- Local departments of health.
- Community services boards.

- Centers for independent living.
- State facility staff of the Department of Behavioral Health and Developmental Services (DBHDS). Note: initial assessments only.
- Designated staff of the Department of Corrections. Note: initial assessments only.
- Acute care hospitals. Note: initial assessments only.
- Independent physicians contracting with DMAS to complete the UAI for individuals in ALFs. An independent physician is a physician chosen by the individual and who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence.

Pursuant to 22 VAC 30-110-90, the LDSS is the assessor of last resort if there is no other assessor willing or able to perform the assessment or reassessment.

In order to ensure that the adult is being admitted to/residing in an ALF that is licensed by VDSS and has a valid AG provider agreement with DARS, service workers shall review the list of ALFs that accept AG at the time of the assessment or reassessment. If the adult is being admitted to or residing in a facility that does not appear on the list, the assessor shall contact the DARS AG Program Consultant or the AG Program Manager immediately.

#### **4.5.5 Assessors for private pay individuals in ALFs**

Unless a private pay individual requests that an assessment be completed by a public assessor, qualified staff of the ALF or an independent private physician may complete the UAI for private pay individuals. Qualified staff of the ALF is an employee with documented training in the completion of the UAI. The administrator or the administrator's designated representative shall approve and sign the completed assessment.

#### **4.5.6 Assessment and determination of services to be provided in ALFs**

The User's Manual: Virginia Uniform Assessment Instrument, available on the VDSS internal website, provides thorough instructions regarding completion of the assessment. Information gathered on the UAI will allow the assessor to determine whether the individual meets the level of care criteria for ALF placement. An individual shall meet these criteria to be considered for public-funded ALF placement.

The UAI is comprised of a short assessment or a full assessment. The short assessment may be used when the intake information indicates that the adult will need

only residential level of care. The short assessment (Part A or pages 1-4) plus an assessment of the individual's medication management ("How do you take your medicine?" question on page 5 of the UAI) and behavior ("Behavior Pattern" section on page 8 of the UAI) is designed to briefly assess the individual's need for services and to determine if a full assessment (Parts A+B or entire UAI) is needed. The UAI and the "Short Form Attachment" are available on the DSS internal website. The assessment focuses on the individual's ability to function while documenting functional dependencies and other needs. Emphasis shall be on assessing the total individual to determine activities he or she is able to safely perform in his or her usual environment.

For public pay individuals, the short assessment shall be completed. If, upon completing the short assessment, it is noted that the individual is rated dependent in two or more ADLs or is rated dependent in behavior pattern, then a full assessment is completed.

#### **4.5.7 When to complete a UAI for individuals residing in an ALF**

- The UAI shall be completed within 90 days prior to the date of admission to the ALF. No one can be admitted to an ALF without having been assessed prior to admission except in the case of a documented emergency and:
  - With the approval of a Virginia APS worker for public pay individuals; or
  - With the approval of a Virginia APS worker or a physician for private pay individuals.
- The UAI shall be completed or updated at least once every 12 months on all individuals residing in an ALF.
- The UAI shall be completed or updated as needed whenever there is a change in the individual's condition that appears to warrant a change in the individual's approved level of care.

#### **4.5.8 Criteria for placement in an ALF**

##### **4.5.8.1 Criteria for residential living**

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

- Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding) (page 4 of UAI).

- Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management) (page 4 of UAI).
- Rated dependent in medication administration (page 5 of UAI).

#### **4.5.8.2 Criteria for assisted living**

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their functional capacity:

- Rated dependent in two or more of seven ADLs (page 4 of UAI).
- Rated dependent in behavior pattern (i.e., abusive, aggressive, or disruptive) (page 8 of UAI).

#### **4.5.8.3 Prohibited conditions**

Assessors shall also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions are present, the assessor shall document that they are present on the UAI and the individual is not eligible for ALF placement. Please refer to the ALF Assessment Manual for more specific information on prohibited conditions.

#### **4.5.9 Possible results from an ALF assessment**

- A recommendation for ALF care;
- Referral to a Screening Team to determine if the individual is appropriate for Medicaid-funded long-term care services and supports;
- Referrals to other community resources (non-Medicaid-funded) such as home-based care services, health services, adult day care centers, home-delivered meals, etc.; or
- Referral for services not required.

#### **4.5.10 Case management ALF assessments**

An individual who needs an annual reassessment shall be registered in the Adult Services Program in PeerPlace. As service plan is not required if the LDSS is only conducting an annual reassessment and no other services are needed.

## **4.6 Auxiliary Grant Supportive Housing**

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Supportive Housing (SH) was added as an approved setting to the Auxiliary Grant (AG) program in 2016. SH is defined as a residential setting with access to supportive services for an AG recipient in which tenancy as described in §37.2-421.1 of the Code of Virginia is provided or facilitated by a provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services that has entered into an agreement with the Department Behavioral Health and Developmental Services (DBHDS) pursuant to §37.2-421.1 of the Code of Virginia.

The AG recipient must be a current AG recipient receiving AG payments in an ALF for a minimum of one year. At the time of the annual reassessment, the individual may apply to live in a SH setting. The qualified assessor will evaluate the individual's level of care and will make a referral to the AGSH provider. The AGSH provider will conduct an SH evaluation.

At this time SH is only available to 60 individuals through the following organizations:

- Blue Ridge Behavioral Health Authority (20 slots)
- Mount Rogers Community Services Board (20 slots)
- Richmond Behavioral Health Authority (20 slots)

## **4.7 Screenings for long-term care services and supports**

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Individuals who are Medicaid eligible or will be Medicaid eligible within 180 days of placement and who are seeking Medicaid long-term care services and supports shall be screened within 30 days of the individual's request for a screening to determine their need for the service (§ 32.1-330 of the Code of Virginia).

Additionally, pursuant to § 32.1-330.4 of the Code of Virginia, screenings are required for individuals who are applying for Programs for All-Inclusive Care for the Elderly (PACE) whether or not the individual is eligible for Medicaid.

All screening UAls and paperwork shall be entered into the DMAS electronic PAS system, (ePAS).

Sections 4.7.1 through 4.7.3 provide basic information about the screening process. However, screening teams shall follow DMAS screening regulations and the DMAS Screening Provider Manual for Long-Term Services and Support.

#### **4.7.1 Community-Based screening team**

##### **4.7.1.1 Composition of the team**

The team shall consist of a nurse, and a social worker or other Department-designated assessor, and a physician, who are employees of either the local health department (LHD) or LDSS. Per DMAS “other Department-designated assessor” means qualified LDSS employees including family services specialists and others who have been trained to administer the UAI and conduct screenings.

DMAS has a contract with the Virginia Department of Health to administer child screenings in Virginia. LDSS may opt in or out of completing child screenings with the LHD. Additionally, LDSS may change the original opt in or opt out decision as long as a 30-day notice is provided to the LHD.

The team composition has not changed for adult screenings.

##### **4.7.1.2 Protocols for managing screening requests**

LDSS are encouraged to establish a protocol to manage individuals’ requests for screenings. LDSS may determine the manner in which they will track screening requests and may collaborate with the LHD to track requests. LDSS should consider tracking the following information:

- Name of and contact information for individual who needs the screening.
- Date and time of the request.
- Name of the LDSS employee who received the request.
- Name of and contact information for individual who made the request.
- Date the screening is scheduled to occur.
- Date the screening was completed.

##### **4.7.1.3 Responsibilities and procedures of the team**

- The team is responsible for screening individuals:
  - At the individual’s residence. Pursuant to DMAS regulations a residence means an individual’s private home, apartment, assisted living facility, nursing facility, or jail.

- Who move or plan to move into the LDSS' jurisdiction and request services (see the Screening Provider Manual for Long-Term Services and Supports on DMAS website for additional information).
- LDSS do not have screening responsibilities for individuals who are:
  - **In acute-care hospitals.** Adults seeking screenings when in an acute-care hospital should be referred to the hospital-based screening team. For adults being discharged from military or Veterans' Administration hospitals, refer to the DMAS Screening Provider Manual for Long-Term Services and Supports.
  - **Transferred between nursing facilities within the state.** Adults transferred between nursing facilities within the state are not required to be screened by screening teams. The nursing facility from which the individual is transferring sends a copy of all screening material to the receiving facility; the receiving facility initiates appropriate documentation for admission certification purposes.
  - **Transferred from out-of-state nursing facilities and entering in-state nursing facilities.** Direct transfers from an out-of-state nursing facility should be referred to the receiving nursing facility.
  - **Currently receiving Medicaid-funded community-based care waivers.** The screening team is not responsible for screening individuals who are receiving CCC Plus waiver services or PACE and who are transferring to a nursing facility.
  - **Currently receiving nursing facility services and transferring to a Medicaid-funded community-based waiver.** The local screening team is not responsible for screening individuals who currently are in a nursing facility and are transferring to a Medicaid-funded community-based program (e.g. CCC Plus or PACE), provided that the screening was completed prior to the client's admission to the nursing facility.
- The team determines:
  - If the adult meets nursing facility criteria upon completion of the screening.
  - If the adult has a condition of mental illness, intellectual disability, or a related condition, the team shall determine whether an additional screening for active treatment needs is necessary.

- If the adult's needs can best be provided in a nursing facility or in the community.
- Team members shall collaborate with the adult and the adult's family to identify resources to meet the adult's needs. All community-based services are to be considered.
- The team shall notify the adult by letter of its decision to approve or deny the requested services. If an individual wishes to appeal, he or she must follow the guidance in the decision letter issued by the Screening Team.

#### **4.7.2 Procedures for adults residing in the community**

- Adults or their representatives should be referred to the LHD and/or LDSS in the jurisdiction in which the adult is residing to request a screening.
- If the adult is not already Medicaid-eligible or has not applied for Medicaid, the adult should be referred to the LDSS so that eligibility for Medicaid can be determined. However, the screening team shall not require that the individual apply for Medicaid or have Medicaid before a screening occurs. See the DMAS Screening Provider Manual for Long-Term Services and Supports for additional information.

### **4.8 The Department of Behavioral Health and Developmental Services (DBHDS) and Community Services Boards (CSB)**

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#### **4.8.1 Case management**

The local community services board (CSB) shall be contacted for information regarding the availability of case management services in the locality that it serves. CSB case management services include assessing the need for services, planning for service delivery, linking the adult to the needed services, and monitoring the provision of services to the individual. The LDSS may participate in the case management process.

#### **4.8.2 Case review by a prescription team**

The local CSB should be contacted for information regarding the specific activities and services of the local CSB prescription team.

The LDSS is identified in the Code of Virginia as a member of the prescription team established by the CSB. The team, under the direction of the CSB, shall be responsible for integrating the community services necessary to accomplish effective prescreening and pre-discharge planning for adults referred to the CSB (§§ 37.2-505 and 37.2-837 of the Code of Virginia).

### 4.8.3 Admission to a state facility operated by DBHDS

The LDSS shall refer adults to the local CSB for screening for admission into state psychiatric and intellectual disability facilities. When admission to a state facility operated by DBHDS is being sought, the LDSS may be requested to assist in preparing portions of the comprehensive evaluation.

### 4.8.4 Convalescent leave and discharge planning

When an adult returns to the community from a DBHDS facility, an LDSS may be requested to participate in the facility's pre-discharge planning process (§§ 37.2-505 and 37.2-837 of the Code of Virginia). Adults released on convalescent status or expected to be discharged from DBHDS facilities who will be in need of social services are the responsibility of the LDSS of:

- First, the county or city where the adult was residing at the time of admission; or
- Second, the locality where the adult has chosen to reside, if the locality where the adult previously resided has not maintained service responsibility for the case; or
- Third, in the absence of such a place, the jurisdiction of the institution from which the adult is being released.

## 4.9 Long-term care coordinating committees

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The Code of Virginia requires the establishment of a local long-term care coordinating committee in each city or county or combination thereof. Pursuant to §§ 63.2-1602 of the Code of Virginia, the LDSS is a member of the committee. The purpose of the committee is to guide the coordination and administration of public long-term care services in the locality.

(§ 51.5-138 of the Code of Virginia). The governing body of each county or city, or a combination thereof, shall designate a lead agency and member agencies to accomplish the coordination of local long-term care services and supports. The agencies shall establish a long-term care coordination committee composed of, but not limited to, representatives of each agency. The coordination committee shall guide the coordination and administration of public long-term care services and supports in the locality. The membership of the coordination committee shall be comprised of, but not limited to, representatives of the local department of public health, the local department of social services, the community services board or community mental health clinic, the area agency on aging, the local nursing home pre-admission screening team, and representatives of housing, transportation, and other appropriate local organizations that provide long-term care services. A plan shall be

implemented that ensures the cost-effective utilization of all funds available for long-term care services and supports in the locality. Localities are encouraged to provide services and supports within each category of service in the continuum and to allow one person to deliver multiple services, when possible.

## **Appendix A: Forms**

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The following forms may be used during the provision of Adult Services. Unless otherwise indicated, these forms are located on the DSS internal website.

### **Adult Foster Care Agreement**

This form is used as an agreement among the individual receiving foster care services, the LDSS and the foster care provider.

### **Adult Foster Care Interagency Agreement**

This form is used when an LDSS is placing an adult in an AFC home in a neighboring jurisdiction.

### **Short-Form Attachment**

This form is used when it is determined that an individual will only need residential level of care in an ALF setting. The attachment is used in conjunction with pages 1-4 of the UAI.

### **Uniform Assessment Instrument (UAI)**

This form is used to assess an individual's need for services including assisted living, home-based services, and Medicaid funded services.

## **4.10 Appendix B: AFC as option for youth aging out of CFC**

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### **4.10.1 Social Security Disability Determination**

Unless an individual is paying privately for AFC placement, an AG payment may be the only means by which an individual can afford AFC placement. Part of the approval process for AG includes an evaluation as to whether an individual meets an AG covered group of aged, blind or disabled (ABD) as determined by the Social Security Administration (SSA). As disability determinations may take several months until approval, if the youth does not currently receive ABD benefits, the CFC worker should explore the youth's potential eligibility for an AG covered group. SSA recently allowed youth with disabilities who are eligible for Supplemental Security Income (SSI) to file an SSI application up to 180 days before federal foster care payments are expected to end. This change in SSA policy will aid foster care youth with disabilities to make the transition to adult life by helping to ensure that they have income and health benefits in place. For additional information about SSI applications for foster care youth with disabilities see section DI 25201.011 in the Social Security Administration's Program Operations Manual System (POMS).

Additional information about Social Security eligibility and the disability determination process may be found at:

SSI: [http://www.ssa.gov/pgm/links\\_ssi.htm](http://www.ssa.gov/pgm/links_ssi.htm)

SSDI: [http://www.ssa.gov/pgm/links\\_disability.htm](http://www.ssa.gov/pgm/links_disability.htm)

### **4.10.2 AG Eligibility**

CFC workers assisting a youth interested in transitioning to AFC, may need to explore other eligibility requirements for AG, if AG will be the method of payment to the AFC provider. The LDSS eligibility worker is an appropriate resource concerning AG eligibility, including application requirements and income and resources limitations. AG applications may take up to 45 days to process, therefore it is necessary to discuss potential AG eligibility prior to the youth transitioning out of foster care. Additional information about AG eligibility may be found in the AG manual. The form used to apply for AG is the Application for Benefits is used to apply for AG. The Manual and Application for Benefits are located at on FUSION.

### **4.10.3 Assessment**

Assessment of an individual's level of care using the UAI is needed to determine if AFC is an appropriate placement. As the youth approaches possible transition out of CFC, the CFC worker and adult services worker should discuss the youth's needs and dependencies using the UAI as a guide.

Once the individual's ADL and IADL needs are determined, the CFC worker in collaboration with the adult services worker should review potential AFC providers to determine which provider could best meet the needs of the individual. Youth should also have the opportunity to meet potential AFC providers and discuss with which provider he or she would feel most comfortable.

#### **4.10.4 Foster Care Parents as AFC Providers**

In many cases, the child foster parent(s) may have formed an attachment to the young adult and wish to continue the relationship and become an AFC provider. AFC could offer the opportunity for the individual to remain in a home environment in which he or she is most comfortable. Provided that the LDSS has an active AFC program, the adult services and the CFC workers need to coordinate the process of approving the foster care parent (s) as an AFC provider. If the CFC parent does not want to seek approval as an AFC provider, workers may want to explore the possibility of an extended member of the CFC family (uncles, aunts, grandparents) becoming an AFC provider for the individual who is transitioning out of CFC. See Appendix E for a comparison of the CFC and AFC provider approval process.

Some individuals may wish to continue in the role as CFC parents while simultaneously seeking approval as an AFC provider. This situation may allow for siblings living in the CFC household to remain together if an older sibling with a disability ages out of CFC services. Adult services workers may work collaboratively on a dual (CFC & AFC) approval process in order to meet the needs of the youth aging out of CFC as well as the needs of his or her siblings who will continue to receive CFC services.