

Chapter 388-106 WAC

LONG-TERM CARE SERVICES

WAC

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388-106-0725	Am I eligible for MMIP services? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438.05-19-045, § 388-106-0725, filed 9/15/05, effective 10/16/05.] Repealed by 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.		
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- 388-106-0735 How do I disenroll from MMIP? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438.05-19-045, § 388-106-0735, filed 9/15/05, effective 10/16/05.] Repealed by 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.
- 388-106-0740 What is the fair hearing process for enrollee appeals of managed care organization actions? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438.05-19-045, § 388-106-0740, filed 9/15/05, effective 10/16/05.] Repealed by 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.

SCOPE AND DEFINITIONS

WAC 388-106-0005 What is the purpose and scope of this chapter? This chapter applies to applicants and recipients of long-term care services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0005, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0010 What definitions apply to this chapter? "Ability to make self understood" means how you make yourself understood to those closest to you; express or communicate requests, needs, opinions, urgent problems and social conversations, whether in speech, writing, sign language, symbols, or a combination of these including use of a communication board or keyboard:

- (a) Understood: You express ideas clearly;
- (b) Usually understood: You have difficulty finding the right words or finishing thoughts, resulting in delayed responses, or you require some prompting to make self understood;
- (c) Sometimes understood: You have limited ability, but are able to express concrete requests regarding at least basic needs (e.g. food, drink, sleep, toilet);
- (d) Rarely/never understood. At best, understanding is limited to caregiver's interpretation of client specific sounds or body language (e.g. indicated presence of pain or need to toilet.)

"Activities of daily living (ADL)" means the following:

- (a) Bathing: How you take a full-body bath/shower, sponge bath, and transfer in/out of tub/shower.
- (b) Bed mobility: How you move to and from a lying position, turn side to side, and position your body while in bed, in a recliner, or other type of furniture.
- (c) Body care: How you perform with passive range of motion, applications of dressings and ointments or lotions to the body and pedicure to trim toenails and apply lotion to feet. In adult family homes, contracted assisted living, enhanced adult residential care, and enhanced adult residential care-specialized dementia care facilities, dressing changes using clean technique and topical ointments must be performed by a licensed nurse or through nurse delegation in accordance with chapter 246-840 WAC. Body care excludes:

- (i) Foot care if you are diabetic or have poor circulation; or
- (ii) Changing bandages or dressings when sterile procedures are required.
- (d) Dressing: How you put on, fasten, and take off all items of clothing, including donning/removing prosthesis.

(e) Eating: How you eat and drink, regardless of skill. Eating includes any method of receiving nutrition, e.g., by mouth, tube or through a vein.

(f) Locomotion in room and immediate living environment: How you move between locations in your room and immediate living environment. If you are in a wheelchair, locomotion includes how self-sufficient you are once in your wheelchair.

(g) Locomotion outside of immediate living environment including outdoors: How you move to and return from more distant areas. If you are living in a boarding home or nursing facility (NF), this includes areas set aside for dining, activities, etc. If you are living in your own home or in an adult family home, locomotion outside immediate living environment including outdoors, includes how you move to and return from a patio or porch, backyard, to the mailbox, to see the next-door neighbor, etc.

(h) Walk in room, hallway and rest of immediate living environment: How you walk between locations in your room and immediate living environment.

(i) Medication management: Describes the amount of assistance, if any, required to receive medications, over the counter preparations or herbal supplements.

(j) Toilet use: How you use the toilet room, commode, bedpan, or urinal, transfer on/off toilet, cleanse, change pad, manage ostomy or catheter, and adjust clothes.

(k) Transfer: How you move between surfaces, i.e., to/from bed, chair, wheelchair, standing position. Transfer does not include how you move to/from the bath, toilet, or vehicle.

(l) Personal hygiene: How you maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands (including nail care), and perineum (menses care). Personal hygiene does not include hygiene in baths and showers.

"Aged person" means a person sixty-five years of age or older.

"Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to you in your own home.

"Application" means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant must submit the request on a form prescribed by the department.

"Assessment details" means a summary of information that the department entered into the CARE assessment describing your needs.

"Assessment or reassessment" means an inventory and evaluation of abilities and needs based on an in-person interview in your own home or your place of residence, using CARE.

"Assistance available" means the amount of informal support available if the need is partially met. The department determines the amount of the assistance available using one of four categories:

- (a) Less than one-fourth of the time;
- (b) One-fourth to one-half of the time;

(c) Over one-half of the time to three-fourths of the time;
or

(d) Over three-fourths but not all of the time.

"Assistance with body care" means you need assistance with:

(a) Application of ointment or lotions;

(b) Trimming of toenails;

(c) Dry bandage changes; or

(d) Passive range of motion treatment.

"Assistance with medication management" means you need assistance managing your medications. You are scored as:

(a) Independent if you remember to take medications as prescribed and manage your medications without assistance.

(b) Assistance required if you need assistance from a nonlicensed provider to facilitate your self-administration of a prescribed, over the counter, or herbal medication, as defined in chapter 246-888 WAC. Assistance required includes reminding or coaching you, handing you the medication container, opening the container, using an enabler to assist you in getting the medication into your mouth, alteration of a medication for self-administration, and placing the medication in your hand. This does not include assistance with intravenous or injectable medications. You must be aware that you are taking medications.

(c) Self-directed medication assistance/administration if you are a person with a functional disability who is capable of and who chooses to self-direct your medication assistance/administration.

(d) Must be administered if you must have medications placed in your mouth or applied or instilled to your skin or mucus membrane. Administration must either be performed by a licensed professional or delegated by a registered nurse to a qualified caregiver (per chapter 246-840 WAC). Intravenous or injectable medications may never be delegated. Administration may also be performed by a family member or unpaid caregiver if facility licensing regulations allow.

"Authorization" means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

"Blind person" means a person determined blind as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-475-0100 and chapter 388-513 WAC.

"Chronic care management" means programs that provide care management and coordination activities for medical assistance clients receiving long-term care services and supports determined to be at risk for high medical costs.

"Health action plan" means an individual plan which identifies health-related problems, interventions and goals.

"Client" means an applicant for service or a person currently receiving services from the department.

"Current" means a behavior occurred within seven days of the CARE assessment date, including the day of the assessment. Behaviors that the department designates as current must include information about:

(a) Whether the behavior is easily altered or not easily altered; and

(b) The frequency of the behavior.

"Decision making" means your ability and actual performance in making everyday decisions about tasks or activities of daily living. The department determines whether you are:

(a) Independent: Decisions about your daily routine are consistent and organized; reflecting your lifestyle, choices, culture, and values.

(b) Modified independence/difficulty in new situations: You have an organized daily routine, are able to make decisions in familiar situations, but experience some difficulty in decision making when faced with new tasks or situations.

(c) Moderately impaired/poor decisions; unaware of consequences: Your decisions are poor and you require reminders, cues and supervision in planning, organizing and correcting daily routines. You attempt to make decisions, although poorly.

(d) Severely impaired/no or few decisions: Decision making is severely impaired; you never/rarely make decisions.

"Department" means the state department of social and health services, aging and disability services administration or its designee.

"Designee" means area agency on aging.

"Difficulty" means how difficult it is or would be for you to perform an instrumental activity of daily living (IADL). This is assessed as:

(a) No difficulty in performing the activity;

(b) Some difficulty in performing the activity (e.g., you need some help, are very slow, or fatigue easily); or

(c) Great difficulty in performing the activity (e.g., little or no involvement in the activity is possible).

"Disabling condition" means you have a medical condition which prevents you from self performance of personal care tasks without assistance.

"Estate recovery" means the department's process of recouping the cost of medicaid and long-term care benefit payments from the estate of the deceased client. See chapter 388-527 WAC.

"Home health agency" means a licensed:

(a) Agency or organization certified under medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(b) Home health agency, certified or not certified under medicare, contracted and authorized to provide:

(i) Private duty nursing; or

(ii) Skilled nursing services under an approved medicaid waiver program.

"Income" means income as defined under WAC 388-500-0005.

"Individual provider" means a person employed by you to provide personal care services in your own home. See WAC 388-71-0500 through 388-71-05909.

"Disability" is described under WAC 388-511-1105.

"Informal support" means a person or resource that is available to provide assistance without home and community

program funding. The person or resource providing the informal support must be age 18 or older.

"Institution" means medical facilities, nursing facilities, and institutions for the mentally retarded. It does not include correctional institutions. See medical institutions in WAC 388-500-0005.

"Instrumental activities of daily living (IADL)" means routine activities performed around the home or in the community and includes the following:

(a) Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food, utensils, and cleaning up after meals). NOTE: The department will not authorize this IADL to plan meals or clean up after meals. You must need assistance with actual meal preparation.

(b) Ordinary housework: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).

(c) Essential shopping: How shopping is completed to meet your health and nutritional needs (e.g., selecting items). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities and household items required specifically for your health, maintenance or well-being. This includes shopping with or for you.

(d) Wood supply: How wood is supplied (e.g., splitting, stacking, or carrying wood) when you use wood as the sole source of fuel for heating and/or cooking.

(e) Travel to medical services: How you travel by vehicle to a physician's office or clinic in the local area to obtain medical diagnosis or treatment—includes driving vehicle yourself, traveling as a passenger in a car, bus, or taxi.

(f) Managing finances: How bills are paid, checkbook is balanced, household expenses are managed. The department cannot pay for any assistance with managing finances.

(g) Telephone use: How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

"Long-term care services" means the services administered directly or through contract by the aging and disability services administration and identified in WAC 388-106-0015.

"Medicaid" is defined under WAC 388-500-0005.

"Medically necessary" is defined under WAC 388-500-0005.

"Medically needy (MN)" means the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"New Freedom consumer directed services (NFCDS)" means a mix of services and supports to meet needs identified in your assessment and identified in a New Freedom spending plan, within the limits of the individual budget, that provide you with flexibility to plan, select, and direct the purchase of goods and services to meet identified needs. Participants have a meaningful leadership role in:

(a) The design, delivery and evaluation of services and supports;

(b) Exercising control of decisions and resources, making their own decisions about health and well being;

(c) Determining how to meet their own needs;

(d) Determining how and by whom these needs should be met; and

(e) Monitoring the quality of services received.

"New Freedom consumer directed services (NFCDS) participant" means a participant who is an applicant for or currently receiving services under the NFCDS waiver.

"New Freedom spending plan (NFSP)" means the plan developed by you, as a New Freedom participant, within the limits of an individual budget, that details your choices to purchase specific NFCDS and provides required federal medicaid documentation.

"Own home" means your present or intended place of residence:

(a) In a building that you rent and the rental is not contingent upon the purchase of personal care services as defined in this section;

(b) In a building that you own;

(c) In a relative's established residence; or

(d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

"Past" means the behavior occurred from eight days to five years of the assessment date. For behaviors indicated as past, the department determines whether the behavior is addressed with current interventions or whether no interventions are in place.

"Personal aide" is defined in RCW 74.39.007.

"Personal care services" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices.

"Physician" is defined under WAC 388-500-0005.

"Plan of care" means assessment details and service summary generated by CARE.

"Provider or provider of service" means an institution, agency, or person:

(a) Having a signed department contract to provide long-term care client services; and

(b) Qualified and eligible to receive department payment.

"Reasonable cost" means a cost for a service or item that is consistent with the market standards for comparable services or items.

"Representative" means a person who you have chosen, or has been appointed by a court, whose primary duty is to act on your behalf to direct your service budget to meet your identified health, safety, and welfare needs.

"Residential facility" means a licensed adult family home under department contract or licensed boarding home under department contract to provide assisted living, adult residential care or enhanced adult residential care.

"Self performance for ADLs" means what you actually did in the last seven days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period and does not include support provided as defined in WAC 388-106-0010. Your self performance level is scored as:

(a) Independent if you received no help or oversight, or if you needed help or oversight only once or twice;

(b) Supervision if you received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if you were highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if you performed part of the activity, but on three or more occasions, you needed weight bearing support or you received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means you needed physical help with part of the activity (other than transfer);

(e) Total dependence if you received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by you in all aspects of the ADL; or

(f) Activity did not occur if you or others did not perform an ADL over the last seven days before your assessment. The activity may not have occurred because:

(i) You were not able (e.g., walking, if paralyzed);

(ii) No provider was available to assist; or

(iii) You declined assistance with the task.

"Self performance for IADLs" means what you actually did in the last thirty days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the thirty-day period. Your self performance is scored as:

(a) Independent if you received no help, set-up help, or supervision;

(b) Set-up help/arrangements only if on some occasions you did your own set-up/arrangement and at other times you received help from another person;

(c) Limited assistance if on some occasions you did not need any assistance but at other times in the last thirty days you required some assistance;

(d) Extensive assistance if you were involved in performing the activity, but required cueing/supervision or partial assistance at all times;

(e) Total dependence if you needed the activity fully performed by others; or

(f) Activity did not occur if you or others did not perform the activity in the last thirty days before the assessment.

"Service summary" is CARE information which includes: Contacts (e.g. emergency contact), services the client is eligible for, number of hours or residential rates, personal care needs, the list of formal and informal providers and what tasks they will provide, a provider schedule, referral needs/information, and dates and agreement to the services.

"SSI-related" is defined under WAC 388-475-0050.

"Status" means the amount of informal support available. The department determines whether the ADL or IADL is:

(a) Met, which means the ADL or IADL will be fully provided by an informal support;

(b) Unmet, which means an informal support will not be available to provide assistance with the identified ADL or IADL;

(c) Partially met, which means an informal support will be available to provide some assistance, but not all, with the identified ADL or IADL; or

(d) Client declines, which means you do not want assistance with the task.

"Supplemental Security Income (SSI)" means the federal program as described under WAC 388-500-0005.

"Support provided" means the highest level of support provided (to you) by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing you with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

"You/your" means the client.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 11-22-043, § 388-106-0010, filed 10/27/11, effective 11/27/11; 10-08-074, § 388-106-0010, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0010, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0010, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0010, filed 5/17/05, effective 6/17/05.]

APPLYING FOR SERVICES

WAC 388-106-0015 What long-term care services does the department provide? The department provides long-term care services through programs that are designed to help you remain in the community. These programs offer an alternative to nursing home care (which is described in WAC 388-106-0350 through 388-106-0360). You may receive services from any of the following:

(1) **Medicaid personal care (MPC)** is a medicaid state plan program authorized under RCW 74.09.520. Clients eligible for this program may receive personal care in their own home or in a residential facility.

(2) **Community options program entry system (COPES)** is a medicaid waiver program authorized under RCW 74.39A.030. Clients eligible for this program may receive personal care in their own home or in a residential facility.

(3) **Medically needy residential waiver (MNRW)** is a medicaid waiver program authorized under RCW 74.39.041. Clients eligible for this program may receive personal care in a residential facility.

(4) **Medically needy in-home waiver (MNIW)** is a medicaid waiver program authorized under RCW 74.09.700. Clients eligible for this program may receive personal care in their own home.

(5) **Chore** is a state-only funded program authorized under RCW 74.39A.110. Grandfathered clients may receive assistance with personal care in their own home.

(6) **Volunteer chore** is a state-funded program that provides volunteer assistance with household tasks to eligible clients.

(7) **Program of all-inclusive care for the elderly (PACE)** is a medicaid/medicare managed care program authorized under 42 CFR 460.2. Clients eligible for this program may receive personal care and medical services in their own home, in residential facilities, and in adult day health centers.

(8) **Adult day health** is a supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to core services outlined in WAC 388-106-0800.

(9) **Adult day care** is a supervised daytime program providing core services, as defined under WAC 388-106-0800.

(10) **GAU-funded residential care** is a state-funded program authorized under WAC 388-400-0025. Clients eligible for this program may receive personal care services in an adult family home or an adult residential care facility.

(11) **Residential care discharge allowance** is a service that helps eligible clients to establish or resume living in their own home.

(12) **Private duty nursing** is a medicaid service that provides an alternative to institutionalization in a hospital or nursing facility setting. Clients eligible for this program may receive at least four continuous hours of skilled nursing care on a day to day basis in their own home.

(13) **Senior Citizens Services Act (SCSA)** is a program authorized under chapter 74.38 RCW. Clients eligible for this program may receive community-based services as defined in RCW 74.38.040.

(14) **Respite program** is a program authorized under RCW 74.41.040 and WAC 388-106-1200. This program provides relief care for unpaid family or other caregivers of adults with a functional disability.

(15) **Programs for persons with developmental disabilities** are discussed in chapter 388-823 through 388-853 WAC.

(16) **Nursing facility.**

(17) **New Freedom consumer directed services (NFCDS)** is a medicaid waiver program authorized under RCW 74.39A.030.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 08-12-023, § 388-106-0015, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0015, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0015, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438.05-19-045, § 388-106-0015, filed 9/15/05, effective 10/16/05. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0015, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0020 Under the MPC, COPES, MNRW, MNIW, and chore programs, what services are not covered? The following types of services are not covered under MPC, COPES, MNRW, MNIW, and chore:

- (1) Child care.
- (2) Individual providers must not provide:
 - (a) Sterile procedures unless the provider is a family member or the client self directs the procedure;
 - (b) Administration of medications or other tasks requiring a licensed health professional unless these tasks are provided through nurse delegation, self-directed care, or the provider is a family member.

(10/27/11)

(3) Agency providers, including family members who provide care while working as an agency provider, must not provide:

- (a) Sterile procedures;
- (b) Self-directed care;
- (c) Administration of medications or other tasks requiring a licensed health care professional unless these tasks are provided through nurse delegation.
- (4) Services provided over the telephone.
- (5) Services to assist other household members not eligible for services.
- (6) Development of social, behavioral, recreational, communication, or other types of community living skills.
- (7) Nursing care.
- (8) Pet care.
- (9) Assistance with managing finances.
- (10) Respite.
- (11) Yard care.

[Statutory Authority: RCW 74.08.090, 74.09.520. 08-05-026, § 388-106-0020, filed 2/12/08, effective 3/14/08; 05-11-082, § 388-106-0020, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0025 How do I apply for long-term care services? To apply for long-term care services, you must request an assessment from the department and submit a medicaid application.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0025, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0030 Where can I receive services? You may receive services:

- (1) In your own home.
- (2) In a residential facility, which includes licensed:
 - (a) Adult family homes, as defined in RCW 70.128.010.
 - (b) Boarding homes. Types of licensed and contracted boarding homes include:
 - (i) Assisted living facilities, as defined in WAC 388-110-020;
 - (ii) Enhanced adult residential care facilities, as defined in WAC 388-110-020;
 - (iii) Enhanced adult residential care facilities-specialized dementia care, as defined in WAC 388-110-020; and
 - (iv) Adult residential care facilities, as defined in WAC 388-110-020.
 - (3) In a nursing home, as defined in WAC 388-97-005.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0030, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0035 May I receive personal care services through any of the long-term care programs when I am out of the state of Washington? (1) You may receive personal care assistance through any long-term care programs in WAC 388-106-0015 subsections (1) through (5) when temporarily traveling out of state for less than thirty days, as long as your:

- (a) Individual provider is contracted with the state of Washington;
- (b) Travel plans are coordinated with your case manager prior to departure;
- (c) Services are authorized on your plan of care prior to departure; and

(d) Services are strictly for your personal care and do not include your provider's travel time, expenses.

(2) You may not receive personal care services outside of the United States.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0035, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0035, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0040 Who can provide long-term care services? The following types of providers can provide long-term care services:

(1) Individual providers (IPs), who provide services to clients in their own home. IPs must meet the requirements outlined in WAC 388-71-0500 through 388-71-05909.

(2) Home care agencies, who provide services to clients in their own home. Home care agencies must be licensed under chapter 70.127 RCW and chapter 246-336 WAC and contracted with area agency on aging.

(3) Residential providers, which include licensed adult family homes and boarding homes, who contract with the department to provide assisted living, adult residential care, and enhanced adult residential care services (which may also include specialized dementia care).

(4) Providers who have contracted with the department to perform other services.

(5) In the case of New Freedom consumer directed services (NFCDS), providers meeting NFCDS HCBS waiver requirements contracting with a department approved provider of fiscal management services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0040, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0040, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0045 When will the department authorize my long-term care services? The department will authorize long-term care services when you:

(1) Are assessed using CARE;

(2) Are found financially and functionally eligible for services including, if applicable, the determination of the amount of participation toward the cost of your care and/or the amount of room and board that you must pay;

(3) Have given consent for services and approved your plan of care; and

(4) Have chosen a provider(s), qualified for payment.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0045, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0047 When can the department terminate or deny long-term care services to me? (1) The department will deny or terminate long-term care services if you are not eligible for long-term care services pursuant to WAC 388-106-0210, 388-106-0310, 388-106-0410, 388-106-0510, or 388-106-0610.

(2) The department may deny or terminate long-term care services to you if, after exhaustion of standard case management activities and the approaches delineated in the department's challenging cases protocol, which must include an attempt to reasonably accommodate your disability or disabilities, any of the following conditions exist:

(a) After a department representative reviews with you your rights and responsibilities as a client of the department, per WAC 388-106-1300 and 388-106-1303, you refuse to accept those long-term care services identified in your plan of care that are vital to your health, welfare or safety;

(b) You choose to receive services in your own home and you or others in your home demonstrate behaviors that are substantially likely to cause serious harm to you or your care provider;

(c) You choose to receive services in your own home and hazardous conditions in or immediately around your home jeopardize the health, safety, or welfare of you or your provider. Hazardous conditions include but are not limited to the following:

(i) Threatening, uncontrolled animals (e.g., dogs);

(ii) The manufacture, sale, or use of illegal drugs;

(iii) The presence of hazardous materials (e.g., exposed sewage, evidence of a methamphetamine lab).

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 441.302(a); Social Security Act section 1915c waiver rules, 42 C.F.R. 440.180. 06-16-070, § 388-106-0047, filed 7/28/06, effective 8/28/06.]

COMPREHENSIVE ASSESSMENT REPORTING EVALUATION (CARE) ASSESSMENT

WAC 388-106-0050 What is an assessment? (1) An assessment is an in-person interview in your home or your place of residence that is conducted by the department to inventory and evaluate your ability to care for yourself. The department will assess you at least annually or more often when there are significant changes to your ability to care for yourself.

(2) Between assessments, the department may modify your current assessment without an in-person interview in your home or place of residence. The reasons that the department may modify your current assessment without conducting an in-person interview in your home or place of residence include but are not limited to the following:

(a) Errors made by department staff in coding the information from your in-person interview;

(b) New information requested by department staff at the time of your assessment and received after completion of the in-person interview (e.g. medical diagnosis);

(c) Changes in the level of informal support available to you; or

(d) Clarification of the coding selected.

(3) When the department modifies your current assessment, it will notify you using a Planned Action Notice of the modification regardless of whether the modification results in a change to your benefits. You will also receive a new service summary and assessment details.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0050, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0050, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0055 What is the purpose of an assessment? The purpose of an assessment is to:

(1) Determine eligibility for long-term care programs;

(2) Identify your strengths, limitations, and preferences;

(3) Evaluate your living situation and environment;

- (4) Evaluate your physical health, functional and cognitive abilities;
- (5) Determine availability of informal supports and other nondepartment paid resources;
- (6) Determine need for intervention;
- (7) Determine need for case management activities;
- (8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;
- (9) Determine need for referrals; and
- (10) Develop a plan of care, as defined in WAC 388-106-0010.

(11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 06-16-035, § 388-106-0055, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0055, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0060 Who must perform the assessment? The assessment must be performed by the department. Beginning January 1, 2008, individuals requesting personal care services will be assessed as described in the following chart:

Age of person requesting an assessment for personal care services	Has the person been determined to meet DDD eligibility requirements?	Who will perform the assessment for personal care services?	What assessment will be used?
Under eighteen years of age	Yes	DDD	CARE/DDD Assessment per chapter 388-828 WAC
Under eighteen years of age	No	DDD	CARE/LTC Assessment per chapter 388-106 WAC
Eighteen years of age and older	Yes	DDD	CARE/DDD Assessment per chapter 388-828 WAC
Eighteen years of age and older	No	HCS	CARE/LTC Assessment per chapter 388-106 WAC

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-24-026, § 388-106-0060, filed 11/28/07, effective 1/1/08; 05-11-082, § 388-106-0060, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0065 What is the process for conducting an assessment? The department:

- (1) Will assess you using a department-prescribed assessment tool, titled the comprehensive assessment reporting evaluation (CARE).
- (2) May request the assessment be conducted in private. However, you have the right to request that third parties be present.
- (3) Has the right to end the assessment if behaviors by any party are impeding the assessment process. If an assessment is terminated, the department will reschedule.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0065, filed 2/6/06, effective 3/9/06. Stat-

utory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0065, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0070 Will I be assessed in CARE? You will be assessed in CARE if you are applying for or receiving DDD services, COPEs, MNIW, MNRW, MPC, chore, respite, adult day health, GAU-funded residential care, PACE, private duty nursing, New Freedom or long-term care services within the WMIP program.

If you are under the age of eighteen and within thirty calendar days of your next birthday, CARE determines your assessment age to be that of your next birthday.

[Statutory Authority: RCW 74.08.090 and 74.09.520, 08-12-023, § 388-106-0070, filed 5/29/08, effective 7/1/08; 07-24-026, § 388-106-0070, filed 11/28/07, effective 1/1/08; 07-10-024, § 388-106-0070, filed 4/23/07, effective 6/1/07; 05-11-082, § 388-106-0070, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0075 How is my need for personal care services assessed in CARE? To assess your need for personal care services, the department gathers information from you, your caregivers, family members, and other sources. The department will assess your ability to perform:

- (1) Activities of daily living (ADL) using self performance, support provided, status and assistance available, as defined in WAC 388-106-0010. Also, the department determines your need for "assistance with body care" and "assistance with medication management," as defined in WAC 388-106-0010; and
- (2) Instrumental activities of daily living (IADL) using self performance, difficulty, status and assistance available, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0075, filed 5/17/05, effective 6/17/05.]

CARE CLASSIFICATION

WAC 388-106-0080 How is the amount of long-term care services I can receive in my own home or in a residential facility determined? The amount of long-term care services you can receive in your own home or in a residential facility is determined through a classification system. Seventeen classifications apply to clients served in residential and in-home settings. The department has assigned each classification a residential facility daily rate or a base number of hours you can receive in your own home.

[Statutory Authority: 2008 c 329, 08-19-102, § 388-106-0080, filed 9/17/08, effective 10/18/08. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0080, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0085 What criteria does the CARE tool use to place me in one of the classification groups? The department uses CARE to assess your characteristics. Based on this assessment, the CARE tool uses the following criteria to place you in one of the classification groups:

- (1) Cognitive performance.
- (2) Clinical complexity.
- (3) Mood/behaviors symptoms.
- (4) Activities of daily living (ADLs).

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0085, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0090 How does the CARE tool measure cognitive performance? (1) The CARE tool uses a tool called the cognitive performance scale (CPS) to evaluate your cognitive impairment. The CPS results in a score that ranges from zero (intact) to six (very severe impairment). Your CPS score is based on:

- (a) Whether you are comatose.
- (b) Your ability to make decisions, as defined in WAC 388-106-0010 "Decision making."
- (c) Your ability to make yourself understood, as defined in WAC 388-106-0010 "Ability to make self understood."
- (d) Whether you have short-term memory problem (e.g. can you remember recent events?) or whether you have delayed recall; and

(e) Whether you score as total dependence for self performance in eating, as defined in WAC 388-106-0010 "Self performance of ADLs."

(2) You will receive a CPS score of:

(a) **Zero** when you do not have problems with decision-making ability, making yourself understood, or recent memory.

(b) **One** when you meet one of the following:

- (i) Your decision-making ability is scored as modified independence or moderately impaired;
- (ii) Your ability to make yourself understood is usually, sometimes, or rarely/never understood; or
- (iii) You have a recent memory problem.

(c) **Two** when you meet two of the following:

- (i) Your decision-making ability is scored as modified independence or moderately impaired;
- (ii) Your ability to make yourself understood is usually, sometimes, or rarely/never understood; and/or
- (iii) You have a short-term memory problem or delayed recall.

(d) **Three** when you meet at least two of the criteria listed in subsection (2)(b) of this section and one of the following applies:

- (i) Your decision making is moderately impaired; or
- (ii) Your ability to make yourself understood is sometimes or rarely/never understood.

(e) **Four** when both of the following criteria applies:

- (i) Your decision making is moderately impaired; and
- (ii) Your ability to make yourself understood is sometimes or rarely/never understood.

(f) **Five** when your ability to make decisions is scored as severely impaired.

(g) **Six** when one of the following applies:

- (i) Your ability to make decisions is severely impaired and you require total dependence in eating; or
- (ii) You are comatose.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0090, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0095 How does the CARE tool measure clinical complexity? The CARE tool places you in the clinically complex classification group only when you have one or more of the following criteria and corresponding ADL scores:

Condition	AND an ADL Score of
ALS (Lou Gehrig's Disease)	>14
Aphasia (expressive and/or receptive)	>=2
Cerebral Palsy	>14
Diabetes Mellitus (insulin dependent)	>14
Diabetes Mellitus (noninsulin dependent)	>14
Emphysema & Shortness of Breath (at rest or exertion) or dizziness/vertigo	>10
COPD & Shortness of Breath (at rest or exertion) or dizziness/vertigo	>10
Explicit terminal prognosis	>14
Hemiplegia	>14
Multiple Sclerosis	>14
Parkinson Disease	>14
Pathological bone fracture	>14
Quadriplegia	>14
Rheumatoid Arthritis	>14
You have one or more of the following skin problems: <ul style="list-style-type: none"> ■ Pressure ulcers, with areas of persistent skin redness; ■ Pressure ulcers with partial loss of skin layers; ■ Pressure ulcers, with a full thickness lost; ■ Skin desensitized to pain/pressure; ■ Open lesions; and/or ■ Stasis ulcers. AND You require one of the following types of assistance: <ul style="list-style-type: none"> ■ Ulcer care; ■ Pressure relieving device; ■ Turning/reposition program; ■ Application of dressing; or ■ Wound/skin care. 	>=2
You have a burn(s) and you need one of the following: <ul style="list-style-type: none"> ■ Application of dressing; or ■ Wound/skin care 	>=2
You have one or more of the following problems: <ul style="list-style-type: none"> ■ You are frequently incontinent (bladder); ■ You are incontinent all or most of the time (bladder); ■ You are frequently incontinent (bowel); or ■ You are incontinent all or most of the time (bowel). AND One of the following applies: <ul style="list-style-type: none"> ■ The status of your individual management of bowel bladder supplies is "Uses, has leakage, needs assistance"; ■ The status of your individual management of bowel bladder supplies is "Does not use, has leakage"; or ■ You use any scheduled toileting plan. 	>10
You have a current swallowing problem, and you are not independent in eating.	>10
You have Edema.	>14
You have Pain daily.	>14
You need and receive a Bowel program.	>10
You need Dialysis.	>10
You require IV nutritional support or tube feedings; and Your total calories received per IV or tube was at least 25%; and Your fluid intake is greater than 2 cups.	>=2
You need Hospice care.	>14
You need Injections.	>14
You need Intravenous medications.	>10
You need management of IV lines.	>10
You need Ostomy care.	>=2
You need Oxygen therapy.	>10
You need Radiation.	>10
You need and receive Passive range of motion.	>10
You need and receive Walking training.	>10
You need Suction treatment.	>=2

Condition	AND an ADL Score of
You need Tracheostomy care.	>10
You need a Ventilator/respirator	>10
You are <18 and you have pain related to your disability and you complain of pain or show evidence of pain daily. (If you are under eighteen and do not have pain related to your disability, you may be placed in the clinically complex classification based on other factors above.)	>14
Key: < means less than. > means greater than. >= means greater than or equal to.	

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-10-024, § 388-106-0095, filed 4/23/07, effective 6/1/07; 05-11-082, § 388-106-0095, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0100 How does the CARE tool measure mood and behaviors? (1) When you do not meet the criteria for the clinically complex classification group, or the criteria for exceptional care, or for in-home only have a cognitive performance scale score of five or six, then the mood and behavior criteria listed in subsections (3) and (4) below determines your classification group. If you are eligible for more than one "B" group classification based on the two methodologies, CARE will place you in the highest group for which you qualify.

(2) For each behavior that the CARE tool has documented, the department will determine a status as "current" or "past" as defined in WAC 388-106-0010.

(3) CARE places you in the mood and behavior classification group only if you have one or more of the behavior/moods that also meets the listed status, frequency, and alterability as identified in the following chart:

Behavior/Mood	AND Status, Frequency & Alterability
Assaultive	Current
Combative during personal care	Current
Combative during personal care	In past and addressed with current interventions
Crying tearfulness	Current, frequency 4 or more days per week
Delusions	In past, addressed with current interventions
Depression score of 14 or greater	N/A
Disrobes in public	Current and not easily altered
Easily irritable/agitated	Current and not easily altered
Eats nonedible substances	Current
Eats nonedible substances	In past, addressed with current interventions
Hallucinations	Current
Hiding items	In past, addressed with current interventions
Hoarding/collecting	In past, addressed with current interventions
Mental health therapy/program	Need
Repetitive complaints/questions	Current, daily
Repetitive complaints/questions	In past, addressed with current interventions
Repetitive movement/pacing	Current, daily
Resistive to care	Current
Resistive to care	In past, addressed with current interventions
Sexual acting out	Current
Sexual acting out	In past, addressed with current interventions
Spitting	Current and not easily altered
Spitting	In past, addressed with current interventions
Breaks/throws items	Current
Unsafe smoking	Current and not easily altered

Behavior/Mood	AND Status, Frequency & Alterability
Up at night and requires intervention	Current
Wanders exit seeking	Current
Wanders exit seeking	In past, addressed with current interventions
Wanders not exit seeking	Current
Wanders not exit seeking	In past, addressed with current interventions
Yelling/screaming	Current, frequency 4 or more days per week

or

(4) CARE places you in the mood and behavior classification group if you have a behavior point score greater than 1, your CPS score (as defined in WAC 388-106-0090) is greater than 2, and your ADL score (as defined in WAC 388-106-0105) is greater than 1.

Status	Intervention	Frequency	Weight
Past	No Intervention	N/A	0
Past	With Intervention	N/A	0.25
Current	N/A	1-3 days/wk	0.5
Current	N/A	4-6 days/wk	0.75
Current	N/A	Daily	1

Each current behavior (as shown in the table below) has a value from .5 to 6 depending on the severity and alterability. Each status combination (shown in the table above) has a weight from 0 to 1. Behavior points are determined by multiplying the value of each current behavior (from the list below) by the weight of the status combination (above). Behavior points for past behaviors will be determined by multiplying the easily altered value of the behavior from the table below by the appropriate weight from the table above (0 or .25).

The list of behaviors below is divided into categories. Each category has a point limit of how many points can be counted toward the total behavior point score as detailed below. The total behavior point score is determined by totaling the weight-adjusted values for each category below.

Behavior	Value	
	Easily Altered/Past	Not Easily Altered
1. Crying and Tearfulness	.5	1
2. Easily Irritable/Agitated	.5	1
3. Obsessive about health or body functions	.5	1
4. Repetitive Physical Movement	.5	1
5. Hiding Items	.5	1
6. Hoarding/Collecting	.5	1
7. Inappropriate Verbal Noise	.5	1
8. Wanders, not exit seeking	.5	1
Maximum total points after adjusting for status for behaviors 1-8 = 2		
9. Repetitive anxious complaints/questions	1	2
10. Rummaging through or takes others belongings	1	2
11. Verbally Abusive	1	2
12. Yelling/Screaming	1	2
13. Spitting	1	2
14. Unrealistic Fears	1	2
15. Accuses others of stealing	1	2

Behavior	Value	
	Easily Altered/Past	Not Easily Altered
Maximum total points after adjusting for status for behaviors 9-15 = 3		
16. Resistive to care with words/gestures	2	3
17. Up at night, requires intervention	2	3
18. Unsafe cooking	2	3
19. Inappropriate toilet-ing/menses activity	2	3
20. Unsafe smoking	2	3
21. Left home and became lost	2	3
22. Disrobes in public	2	3
Maximum total points after adjusting for status for behaviors 16-22 = 4		
23. Injures self	4	5
24. Wanders/Exit seeking	4	5
25. Sexual acting out	4	5
26. Intimidating	4	5
27. Assaultive	4	5
28. Breaks, throws items	4	5
Maximum total points after adjusting for status for behaviors 23-28 = 10		
29. Fire setting	5	6
30. Combative during care	5	6
31. Pica	5	6
32. Seeks vulnerable partners	5	6
Maximum total points after adjusting for status for behaviors 29-32 = 12		

[Statutory Authority: RCW 74.08.090, 74.09.520, and 2007 c 522. 08-10-022, § 388-106-0100, filed 4/25/08, effective 5/26/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0100, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0105 How does the CARE tool measure activities of daily living (ADLs)? (1) CARE determines an ADL score ranging from zero to twenty-eight for each of the following ADLs.

- (a) Personal hygiene;
- (b) Bed mobility;
- (c) Transfers;
- (d) Eating;
- (e) Toilet use;
- (f) Dressing;
- (g) Locomotion in room;
- (h) Locomotion outside room; and
- (i) Walk in room.

(2) The department through the CARE tool determines the ADL score by using the definitions in WAC 388-106-0010 under "Self-performance for ADLs." The CARE tool assigns the following points to the level of self performance for each of the ADLs listed in subsection (1) of this section. For the locomotion in room, locomotion outside of room and walk in room, the department uses the highest score of the three in determining the total ADL score.

ADL Scoring Chart	
If Self Performance is:	Score Equals
Independent	0
Supervision	1
Limited assistance	2

ADL Scoring Chart	
If Self Performance is:	Score Equals
Extensive assistance	3
Total dependence	4
Did not occur/no provider	4
Did not occur/client not able	4
Did not occur/client declined	0

(3) Although assessed by CARE, the department does not score bathing and medication management to determine classification groups.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0105, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0110 How does the CARE tool evaluate me for the exceptional care classification of the E Group? CARE places you in the exceptional care E Group classifications when the following criteria are met in either diagram 1 or 2:

Diagram 1
You have an ADL score of greater than or equal to 22.
AND
You need a turning/repositioning program.
AND
You need at least one of the following:
<ul style="list-style-type: none"> ■ External catheter; ■ Intermittent catheter; ■ Indwelling catheter care; ■ Bowel program; ■ Ostomy care; or ■ Total in self performance for toilet use.
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting, or provided by AFH/boarding home staff, facility RN/LPN, facility staff or private duty nursing when living in a residential setting:
<ul style="list-style-type: none"> ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).

Diagram 2
You have an ADL score of greater than or equal to 22.
AND
You need a turning/repositioning program.
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting, or provided by AFH/boarding home staff, facility RN/LPN, facility staff or private duty nursing when living in a residential setting:
<ul style="list-style-type: none"> ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).
AND
All of the following apply:
<ul style="list-style-type: none"> ■ You require IV nutrition support or tube feeding; ■ Your total calories received per IV or tube was greater than 50%; and ■ Your fluid intake by IV or tube is greater than 2 cups per day.

AND
You need assistance with one of the following, provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting or provided by AFH/boardng home staff, facility RN/LPN, facility staff, a private duty nurse or nurse delegation when living in a residential setting: <ul style="list-style-type: none"> ■ Dialysis; or ■ Ventilator/respirator.

[Statutory Authority: 2008 c 329. 08-19-102, § 388-106-0110, filed 9/17/08, effective 10/18/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 2007 c 522. 08-10-022, § 388-106-0110, filed 4/25/08, effective 5/26/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0110, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0115 How does CARE use criteria to place me in a classification group for residential facilities?

The CARE tool uses the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105 and exceptional care under WAC 388-106-0110 to place you into one of the following seventeen residential classification groups:

CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification subgroup following a classification path of highest possible group to lowest qualifying group.

(1) If you meet the criteria for exceptional care, then CARE will place you in Group E. CARE then further classifies you into:

- (a) Group E High if you have an ADL score of 26-28; or
- (b) Group E Medium if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have a cognitive performance score of 4-6 then you are classified in Group D regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

- (a) Group D High if you have an ADL score of 25-28; or
- (b) Group D Medium-High if you have an ADL score of 18-24; or
- (c) Group D Medium if you have an ADL score of 13-17;

or

- (d) Group D Low if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in Group C regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

- (a) Group C High if you have an ADL score of 25-28; or
- (b) Group C Medium-High if you have an ADL score of 18-24; or
- (c) Group C Medium if you have an ADL score of 9-17;

or

- (d) Group C Low if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into Group B. CARE further classifies you into:

- (a) Group B High if you have an ADL score of 15-28; or

(10/27/11)

(b) Group B Medium if you have an ADL score of 5-14; or

- (c) Group B Low if you have an ADL score of 0-4.

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in Group B. CARE further classifies you into:

(a) Group B High if you have a behavior point score 12 or greater; or

(b) Group B Medium-High if you have a behavior point score greater than 6; or

(c) Group B Medium if you have a behavior point score greater than 4; or

(d) Group B Low if you have a behavior point score greater than 1.

(6) If you are not clinically complex and you do not qualify under either mood and behavior criteria, then you are classified in Group A. CARE further classifies you into:

- (a) Group A High if you have an ADL score of 10-28; or
- (b) Group A Medium if you have an ADL score of 5-9;

or

- (c) Group A Low if you have an ADL score of 0-4.

[Statutory Authority: 2008 c 329. 08-19-102, § 388-106-0115, filed 9/17/08, effective 10/18/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0115, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0120 What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility?

The department publishes rates and/or adopts rules to establish how much the department pays toward the cost of your care in a residential facility. The department assigns payment rates to the CARE classification groups. Payment for care in a residential facility corresponds to the payment rate assigned to the classification group in which the CARE tool has placed you.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0120, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0125 If I am age twenty-one or older, how does CARE use criteria to place me in a classification group for in-home care?

CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a classification path of highest possible base hours to lowest qualifying base hours.

(1) If you meet the criteria for exceptional care, then CARE will place you in **Group E**. CARE then further classifies you into:

(a) **Group E High** with 416 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with 346 base hours if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have cognitive performance score of 4-6 or you have cognitive performance score of 5-6, then you are classified in **Group D** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group D High** with 277 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with 234 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with 185 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with 138 base hours if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in **Group C** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group C High** with 194 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with 174 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with 132 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with 87 base hours if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into **Group B**. CARE further classifies you into:

(a) **Group B High** with 147 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with 82 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with 47 base hours if you have an ADL score of 0-4; or

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in **Group B**. CARE further classifies you into:

(a) **Group B High** with 147 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with 101 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with 82 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with 47 base hours if you have a behavior point score greater than 1.

(6) If you are not clinically complex and your CPS score is less than 5 and you do not qualify under either mood and behavior criteria, then you are classified in **Group A**. CARE further classifies you into:

(a) **Group A High** with 71 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with 56 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with 26 base hours if you have an ADL score of 0-4.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 564 § 206(5), 10-11-050, § 388-106-0125, filed 5/12/10, effective 6/12/10. Statutory Authority: RCW 74.08.090, 74.09.520, and 2007 c 522, 08-10-022, § 388-106-

0125, filed 4/25/08, effective 5/26/08. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0125, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0126 If I am under age twenty-one, how does CARE use criteria to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLS as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a classification path of highest possible base hours to lowest qualifying base hours.

(1) If you meet the criteria for exceptional care, then CARE will place you in **Group E**. CARE then further classifies you into:

(a) **Group E High** with 420 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with 350 base hours if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have cognitive performance score of 4-6 or you have cognitive performance score of 5-6, then you are classified in **Group D** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group D High** with 280 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with 240 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with 190 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with 145 base hours if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in **Group C** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group C High** with 200 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with 180 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with 140 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with 95 base hours if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into **Group B**. CARE further classifies you into:

(a) **Group B High** with 155 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with 90 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with 52 base hours if you have an ADL score of 0-4; or

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in **Group B**. CARE further classifies you into:

(a) **Group B High** with 155 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with 110 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with 90 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with 52 base hours if you have a behavior point score greater than 1.

(6) If you are not clinically complex and your CPS score is less than 5 and you do not qualify under either mood and behavior criteria, then you are classified in **Group A**. CARE further classifies you into:

(a) **Group A High** with 78 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with 62 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with 29 base hours if you have an ADL score of 0-4.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 564 § 206(5), 10-11-050, § 388-106-0126, filed 5/12/10, effective 6/12/10.]

WAC 388-106-0130 How does the department determine the number of hours I may receive for in-home care?

(1) The department assigns a base number of hours to each classification group as described in WAC 388-106-0125.

(2) The department will deduct from the base hours to account for informal supports, as defined in WAC 388-106-0010, or other paid services that meet some of an individual's need for personal care services, including adult day health, as follows:

(a) The CARE tool determines the adjustment for informal supports by determining the amount of assistance available to meet your needs, assigns it a numeric percentage, and reduces the base hours assigned to the classification group by the numeric percentage. The department has assigned the following numeric values for the amount of assistance available for each ADL and IADL:

Meds	Self Performance	Status	Assistance Available	Value Percentage
Self administration of medications	Rules for all codes apply except independent is not counted	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
	1/2 to 3/4 time	.5		
	>3/4 time	.3		
Unscheduled ADLs	Self Performance	Status	Assistance Available	Value Percentage
Bed mobility, transfer, walk in room, eating, toilet use	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
	1/2 to 3/4 time	.5		
	>3/4 time	.3		
Scheduled ADLs	Self Performance	Status	Assistance Available	Value Percentage
Dressing, personal hygiene, bathing	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.75
			1/4 to 1/2 time	.55
	1/2 to 3/4 time	.35		
	>3/4 time	.15		
IADLs	Self Performance	Status	Assistance Available	Value Percentage
Meal preparation, Ordinary housework, Essential shopping	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.3
			1/4 to 1/2 time	.2
	1/2 to 3/4 time	.1		
	>3/4 time	.05		

IADLs	Self Performance	Status	Assistance Available	Value Percentage
Travel to medical	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
1/2 to 3/4 time	.5			
		>3/4 time	.3	
Key: > means greater than < means less than				

(b) To determine the amount of reduction for informal support, the value percentages are totaled and divided by the number of qualifying ADLs and IADLs needs. The result is value A. Value A is then subtracted from one. This is value B. Value B is divided by three. This is value C. Value A and Value C are summed. This is value D. Value D is multiplied by the "base hours" assigned to your classification group and the result is the number of in-home hours reduced for informal supports.

(3) Also, the department will adjust in-home base hours when:

(a) There is more than one client receiving ADSA-paid personal care services living in the same household, the status

under subsection (2)(a) of this section must be met or partially met for the following IADLs:

- (i) Meal preparation;
- (ii) Housekeeping;
- (iii) Shopping; and
- (iv) Wood supply.

(b) You are under the age of eighteen, your assessment will be coded according to age guidelines codified in WAC 388-106-0213.

(4) After deductions are made to your base hours, as described in subsections (2) and (3), the department may add on hours based on your living environment:

Condition	Status	Assistance Available	Add On Hours
Offsite laundry facilities, which means the client does not have facilities in own home and the caregiver is not available to perform any other personal or household tasks while laundry is done.	N/A	N/A	8
Client is >45 minutes from essential services (which means he/she lives more than 45 minutes one-way from a full-service market).	Unmet	N/A	5
	Met	N/A	0
	Partially met	<1/4 time	5
		between 1/4 to 1/2 time	4
		between 1/2 to 3/4 time	2
>3/4 time	2		
Wood supply used as sole source of heat.	Unmet	N/A	8
	Met	N/A	0
	Declines	N/A	0
	Partially met	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
>3/4 time	2		

(5) In the case of New Freedom consumer directed services (NFCDS), the department determines hours as described in WAC 388-106-1445.

(6) The result of actions under subsections (2), (3), and (4) is the maximum number of hours that can be used to develop your plan of care. The department must take into account cost effectiveness, client health and safety, and program limits in determining how hours can be used to meet your identified needs. In the case of New Freedom consumer directed services (NFCDS), a New Freedom spending plan (NFSP) is developed in place of a plan of care.

(7) You and your case manager will work to determine what services you choose to receive if you are eligible. The hours may be used to authorize:

(a) Personal care services from a home care agency provider and/or an individual provider.

(b) Home delivered meals (i.e. a half hour from the available hours for each meal authorized).

(c) Adult day care (i.e. a half hour from the available hours for each hour of day care authorized).

(d) A home health aide if you are eligible per WAC 388-106-0300 or 388-106-0500.

(e) A private duty nurse (PDN) if you are eligible per WAC 388-71-0910 and 388-71-0915 or WAC 388-551-3000 (i.e. one hour from the available hours for each hour of PDN authorized).

(f) The purchase of New Freedom consumer directed services (NFCDS).

[Statutory Authority: RCW 74.08.090, 74.09.520, and 2010 c 37. 11-11-024, § 388-106-0130, filed 5/10/11, effective 6/10/11. Statutory Authority: RCW 74.08.090, 74.09.520, 08-23-011, § 388-106-0130, filed 11/6/08, effective 12/7/08; 08-03-111, § 388-106-0130, filed 1/22/08, effective 2/22/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-

16-035, § 388-106-0130, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0130, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0130, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0135 What are the maximum hours that I can receive for in-home services? The maximum hours that you may receive is the base hours assigned to your classification group and adjusted per WAC 388-106-0130. For chore program clients, the maximum personal care hours per month the department will pay is one hundred sixteen.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0135, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0140 What may change the maximum number of hours that I can receive for in-home personal care services? The maximum number of in-home personal care hours you can receive may change:

- (1) When you have a change in any of the criteria listed in WAC 388-106-0125 and/or 388-106-0130; or
- (2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department for in-home personal care hours in excess of the amount determined to be available to you by the CARE tool.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. 07-01-046, § 388-106-0140, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0140, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0145 What may change the maximum payment rate that will be paid for residential personal care services provided to me? The maximum payment rate that will be paid for residential personal care services provided to you may change:

- (1) When you have a change in any of the criteria listed in WAC 388-106-0115 and/or 388-106-0120; or
- (2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department for a payment rate for your residential personal care services in excess of the rate determined to be applicable to you by the CARE tool.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. 07-01-046, § 388-106-0145, filed 12/14/06, effective 1/14/07.]

MEDICAID PERSONAL CARE (MPC)

WAC 388-106-0200 What services may I receive under medicaid personal care (MPC)? You may be eligible to receive only the following services under medicaid personal care (MPC):

- (1) Personal care services, as defined in WAC 388-106-0010, in your own home and, as applicable, assistance with personal care tasks while you are out of the home accessing community resources or working.
- (2) Personal care services in one of the following residential care facilities:
 - (a) Adult family homes; or
 - (b) A licensed boarding home that has contracted with the department to provide adult residential care services.

(10/27/11)

(3) Nursing services, if you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager:

- (a) Nursing assessment/reassessment;
- (b) Instruction to you and your providers;
- (c) Care coordination and referral to other health care providers;
- (d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource;
- (e) File review; and/or
- (f) Evaluation of health-related care needs affecting service planning and delivery.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0200, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0200, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0210 Am I eligible for MPC-funded services? You are eligible for MPC-funded services when the department assesses your needs and determines that you meet all of the following criteria:

- (1) You are certified as noninstitutional categorically needy, as defined in WAC 388-500-0005. Categorically needy medical institutional programs described in chapter 388-513 WAC do not meet this criteria.
- (2) You are functionally eligible which means one of the following applies:
 - (a) You have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in:		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Dressing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup

Medication Management	Assistance Required	N/A
Personal Hygiene	Supervision	N/A
Body care which includes: Application of ointment or lotions; Toenails trimmed; Dry bandage changes; or Passive range of motion treatment.	Need	N/A
Your need for assistance in any of the activities listed in subsection (a) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

; or

(b) You have an unmet or partially met need or the activity did not occur (because you were unable or no provider was available) with at least one or more of the following:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist
Dressing	Extensive Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist

Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Personal Hygiene	Extensive Assistance	One person physical assist
Body care which includes: Application of ointment or lotions; Toenails trimmed; Dry bandage changes; or Passive range of motion treatment.	Need	N/A
Your need for assistance in any of the activities listed in subsection (b) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose determining your functional eligibility.		

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0210, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0213 How are my needs assessed if I am a child applying for MPC services? If you are a child applying for MPC services, the department will complete a CARE assessment and:

- (1) Consider and document the role of your legally responsible natural/step/adoptive parent(s).
- (2) The CARE tool will determine your needs as met based on the guidelines outlined in the following table:

Ages	Activities of Daily Living (ADLs)																	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Medication Management	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Independent, self-directed, administration required, or must be administered	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Locomotion in Room ^{Note}	■	■	■	■														
Independent, supervision, limited or extensive	■	■																
Total	■	■																
Locomotion Outside Room ^{Note}	■	■	■	■	■	■												
Independent or supervision	■	■	■	■	■	■												
Limited or extensive	■	■	■	■														
Total	■	■	■	■														
Walk in Room ^{Note}	■	■	■	■														
Independent, supervision, limited or extensive	■	■	■	■														

Activities of Daily Living (ADLs)

Ages

■ = Code status as Met

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Total	■	■																
Bed Mobility																		
Independent, supervision, limited or extensive	■	■	■															
Total	■	■																
Transfers																		
Independent, supervision, limited, extensive or total & under 30 pounds (Total & 30 pounds or more = no age limit)	■	■	■															
Toilet Use																		
Support provided for nighttime wetting only (independent, supervision, limited, extensive)	■	■	■	■	■	■	■	■										
Independent, supervision, limited, extensive	■	■	■	■	■	■												
Total	■	■	■	■														
Eating																		
Independent, supervision, limited, extensive, or total	■	■	■															
Bathing																		
Independent or supervision	■	■	■	■	■	■	■	■	■	■	■	■						
Physical help/transfer only or physical help/part of bathing	■	■	■	■	■	■	■	■										
Total	■	■	■	■	■													
Dressing																		
Independent or supervision	■	■	■	■	■	■	■	■	■	■	■	■						
Limited or extensive	■	■	■	■	■	■	■	■										
Total	■	■	■	■	■													
Personal Hygiene																		
Independent or supervision	■	■	■	■	■	■	■	■	■	■	■	■						
Limited or extensive	■	■	■	■	■	■	■	■										
Total	■	■	■	■	■													

Instrumental Activities of Daily Living

Ages

■ = Code status as Met

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Telephone																		
Independent, supervision, limited, extensive, or total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Transportation																		
Independent, supervision, limited, extensive, or total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Shopping																		
Independent, supervision, limited, extensive, or total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Wood Supply																		
Independent, supervision, limited, extensive, or total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Housework																		
Independent, supervision, limited, extensive, or total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Finances																		
Independent, supervision, limited, extensive, or total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Meal Preparation																		
Independent, supervision, limited, extensive, or total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

NOTE: If the activity did not occur, the department codes self performance as total and status as met.

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Additional guidelines based on age																		
Diagnosis	■	■	■	■	■	■												
Is client comatose? = No	■	■	■	■	■	■												
Pain Daily = No	■	■	■	■	■	■												
Any foot care needs																		
Status = Need met	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

	Ages																	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Any skin care (other than feet)																		
Status = Need met	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Speech/Hearing																		
Score comprehension as understood	■	■	■															
MMSE can be administered = no	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Memory																		
Short term memory ok	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Long term memory ok	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Depression																		
Select interview = unable to obtain	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Decision making																		
Rate how client makes decisions = independent	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Bladder/Bowel																		
Support provided for nighttime wetting only - Individual management = Does not need/use	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Support provided for daytime wetting - Individual Management = Does not need/use	■	■	■	■	■	■												
Treatment																		
Passive range of motion Need = No	■	■	■	■														

(3) In addition, determine that the status and assistance available are met or partially met over three-fourths of the time, when you are living with your legally responsible natural/step/adoptive parent(s).

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-24-026, § 388-106-0213, filed 11/28/07, effective 1/1/08; 07-10-024, § 388-106-0213, filed 4/23/07, effective 6/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0213, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0213, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0215 When do MPC services start?

Your eligibility for MPC begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0215, filed 2/6/06, effective 3/9/06.]

WAC 388-106-0220 How do I remain eligible for MPC?

(1) In order to remain eligible for MPC, you must be in need of services in accordance with WAC 388-106-0210 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for MPC change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your MPC services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0220, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0225 How do I pay for MPC?

(1) If you live in your own home, you do not participate toward the cost of your personal care services.

(2) If you live in a residential facility and are:

(a) An SSI beneficiary who receives only SSI income, you only pay for board and room. You are allowed to keep a personal needs allowance of forty-one dollars and forty-four cents per month. Effective January 1, 2009 this amount will change to sixty-two dollars and seventy-nine cents;

(b) An SSI beneficiary who receives SSI and another source of income, you only pay for board and room. You are allowed to keep a personal needs allowance of forty-one dollars and forty-four cents. You keep an additional twenty dollars from non-SSI income. Effective January 1, 2009 this amount will change to sixty-two dollars and seventy-nine cents. This new amount includes the twenty dollar disregard;

(c) An SSI-related person under WAC 388-475-0050, you may be required to participate towards the cost of your personal care services in addition to your board and room if your financial eligibility is based on the facility's state contracted rate described in WAC 388-513-1305. You are allowed to keep a personal needs allowance of forty-one dollars and forty-four cents. You keep an additional twenty dollars from non-SSI income. Effective January 1, 2009 this amount will change to sixty-two dollars and seventy-nine cents. This new amount includes the twenty dollar disregard; or

(d) A general assistance client eligible for categorically needy medicaid coverage in an adult family home (AFH), you are allowed to keep a personal needs allowance (PNA) of thirty-eight dollars and eighty-four cents per month. The remainder of your income must be paid to the AFH as your room and board up to the ADSA room and board standards.

(e) A general assistance client eligible for categorically needy medicaid coverage in a boarding home, you are authorized a personal needs grant of up to thirty-eight dollars and eighty-four cents per month.

(f) Personal needs allowance (PNA) standards and the ADSA room and board standard can be found at <http://www>.

dshs.wa.gov/manuals/eaz/sections/LongTermCare/lcstandardsPNAchartsubfile.shtml.

(3) The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the medicaid resident dies in the facility; or

(b) Day of service before the day the medicaid resident is discharged.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). 08-22-052, § 388-106-0225, filed 11/3/08, effective 12/4/08. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-106-0225, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520 and 2007-09 operating budget (SHB 1128). 07-21-020, § 388-106-0225, filed 10/8/07, effective 11/8/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0225, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0230 Can I be employed and receive MPC? You can be employed and receive MPC services if you remain medicaid eligible under the noninstitutional categorically needy program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0230, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0235 Are there waiting lists for MPC? There are no waiting lists for MPC. Instead of waiting lists, the department may revise rules to reduce caseload size, hours, rates, or payments in order to stay within the legislative appropriation.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0235, filed 5/17/05, effective 6/17/05.]

ROADS TO COMMUNITY LIVING

WAC 388-106-0250 What is the roads to community living (RCL) demonstration project and who is eligible?

(1) Roads to community living (RCL) is a demonstration project, funded by a five-year "money follows the person" grant authorized under section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171). It is designed to test services and supports which help customers move from institutional settings into the community if they wish to.

(2) To be eligible, the department must assess your needs in CARE and you must:

(a) Have a continuous six months or longer stay in a qualified institutional setting (hospital, nursing home, residential habilitation center);

(b) Be medicaid eligible for at least thirty days prior to discharge from the institutional setting;

(c) Intend to move to a qualified community setting (home, apartment, licensed residential setting with four or less unrelated individuals); and

(d) Not be able to move into a qualified community setting using available long-term care resources.

(3) When you are discharged to a qualified community setting, you are eligible for continuous medicaid coverage until your RCL services end.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). 08-18-046, § 388-106-0250, filed 8/29/08, effective 9/29/08.]

(10/27/11)

WAC 388-106-0255 How long are RCL services available to me? Roads to community living (RCL) can be authorized for no longer than three hundred sixty-five days in a qualified community setting. Day one of the demonstration year is the day you move from the institutional setting into the qualified community setting. Day three hundred sixty-five is the last day you can receive demonstration services.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). 08-18-046, § 388-106-0255, filed 8/29/08, effective 9/29/08.]

WAC 388-106-0260 How do I pay for RCL services? Depending on your income and resources, you may be required to pay participation toward the cost of your care, as outlined in chapters 388-515 or 388-106 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). 08-18-046, § 388-106-0260, filed 8/29/08, effective 9/29/08.]

WAC 388-106-0265 Do I have the right to a fair hearing while receiving RCL services? Yes, you may request a fair hearing based on the rules outlined in WAC 388-106-1305 to contest eligibility decisions made by the department. Once your three hundred sixty-five days of roads to community living (RCL) eligibility end, per WAC 388-106-0255, you may not request a fair hearing to contest the conclusion of RCL services or to request an extension.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). 08-18-046, § 388-106-0265, filed 8/29/08, effective 9/29/08.]

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES)

WAC 388-106-0300 What services may I receive under community options program entry system (COPES) when I live in my own home? When you live in your own home, you may be eligible to receive only the following services under COPES:

(1) Personal care services as defined in WAC 388-106-0010 in your own home and, as applicable, while you are out of the home accessing community resources or working.

(2) Adult day care if you meet the eligibility requirements under WAC 388-106-0805.

(3) Environmental modifications, if the minor physical adaptations to your home:

(a) Are necessary to ensure your health, welfare and safety;

(b) Enable you to function with greater independence in the home;

(c) Directly benefit you medically or remedially;

(d) Meet applicable state or local codes; and

(e) Are not adaptations or improvements, which are of general utility or add to the total square footage.

(4) Home delivered meals, providing nutritional balanced meals, limited to one meal per day, if:

(a) You are homebound and live in your own home;

(b) You are unable to prepare the meal;

(c) You don't have a caregiver (paid or unpaid) available to prepare this meal; and

(d) Receiving this meal is more cost-effective than having a paid caregiver.

(5) Home health aide service tasks in your own home, if the service tasks:

(a) Include assistance with ambulation, exercise, self-administered medications and hands-on personal care;

(b) Are beyond the amount, duration or scope of medic-aid reimbursed home health services as described in WAC 388-551-2120 and are in addition to those available services;

(c) Are health-related. Note: Incidental services such as meal preparation may be performed in conjunction with a health-related task as long as it is not the sole purpose of the aide's visit; and

(d) Do not replace medicare home health services.

(6)(a) Personal emergency response system (PERS), if the service is necessary to enable you to secure help in the event of an emergency and if:

(i) You live alone in your own home;

(ii) You are alone, in your own home, for significant parts of the day and have no regular provider for extended periods of time; or

(iii) No one in your home, including you, can secure help in an emergency.

(b) A medication reminder if you:

(i) Are eligible for a PERS unit;

(ii) Do not have a caregiver available to provide the service; and

(iii) Are able to use the reminder to take your medications.

(7) Skilled nursing, if the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse; and

(b) Beyond the amount, duration or scope of medic-aid-reimbursed home health services as provided under WAC 388-551-2100.

(8) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, if the items are:

(a) Medically necessary under WAC 388-500-0005;

(b) Necessary for: Life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under medic-aid and/or medicare.

(9) Training needs identified in CARE or in a professional evaluation, which meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers.

(10) Transportation services, when the service:

(a) Provides access to community services and resources to meet your therapeutic goal;

(b) Is not diverting in nature; and

(c) Is in addition to and does not replace the medic-aid-brokered transportation or transportation services available in the community.

(11) Nurse delegation services, when:

(a) You are receiving personal care from a registered or certified nursing assistant who has completed nurse delegation core training;

(b) Your medical condition is considered stable and predictable by the delegating nurse; and

(c) Services are provided in compliance with WAC 246-840-930.

(12) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager.

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In non-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource.

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service plan and delivery.

(13) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to set up your own home. Services:

(a) May include: Safety deposits, utility set-up fees or deposits, health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to occupation, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution; and

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-24-026, § 388-106-0300, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0300, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0300, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0305 What services may I receive under COPES if I live in a residential facility?

If you live in one of the following residential facilities: A licensed boarding home contracted with the department to provide assisted living, enhanced adult residential care, enhanced adult residential care-specialized dementia care or an adult family home, you may be eligible to receive only the following services under COPES:

(1) Personal care services as defined under WAC 388-106-0010.

(2) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, when the items are:

(a) Medically necessary under WAC 388-500-0005; and

(b) Necessary: For life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live; and

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under medicaid and/or medicare; and

(e) In addition to and do not replace the services required by the department's contract with a residential facility.

(3) Training needs identified in CARE or in a professional evaluation, that are in addition to and do not replace the services required by the department's contract with the residential facility and that meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers.

(4) Transportation services, when the service:

(a) Provides access to community services and resources to meet a therapeutic goal;

(b) Is not diverting in nature;

(c) Is in addition to and does not replace the medicaid-brokered transportation or transportation services available in the community; and

(d) Does not replace the services required by DSHS contract in residential facilities.

(5) Skilled nursing, when the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse;

(b) Beyond the amount, duration or scope of medicaid-reimbursed home health services as provided under WAC 388-551-2100; and

(c) In addition to and does not replace the services required by the department's contract with the residential facility (e.g. intermittent nursing services as described in WAC 388-78A-2310).

(6) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager.

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource.

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service plan and delivery.

(7) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to live in a residential facility. Services:

(a) May include: Safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution.

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0305, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0305, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0310 Am I eligible for COPES-funded services? You are eligible for COPES-funded services if you meet all of the following criteria. The department must assess your needs in CARE and determine that:

(1) You are age:

(a) Eighteen or older and blind or have a disability, as defined in WAC 388-475-0050; or

(b) Sixty-five or older.

(2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1505, community options program entry system (COPES).

(3) You:

(a) Are not eligible for medicaid personal care services (MPC); or

(b) Are eligible for MPC services, but the department determines that the amount, duration, or scope of your needs is beyond what MPC can provide.

(4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless COPES services are provided) which is defined in WAC 388-106-0355(1).

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-106-0310, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0310, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0315 When do COPES services start? Your eligibility for COPES begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0315, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0320 How do I remain eligible for COPES? (1) In order to remain eligible for COPES, you must be in need of services in accordance with WAC 388-106-0310 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for COPES change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your COPES services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0320, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0325 How do I pay for COPES services? Depending on your income and resources, you may be required to pay participation toward the cost of your care, as outlined in WAC 388-515-1505. If you have nonexempt income that exceeds the cost of COPES services, you may retain the difference. If you are receiving services in:

(1) Your own home, you are allowed to keep some of your income for a maintenance allowance.

(2) In a residential facility, you must use your income to pay for your room and board and services. You are allowed to keep some of your income for personal needs allowance (PNA). The department determines the amount of PNA that you may keep. The department pays the facility for the difference between what you pay and the department-set rate for the facility. The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the medicaid resident dies in the facility; or

(b) Day of service before the day the medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0325, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0330 Can I be employed and receive COPES? You can be employed and receive COPES, per WAC 388-515-1505.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0330, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0335 Are there waiting lists for COPES? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

(1) Nursing home residents wanting COPES waiver services will be ranked first on the wait list by date of application for services;

(2) Then clients living in the community with a higher level of need, as determined by the CARE assessment, will be ranked higher on the wait list over clients with a lower level of need; and

(3) When two or more clients in the community have equal need levels, the client with the earlier application for services will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0335, filed 5/17/05, effective 6/17/05.]

NURSING FACILITY CARE SERVICES

WAC 388-106-0350 What are nursing facility care services? You may receive care in a nursing facility, as outlined in chapter 388-97 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0350, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0355 Am I eligible for nursing facility care services? You are eligible for nursing facility care if the department:

(1) Assesses you in CARE and determines that you meet the functional criteria for nursing facility level of care which means one of the following applies:

(a) You require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;

(b) You have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Your need for assistance in any activities listed in subsection (b) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose in determining your functional eligibility.		

(c) You have an unmet or partially met need with at least two of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Your need for assistance in any of the activities listed in subsection (c) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

or:

(d) You have a cognitive impairment and require supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Your need for assistance in any of the activities listed in subsection (d) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(2) Determines that you meet the financial eligibility requirements set through WAC 388-513-1315.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0355, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0360 How do I pay for nursing facility care services? (1) If you are medicaid eligible and the nursing facility admits you without a request for assessment from the department, the nursing facility will not:

- (a) Be reimbursed by the department; or
- (b) Be allowed to collect payment, including a deposit or minimum stay fee, from you or your family/representative for any care provided before the date of request for assessment.

(2) If you are eligible for medicaid-funding nursing facility care, the department pays for your services beginning on the date:

- (a) Of the request for a department assessment; or
- (b) Nursing facility care actually begins, whichever is later.

(3) If you become financially eligible for medicaid after you have been admitted, the department pays for your nursing facility care beginning on the date of:

- (a) Request for assessment or financial application, whichever is earlier;
- (b) Nursing facility placement; or
- (c) When you are determined financially eligible, whichever is later.

(4) Exception: Payment back to the request date is limited to three months prior to the month that the financial application is received.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0360, filed 5/17/05, effective 6/17/05.]

MEDICALLY NEEDY RESIDENTIAL WAIVER

WAC 388-106-0400 What services may I receive under medically needy residential waiver (MNRW)? You may be eligible to receive only the following MNRW services in one of the following residential facilities: A licensed boarding home contracted with the department to provide assisted living, enhanced residential care, enhanced adult residential care-specialized dementia care or an adult family home:

- (1) Personal care services as defined in WAC 388-106-0010.
- (2) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, when the items are:
 - (a) Medically necessary under WAC 388-500-0005; and
 - (b) Necessary: For life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;
 - (c) Directly medically or remedially beneficial to you;
 - (d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under medicaid and/or medicare; and
 - (e) In addition to and do not replace the services required by the department's contract with the residential facility.
- (3) Training needs identified in CARE or in a professional evaluation that are in addition to and do not replace

services required by the department's contract with the residential facility and that meet a therapeutic goal such as:

- (a) Adjusting to a serious impairment;
 - (b) Managing personal care needs; or
 - (c) Developing necessary skills to deal with care providers.
- (4) Transportation services, when the service:
- (a) Provides access to community services and resources provided to meet a therapeutic goal;
 - (b) Is not diverting in nature;
 - (c) Is in addition to and does not replace the medicaid-brokered transportation or transportation services available in the community; and
 - (d) Does not replace the services required by the department's contract with a residential facility.
- (5) Skilled nursing, when the service is:
- (a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse;
 - (b) Beyond the amount, duration or scope of medicaid-reimbursed home health services as provided under WAC 388-551-2120; and
 - (c) In addition to and does not replace the services required by the department's contract with the residential facility (e.g. intermittent nursing services as described in WAC 388-78A-2310).
 - (6) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager.
 - (a) Nursing assessment/reassessment;
 - (b) Instruction to care providers and clients;
 - (c) Care coordination and referral to other health care providers;
 - (d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource.
 - (e) File review; and/or
 - (f) Evaluation of health-related care needs affecting service plan and delivery.
 - (7) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to live in a residential facility. Services:
 - (a) May include: Safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution.
 - (b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0400, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0400, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0410 Am I eligible for MNRW-funded services? You are eligible for MNRW-funded services if you choose to receive services in a residential facility and you meet all of the following criteria. The department must assess your needs, using CARE, and determine that:

- (1) You are age:
 - (a) Eighteen or older and blind or have a disability, as defined in WAC 388-475-0050; or
 - (b) Sixty-five or older.
- (2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1540.
- (3) You are not eligible for medicaid personal care services (MPC) or COPES.
- (4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless MNRW services are provided) which is defined in WAC 388-106-0355(1).

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-106-0410, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0410, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0415 When do MNRW services start?

Your eligibility for MNRW begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0415, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0420 How do I remain eligible for MNRW? (1) In order to remain eligible for MNRW, you must be in need of services in accordance with WAC 388-106-0410 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for MNRW change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your MNRW services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0420, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0425 How do I pay for MNRW services?

(1) You must use your income to pay for your room and board and services. The amount you pay is determined in WAC 388-515-1540. You are allowed to keep some of your income for personal needs allowance (PNA). The department pays the facility for the difference between what you pay and the department-set rate for the facility. The department pays the residential care facility from the first day of service through the:

- (a) Last day of service when the medicaid resident dies in the facility; or
- (b) Day of service before the day the medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0425, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0430 Can I be employed and receive MNRW? You may be employed and receive MNRW per WAC 388-515-1540.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0430, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0435 Are there waiting lists for MNRW? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

(1) Nursing home residents wanting MN waiver services will be ranked first on the wait list by date of application for services;

(2) Then clients living in the community with a higher level of need, as determined by the department's CARE assessment, will be ranked higher on the wait list over clients with lower level of need; and

(3) When two or more clients in the community have equal need levels, the client with the earlier application for services will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0435, filed 5/17/05, effective 6/17/05.]

MEDICALLY NEEDY IN-HOME WAIVER

WAC 388-106-0500 What services may I receive under medically needy in-home waiver (MNIW)? You may be eligible to receive only the following medically needy in-home waiver (MNIW) services in your own home:

(1) Personal care services as defined in WAC 388-106-0010 in your own home and, as applicable, while you are out of the home accessing community resources or working.

(2) Adult day care if you meet the eligibility requirements under WAC 388-106-0805.

(3) Environmental modifications, if the minor physical adaptations to your home:

(a) Are necessary to ensure your health, welfare and safety;

(b) Enable you to function with greater independence in the home;

(c) Directly benefit you medically or remedially;

(d) Meet applicable state or local codes; and

(e) Are not adaptations or improvements, which are of general utility or add to the total square footage.

(4) Home delivered meals, providing nutritional balanced meals, limited to one meal per day, if:

(a) You are homebound and live in your own home;

(b) You are unable to prepare the meal;

(c) You don't have a caregiver (paid or unpaid) available to prepare this meal; and

(d) Receiving this meal is more cost-effective than having a paid caregiver.

(5) Home health aide service, if the service tasks:

(a) Include assistance with ambulation, exercise, self-administered medications and hands on personal care;

(b) Are beyond the amount, duration or scope of medicare reimbursed home health services (WAC 388-551-2120) and are in addition to those available services;

(c) Are health-related. Note: Incidental services such as meal preparation may be performed in conjunction with a

health-related task as long as it is not the sole purpose of the aide's visit; and

(d) Do not replace medicare home health services.

(6)(a) Personal emergency response system (PERS), if the service is necessary to enable you to secure help in the event of an emergency and if:

(i) You live alone in your own home;

(ii) You are alone, in your own home, for significant parts of the day and have no regular provider for extended periods of time; or

(iii) No one in your home, including you, can secure help in an emergency.

(b) A medication reminder if you:

(i) Are eligible for a PERS unit;

(ii) Do not have a caregiver available to provide the service; and

(iii) Are able to use the reminder to take your medications.

(7) Skilled nursing, if the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse; and

(b) Beyond the amount, duration or scope of medicare-reimbursed home health services as provided under WAC 388-551-2120.

(8) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, if the items are:

(a) Medically necessary under WAC 388-500-0005;

(b) Necessary: For life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under medicare and/or medicare.

(9) Training needs identified in CARE or in a professional evaluation, which meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers.

(10) Transportation services if you live in your own home, when the service:

(a) Provides access to community services and resources to meet a therapeutic goal;

(b) Is not diverting in nature;

(c) Is in addition to and does not replace the medicare-brokered transportation or transportation services available in the community.

(11) Nurse delegation services when:

(a) You are receiving personal care from a registered or certified nursing assistant who has completed nurse delegation core training;

(b) Your medical condition is considered stable and predictable by the delegating nurse; and

(c) Services are provided in compliance with WAC 246-840-930.

(12) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activi-

ties. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any collateral contact information obtained by your case manager.

- (a) Nursing assessment/reassessment;
- (b) Instruction to you and your providers;
- (c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In non-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource;

- (e) File review; and/or
- (f) Evaluation of health-related care needs affecting service planning and delivery.

(13) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to set up your own home. Services:

(a) May include: Safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution.

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520. 07-24-026, § 388-106-0500, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0500, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0500, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0510 Am I eligible for MNIW-funded services? You are eligible for MNIW-funded services if you choose to receive services in your own home and you meet all of the following criteria. The department must assess your needs in CARE and determine that:

- (1) You are age:
 - (a) Eighteen or older and blind or have a disability, as defined in WAC 388-475-0050; or
 - (b) Sixty-five or older.
- (2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1505;
- (3) You are not eligible for medicaid personal care services (MPC) or COPES;
- (4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless MNIW services are provided) which is defined in WAC 388-106-0355(1).

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-106-0510, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0510, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0515 When do MNIW services start? Your eligibility for MNIW begins the date the department authorizes services.

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[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0515, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0520 How do I remain eligible for MNIW? (1) In order to remain eligible for MNIW, you must be in need of services in accordance with WAC 388-106-0510 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for MNIW change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your MNIW services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0520, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0525 How do I pay for MNIW? The amount you pay is determined in WAC 388-515-1550.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0525, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0530 Can I be employed and receive MNIW? You can be employed and receive MNIW, per WAC 388-515-1550.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0530, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0535 Are there waiting lists for MNIW? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

- (1) Nursing home residents wanting MN waiver services will be ranked first on the wait list by date of application for services;
- (2) Then clients living in the community with a higher level of need as determined by the department's CARE assessment will be ranked higher on the wait list over clients with lower level of need; and
- (3) When two or more clients in the community have equal need levels, the client with the earlier application for services will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0535, filed 5/17/05, effective 6/17/05.]

CHORE

WAC 388-106-0600 What services may I receive under chore? You may receive personal care services in your own home and, as applicable, assistance with personal care tasks while you are out of the home accessing community resources or working.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0600, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0610 Am I eligible for chore-funded services? To be eligible for chore-funded services you must meet all of the following criteria:

(1) Be grandfathered on the chore program before August 1, 2001 and have continued to receive chore without a break in service.

(2) Not be eligible for MPC or COPES.

(3) Be eighteen years of age or older.

(4) Have an unmet or partially met need with at least one of the following activities of daily living, as defined in WAC 388-106-0010.

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Dressing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Personal Hygiene	Supervision	N/A
Body care which includes: Application of ointment or lotions; Toenails trimmed; Dry bandage changes; or Passive range of motion treatment.	Need	N/A
Your need for assistance in any of the activities listed in this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(5) Have net household income (as described in WAC 388-450-0005 and 388-450-0040) not exceeding:

(a) The sum of the cost of your chore services; and

(b) One-hundred percent of the federal poverty level (FPL) adjusted for family size.

(6) Have resources, as described in chapter 388-470 WAC, which do not exceed ten thousand dollars for a one-person family or fifteen thousand dollars for a two-person family. (Note: One thousand dollars for each additional family member may be added to these limits.); and

(7) Not transfer assets on or after November 1, 1995 for less than fair market value, as described in WAC 388-513-1365.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0610, filed 5/17/05, effective 6/17/05.]

(10/27/11)

WAC 388-106-0615 When do chore services start?

Your eligibility for chore services begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0615, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0620 How do I remain eligible for chore?

(1) In order to remain eligible for chore, you must be in need of services in accordance with WAC 388-106-0610 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for chore change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your chore services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0620, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0625 How do I pay for chore?

You may retain an amount equal to one hundred percent of the federal poverty level, adjusted for family size, as the home maintenance allowance and pay the difference between the FPL and your nonexempt income. Exempt income includes:

(1) Income listed in WAC 388-513-1340;

(2) Spousal income allocated and actually paid as participation in the cost of the spouse's community options program entry system (COPES) services;

(3) Amounts paid for medical expenses not subject to third party payment;

(4) Health insurance premiums, coinsurance or deductible charges; and

(5) If applicable, those work expense deductions listed in WAC 388-106-0630(2).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0625, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0630 Can I be employed and receive chore?

If you are not medicaid eligible due to your earned income and resources and are receiving chore personal care services:

(1) You may be required to pay participation, per WAC 388-106-0625, for any earned income above one hundred percent of the federal poverty level.

(2) The department will exempt fifty percent of your earned income after work expense deductions. Work expense deductions are:

(a) Personal work expenses in the form of self-employment taxes (FICA); and income taxes when paid;

(b) Payroll deductions required by law or as a condition of employment in the amounts actually withheld;

(c) The necessary cost of transportation to and from the place of employment by the most economical means, except rental cars;

(d) Expenses necessary for continued employment such as tools, materials, union dues, transportation to service customers not furnished by the employer; and

(e) Uniforms needed on the job and not suitable for wear away from the job.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0630, filed 5/17/05, effective 6/17/05.]

VOLUNTEER CHORE

WAC 388-106-0650 What services may I receive under volunteer chore? Volunteer chore is a state-funded program which provides volunteer assistance with household tasks and:

- (1) Assists people who need but are not eligible for DSHS services.
- (2) Complements DSHS services by using volunteer assistance to perform tasks which do not require specially-skilled personnel.
- (3) Provides assistance with housework, laundry, shopping, cooking, moving, minor home repair, yard care, limited personal care, monitoring and transportation.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0650, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0655 Am I eligible to receive volunteer chore services? You may receive volunteer chore services if you are:

- (1) Eighteen years of age or older;
- (2) Living at home unless you are moving from a residential facility to home and need assistance moving;
- (3) Unable to perform certain personal care tasks due to functional or cognitive impairment;
- (4) Financially unable to purchase services from a private provider;
- (5) Not receiving services under COPES, MNIW, MPC, or chore because you:
 - (a) Do not meet the eligibility requirements; or
 - (b) Decline these services.
- (6) In need of assistance from volunteer chore in addition to or in substitution of paid services under COPES, MNIW, MPC, or chore.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0655, filed 5/17/05, effective 6/17/05.]

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

WAC 388-106-0700 What services may I receive under PACE? Under their contract with the department, the PACE provider develops an individualized plan of care, as defined in 42 CFR 460.106, that integrates necessary long-term care, medical services, mental health services, and alcohol and substance abuse treatment services.

- (1) The care plan includes, but is not limited to any of the following long-term care services:
 - (a) Care coordination;
 - (b) Home and community-based services:
 - (i) Personal (in-home) care;
 - (ii) Residential care.
 - (c) And, if necessary, nursing facility care.
- (2) The care plan may also include, but is not limited to, the following medical services:
 - (a) Primary medical care;
 - (b) Vision care;
 - (c) End of life care;

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- (d) Restorative therapies, including speech, occupational, and physical therapy;
 - (e) Oxygen therapy;
 - (f) Audiology (including hearing aids);
 - (g) Transportation;
 - (h) Podiatry;
 - (i) Durable medical equipment (e.g., wheelchair);
 - (j) Dental care;
 - (k) Pharmaceutical products;
 - (l) Immunizations and vaccinations;
 - (m) Emergency room visits and inpatient hospital stays.
- (3) The care plan may also include any other services determined necessary by the interdisciplinary team to improve and maintain your overall health status.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0700, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0705 Am I eligible for PACE services?

To qualify for medicaid-funded PACE services, you must apply for an assessment by contacting your local home and community services office. The department will assess and determine whether you:

- (1) Are age:
 - (a) Fifty-five or older, and blind or have a disability, as defined in WAC 388-475-0050, SSI-related eligibility requirements; or
 - (b) Sixty-five or older.
- (2) Need nursing facility level of care as defined in WAC 388-106-0355;
- (3) Live within the designated service area of the PACE provider;
- (4) Meet financial eligibility requirements. This means the department will assess your finances, determine if your income and resources fall within the limits, and determine the amount you may be required to contribute, if any, toward the cost of your care as described in WAC 388-515-1505;
- (5) Not be enrolled in any other medicare or medicaid prepayment plan or optional benefit; and
- (6) Agree to receive services exclusively through the PACE provider and the PACE provider's network of contracted providers.

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW, 08-11-047, § 388-106-0705, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0705, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0705, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0710 How do I pay for PACE services? Depending on your income and resources, you may be required to pay for part of the PACE services. The department's financial worker will determine what amount, if any, you must contribute if you decide to enroll. The department pays the PACE provider the remaining amount.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0710, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0715 How do I end my enrollment in the PACE program? (1) You may choose to voluntarily end your enrollment in the PACE program without cause at any

time. To do so, you must give the PACE provider written notice. If you give notice:

(a) Before the fifteenth of the month, the department will end your enrollment effective at the end of the month; or

(b) After the fifteenth, the department will end your enrollment effective until the end of the following month.

(2) Your enrollment may also end involuntarily if you:

(a) Move out of the designated service area or are out of the service area for more than thirty consecutive days, unless the PACE provider agrees to a longer absence due to extenuating circumstances;

(b) Engage in disruptive or threatening behavior such that the behavior jeopardizes your health or safety, or the safety of others;

(c) Fail to comply with your plan of care or the terms of the PACE enrollment agreement;

(d) Fail to pay or make arrangements to pay your part of the costs after the thirty-day grace period;

(e) Become financially ineligible for medicaid services, unless you choose to pay privately;

(f) Are enrolled with a provider that loses its license and/or contract; or

(g) No longer meet the nursing facility level of care requirement as defined in WAC 388-106-0205.

(3) For any of the above reasons, the PACE provider must give you written notice, explaining that they are terminating benefits. If the provider gives you notice:

(a) Before the fifteenth of the month, then the department will end your enrollment at the end of the month; or

(b) After the fifteenth, then the department will end your enrollment at the end of the following month.

(4) Before the PACE provider can involuntarily end your enrollment in the PACE program, the department must review and approve it.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0715, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0715, filed 5/17/05, effective 6/17/05.]

WASHINGTON MEDICAID INTEGRATION PARTNERSHIP (WMIP)

WAC 388-106-0745 What services may I receive under WMIP? (1) Once you are determined eligible, your care plan could include, but is not limited to, any of the following long-term care services:

(a) Care coordination;

(b) Personal care services in your own home or in a residential facility;

(c) Home health aide;

(d) Adult day services;

(e) Environmental modifications;

(f) Personal emergency response system (PERS);

(g) Skilled nursing;

(h) Specialized medical equipment and supplies;

(i) Home delivered meals;

(j) Residential care;

(k) Nursing facility care.

(2) The care plan may also include medical, chemical dependency, and/or mental health services.

(10/27/11)

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438.06-18-058, § 388-106-0745, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0750 Am I eligible to enroll in WMIP?

(1) To enroll in WMIP you must:

(a) Be aged, blind, or disabled;

(b) Be twenty-one years of age or older;

(c) Receive, or be eligible for, categorically needy medical assistance per WAC 388-500-0005; and

(d) Not be enrolled in any other comparable third party insurance coverage plan that purchases services on a prepaid basis (for example, a prepaid health plan).

(2) To be eligible to receive long-term care services under this program, you must meet functional eligibility for one of the long-term care programs per WAC 388-106-0210(2), 388-106-0310(4), or 388-106-0355(1) and financial eligibility for noninstitutional categorically needy, or institutional categorically needy as described in chapter 388-513 WAC and WAC 388-515-1505.

(3) Ongoing functional and financial eligibility for long-term care services will be determined at least annually by the state.

(4) If you are determined ineligible for long-term care services, you may continue to receive medical, mental health and chemical dependency treatment services through WMIP as long as you continue to meet the criteria listed in subsection (1) above.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438.06-18-058, § 388-106-0750, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0755 How do I pay for WMIP services? Depending on your income and resources, you may be required to pay for part of your long-term care services you receive through WMIP. The department will determine what amount, if any, you must contribute toward the cost of your care.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438.06-18-058, § 388-106-0755, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0760 How do I disenroll from WMIP?

You may choose to disenroll from WMIP for any reason at any time. See WAC 388-538-061 for additional information on ending enrollment in WMIP.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438.06-18-058, § 388-106-0760, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0765 What is the fair hearing process for enrollee appeals of managed care organization actions? See WAC 388-538-112 for additional information specific to the managed care fair hearing process. For hearing information specific to long-term care services eligibility, see WAC 388-106-1305.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438.06-18-058, § 388-106-0765, filed 8/31/06, effective 10/1/06.]

ADULT DAY SERVICES

WAC 388-106-0800 What adult day care services may I receive? You may receive the following services in an adult day care:

- (1) Core services, which include assistance with:
 - (a) Locomotion outside of room, locomotion in room, walk in room;
 - (b) Body care;
 - (c) Eating;
 - (d) Repositioning;
 - (e) Medication management that does not require a licensed nurse;
 - (f) Transfer;
 - (g) Toileting;
 - (h) Personal hygiene at a level that ensures your safety and comfort while in attendance at the program; and
 - (i) Bathing at a level that ensures your safety and comfort while in attendance at the program.
- (2) Social services on a consultation basis, which may include:
 - (a) Referrals to other providers for services not within the scope of medicaid reimbursed adult day care services;
 - (b) Caregiver support and education; or
 - (c) Assistance with coping skills.
- (3) Routine health monitoring with consultation from a registered nurse that a consulting nurse acting within the scope of practice can provide with or without a physician's order. Examples include:
 - (a) Obtaining baseline and routine monitoring information on your health status, such as vital signs, weight, and dietary needs;
 - (b) General health education such as providing information about nutrition, illnesses, and preventative care;
 - (c) Communicating changes in your health status to your caregiver;
 - (d) Annual and as needed updating of your medical record; or
 - (e) Assistance as needed with coordination of health services provided outside of the adult day care program.
- (4) General therapeutic activities that an unlicensed person can provide or that a licensed person can provide with or without a physician's order. These services are planned for and provided based on your abilities, interests, and goals. Examples include:
 - (a) Recreational activities;
 - (b) Diversionary activities;
 - (c) Relaxation therapy;
 - (d) Cognitive stimulation; or
 - (e) Group range of motion or conditioning exercises.
- (5) General health education that an unlicensed person can provide or that a licensed person can provide with or without a physician's order, including but not limited to topics such as:
 - (a) Nutrition;
 - (b) Stress management;
 - (c) Disease management skills; or
 - (d) Preventative care.
- (6) A nutritional meal and snacks are provided every four hours, including a modified diet if needed and within the scope of the program, as provided under WAC 388-71-0768;

(7) Supervision and/or protection if needed for your safety;

(8) Assistance with arranging transportation to and from the program; and

(9) First aid and provisions for obtaining or providing care in an emergency. NOTE: If you require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of your physician, consider adult day health services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0800, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0805 Am I eligible for adult day care?

(1) If you receive COPES or MNIW, you may be eligible for adult day care as a waiver service if you are assessed as having an unmet need for one or more of the following core services:

- (a) Personal care services;
- (b) Routine health monitoring with consultation from a registered nurse;
- (c) General therapeutic activities; or
- (d) Supervision and/or protection if required for your safety.

(2) You are not eligible for adult day care if you receive COPES or MNIW and you:

- (a) Can independently perform or obtain the services provided at an adult day care center;
- (b) Have unmet needs that can be met through the COPES or MNIW program more cost effectively without authorizing day care services;
- (c) Have referred care needs that:
 - (i) Exceed the scope of authorized services that the adult day care center is able to provide;
 - (ii) Can be met in a less structured care setting; or
 - (iii) Are being met by paid or unpaid caregivers.
- (d) Live in a nursing home, boarding home, adult family home, or other licensed institutional or residential facility; or
- (e) Are not capable of participating safely in a group care setting.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0805, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0810 What adult day health services may I receive? You may receive the following adult day health services:

- (1) All core services under WAC 388-106-0800;
- (2) Skilled nursing services other than routine health monitoring with nurse consultation;
- (3) At least one of the following skilled therapy services: physical therapy, occupational therapy, or speech-language pathology or audiology, as defined under chapters 18.74, 18.59, and 18.35 RCW, and
- (4) Psychological or counseling services, including assessing for psycho-social therapy need, dementia, abuse or neglect, and alcohol or drug abuse; making appropriate referrals; and providing brief, intermittent supportive counseling.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0810, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0815 Am I eligible for adult day health? (1) You are eligible for adult day health services if you meet all of the following criteria. You are:

- (a) Age eighteen years or older.
- (b) Enrolled in one of the following medical assistance programs:
 - (i) Categorically needy (CNP);
 - (ii) Categorically needy qualified medicare beneficiaries (CNP-QMB);
 - (iii) General assistance—Expedited medicaid disability (GA-X); or
 - (iv) Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

(c) Assessed as having an unmet need for skilled nursing under WAC 388-71-0712 or skilled rehabilitative therapy under WAC 388-71-0714; and

(i) There is a reasonable expectation that these services will improve, restore or maintain your health status, or in the case of a progressive disabling condition, will either restore or slow the decline of your health and functional status or ease related pain or suffering; and

(ii) You are at risk for deteriorating health, deteriorating functional ability, or institutionalization; and

(iii) You have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.

(d) Assessed as having needs for personal care or other core services, whether or not those needs are otherwise met.

(2) You are not eligible for adult day health if you:

(a) Can independently perform or obtain the services provided at an adult day health center;

(b) Have referred care needs that:

(i) Exceed the scope of authorized services that the adult day health center is able to provide;

(ii) Do not need to be provided or supervised by a licensed nurse or therapist;

(iii) Can be met in a less structured care setting; or

(iv) In the case of skilled care needs, are being met by paid or unpaid caregivers.

(c) Live in a nursing home or other institutional facility; or

(d) Are not capable of participating safely in a group care setting.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0815, filed 5/17/05, effective 6/17/05.]

GAU-FUNDED RESIDENTIAL CARE

WAC 388-106-0900 What services may I receive under GAU-funded residential care? You may receive personal care services in an adult family home or a licensed boarding home contracted with the department to provide adult residential care services. You may also receive nurse delegation services under this program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0900, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0905 Am I eligible to receive GAU-funded residential care services? You are eligible to receive GAU-funded residential care services if:

(10/27/11)

(1) You meet financial eligibility requirements for general assistance unemployable (GAU), described in WAC 388-400-0025;

(2) You are not eligible for services under COPES, MNRW, or MPC; and

(3) You are assessed in CARE and meet the functional criteria outlined in WAC 388-106-0210(2).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0905, filed 5/17/05, effective 6/17/05.]

RESIDENTIAL CARE DISCHARGE ALLOWANCE

WAC 388-106-0950 What services may I receive under the residential care discharge allowance? The residential care discharge allowance is a one-time payment used to help you establish or resume living in your own home. You may receive up to eight hundred and sixteen dollars to cover necessary equipment, remodeling, rent, and utilities.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0950, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0955 Am I eligible for residential care discharge allowance? You are eligible for a residential discharge allowance if you:

(1) Receive long-term care services from home and community services;

(2) Are being discharged from a hospital, nursing facility, a licensed boarding home, or adult family home to your own home;

(3) Do not have other programs, services, or resources to assist you with these costs; and

(4) Have needs beyond what is covered under the community transition service (under COPES, MNRW, and MNIW).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0955, filed 5/17/05, effective 6/17/05.]

PRIVATE DUTY NURSING

WAC 388-106-1000 What is the intent of WAC 388-106-1000 through 388-106-1055? The intent of WAC 388-106-1000 through 388-106-1055 is to:

(1) Describe the eligibility requirements under which an adult age eighteen or older may receive private duty nursing (PDN) services through the department's aging and disability services administration (ADSA);

(2) Provide assistance to clients and enable families to support clients in their own homes; and

(3) Describe the requirements clients and their families, home health agencies, and privately contracted registered nurses (RNs) and licensed practical nurses (LPNs) must meet in order for services to be authorized for PDN.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1000, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1005 What services may I receive under private duty nursing (PDN)? PDN is a program that provides skilled nursing care if you have complex medical needs that cannot be met through other services. PDN is an alternative to institutional care and is the program of last resort.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1005, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1010 Am I eligible for medicaid-funded private duty nursing services? In order to be eligible for medicaid-funded private duty nursing (PDN):

(1) You must be eighteen years of age or older and financially eligible, which means you:

(a) Meet medicaid requirements under the categorically needy program or the medically needy program; and

(b) Use private insurance as first payer, as required by medicaid rules. Private insurance benefits, which cover hospitalization and in-home services, must be ruled out as the first payment source to PDN.

(2) You must be medically eligible, which means:

(a) The department has received the skilled nursing task log or ADSA-approved equivalent completed by a nurse licensed under chapter 18.79 RCW.

(b) You have been assessed by an ADSA community nurse consultant (CNC) or nursing care consultant (NCC) and determined medically eligible for PDN.

(3) The department must assess you using the CARE assessment tool, as provided in chapter 388-106 WAC to determine that you:

(a) Require care in a hospital or meet nursing facility level of care, as defined in WAC 388-106-0310; and

(b) Have unmet skilled nursing needs that cannot be met in a less costly program or less restrictive environment; and

(c) Are not able to have your care tasks provided through nurse delegation, WAC 246-840-910 through 246-840-970; COPES skilled nursing, WAC 388-515-1505; DDD waiver skilled nursing, WAC 388-845-0215 or self-directed care RCW 74.39.050; and

(d) Have a complex medical need that requires four or more hours every day of continuous skilled nursing care that can be safely provided outside a hospital or nursing facility; and

(e) Require skilled nursing care that is medically necessary, per WAC 388-500-0005; and

(f) Are able to supervise your care or have a guardian who is authorized and able to supervise your care; and

(g) Have a family member or other appropriate informal support who is responsible for assuming a portion of your care; and

(h) Are medically stable and appropriate for PDN services, as reflected by your primary care provider's:

(i) Orders for medical services; and

(ii) Documentation of approval for the service provider's PDN care plan.

(i) Do not have any other resources or means to obtain PDN services; and

(j) Are dependent upon technology every day with at least one of the following skilled care needs:

(i) Mechanical ventilation which takes over active breathing due to your inability to breathe on your own due to injury or illness. A tracheal tube is in place and is hooked up to a ventilator that pumps air into the lungs; or

(ii) Complex respiratory support, which means that you require two of the following treatment needs:

(A) Postural drainage and chest percussion;

(B) Application of respiratory vests;

(C) Nebulizer treatments with or without medications;

(D) Intermittent positive pressure breathing;

(E) O2 saturation measurement with treatment decisions dependent on the results; or

(F) Tracheal suctioning.

(iii) Intravenous/parenteral administration of multiple medications, and care is occurring on a continuing or frequent basis; or

(iv) Intravenous administration of nutritional substances, and care is occurring on a continuing or frequent basis.

[Statutory Authority: RCW 74.08.090, 74.09.520, 11-05-079, § 388-106-1010, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1010, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1020 How do I pay for my PDN services? You are not required to pay participation for PDN services, but the cost of services is subject to estate recovery, under chapter 388-527 WAC. If you are also receiving other services (e.g. COPES), you may be responsible for paying participation as required under WAC 388-515-1505, 388-515-1540, or 388-515-1550. Your financial worker will inform you about your participation requirements for those services.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1020, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1025 Who can provide my PDN services? PDN services can be provided by:

(1) A home health agency licensed by the Washington state department of health chapter 246-335 WAC that has a contract with the medicaid agency to provide PDN services; or

(2) A Washington state licensed RN, or LPN under the direction of an RN who has a contract with the medicaid agency to provide PDN services and meets the requirements set forth in WAC 388-106-1040.

[Statutory Authority: RCW 74.08.090, 74.09.520, 11-05-079, § 388-106-1025, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1025, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1030 Are there limitations or other requirements for PDN? Limitations and other requirements to PDN services are as follows:

(1) You may be authorized to receive PDN services for between four to sixteen hours per day, except as noted in WAC 388-106-1045(4).

(2) PDN hours will be deducted from the personal care hours generated by CARE to account for services that meet your need for personal care services (i.e., one hour from the available hours for each hour of PDN authorized). WAC 388-106-0130 (9)(e).

(3) Trained family members must provide for any hours above your assessment determination, or you or your family must pay for these additional hours.

(4) In instances where your family is temporarily absent due to vacations, additional PDN hours must be:

(a) Paid for by you or your family; or

(b) Provided by other trained family members. If this is not possible, you may require placement in a long-term care facility during their absence.

(5) You may use respite care if you and your unpaid family caregiver meet the eligibility criteria defined in WAC 388-106-1210 (for LTC clients) or WAC 388-832-0145 (for DDD individual and family services clients) or WAC 388-845-1605 (for DDD waiver clients).

(6) There may be a one time approval for additional hours for a period not to exceed thirty days when:

- (a) Your family is being trained in care and procedures;
- (b) You have an acute episode that would otherwise require hospitalization;
- (c) Your caregiver is ill or temporarily unable to provide care; or
- (d) There is a family emergency.

[Statutory Authority: RCW 74.08.090, 74.09.520, 11-05-079, § 388-106-1030, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1030, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1035 What requirements must a home health agency meet in order to provide and be paid for my PDN? In order for a home health agency to provide and be paid for your PDN, the home health agency must:

(1) Be licensed by the Washington state department of health pursuant to chapter 246-335 WAC and have a contract with the medicaid agency to provide PDN services;

(2) Operate under primary care provider orders;

(3) Develop and follow a detailed service plan that is reviewed and signed at least every six months by the client's primary care provider and submitted to CNC or NCC for review;

(4) Initiate and complete the PDN skilled nursing task log or an approved equivalent for seven days and submit it to the CNC or NCC for review for an initial eligibility determination and for ongoing eligibility every six months thereafter;

(5) Meet all documentation required by DOH for in-home licensing, WAC 246-335-055, 246-335-080, and 246-335-110; and

(6) Submit timely and accurate invoices for payments.

[Statutory Authority: RCW 74.08.090, 74.09.520, 11-05-079, § 388-106-1035, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1035, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1040 What requirements must a RN, or LPN under the supervision of an RN, meet in order to provide and get paid for my PDN services? In order to be paid by the department, a private RN under the supervision of a primary care provider or an LPN under the supervision of an RN, must:

(1) Be licensed and in good standing, as provided in RCW 18.79.030 (1)(3);

(2) Have a contract with the medicaid agency to provide PDN services;

(3) Complete a background check which requires fingerprinting if the RN or LPN has lived in Washington state less than three years;

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(4) Have no conviction for a disqualifying crime, as provided in RCW 43.43.830 and 43.43.842 and WAC 388-71-0500 through 388-71-05640 series;

(5) Have no finding of fact and conclusion of law (stipulated or otherwise), agreed order, or final order issued by a disciplining authority, a court of law, or entered into a state registry with a finding of abuse, neglect, abandonment or exploitation of a minor or vulnerable adult;

(6) Provide services according to the care plan under the supervision/direction of the primary care provider;

(7) Document all PDN services provided by the care plan as required by WAC 388-502-0020 and 246-840-700;

(8) Meet provider requirements under WAC 388-71-0510, 388-71-0515, 388-71-0540, 388-71-0551, and 388-71-0556;

(9) Complete time sheets on a monthly basis;

(10) Complete the PDN seven-day look back skilled nursing task log and submit it to the CNC or NCC for review for initial eligibility determination, and for ongoing eligibility every six months; and

(11) Submit timely and accurate invoices for payment.

[Statutory Authority: RCW 74.08.090, 74.09.520, 11-05-079, § 388-106-1040, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1040, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1045 Can I receive PDN services in a licensed adult family home (AFH)? You may be eligible to receive PDN services if you are residing in an adult family home (AFH) if the AFH provider (owner and operator):

(1) Possesses a current Washington state registered nurse license and is in good standing;

(2) Signs a contract amendment with ADSA by which the provider agrees to ensure provision of twenty-four-hour personal care and nursing care services. Nursing care services must be provided in accordance with chapter 18.79 RCW;

(3) Provides your PDN service through an RN or an LPN under the supervision of an RN. The level of PDN services provided to you is based on the CARE assessment, the department-designated PDN skilled task log or its approved equivalent, and other documentation that determines eligibility and the number of PDN hours to be authorized;

(4) Provides the PDN services to you. Your service plan may authorize you to receive four to eight hours per day and cannot exceed eight PDN care hours per day;

(5) Has a nursing service plan prescribed for you by your primary care provider. The primary care provider must:

(a) Oversee your care plan, which must be updated at least once every six months; and

(b) Monitor your client's medical stability.

(6) Document the services provided in the care plan, including the submission of the PDN seven-day look back skilled nursing task log by the licensed nursing to the CN or NCC for review for initial eligibility and ongoing eligibility every six months; and

(7) Maintain records in compliance with AFH licensing and contract requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520, 11-05-079, § 388-106-1045, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1045, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1050 May I receive other long-term care services in addition to PDN? (1) In addition to PDN services, you may be eligible to receive care through community options program entry system (COPEs), the medically needy residential waiver (MNRW), the medically needy in-home waiver (MNIW), or medicaid personal care (MPC), for unmet personal needs not performed by informal supports.

(2) PDN hours will be deducted from the personal care hours generated by CARE to account for services that meet some of your need for personal care services (i.e., one hour from the available hours for each hour of PDN authorized per WAC 388-106-1030).

(3) Services may not be duplicated. PDN hours may not be scheduled during the same time that personal care hours are being provided by an individual provider or home care agency provider.

(4) The PDN provider is responsible for providing assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) unless there is an informal support that is providing or assisting at the same time.

[Statutory Authority: RCW 74.08.090, 74.09.520, 11-05-079, § 388-106-1050, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80, 05-24-091, § 388-106-1050, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1055 Can I choose to self-direct my care if I receive PDN services? You may choose to self-direct part of your health-related tasks to an individual provider, as outlined in RCW 74.39.050. You may also still receive PDN services, if you meet the PDN eligibility requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80, 05-24-091, § 388-106-1055, filed 12/6/05, effective 1/6/06.]

SENIOR CITIZENS' SERVICES

WAC 388-106-1100 What services can I receive under the Senior Citizens' Services Act (SCSA) fund? You may receive community-based services, described in RCW 74.38.040.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-1100, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1105 How do I apply for SCSA-funded services? To receive SCSA-funded services, you or your representative must:

- (1) Complete and submit a department application form, providing complete and accurate information; and
- (2) Promptly submit a written report of any changes in income or resources. For the definition of income and resources, refer to WAC 388-500-0005.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-1105, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1110 Am I eligible for SCSA-funded services at no cost? To be eligible for SCSA-funded services at no cost, you must:

- (1) Be age:
 - (a) Sixty-five or older; or
 - (b) Sixty or older, and:
 - (i) Either unemployed, or

- (ii) Working twenty hours a week or less;
- (2) Have a physical, mental, or other type of impairment, which without services would prevent you from remaining in your home;
- (3) Have income at or below forty percent of the state median income (SMI), based on family size; and
- (4) Have nonexempt resources (including cash, marketable securities, and real or personal property) not exceeding ten thousand dollars for a single person or fifteen thousand for a family of two, increased by one thousand dollars for each additional family member of the household. Household means a person living alone or a group of people living together.
- (5) If you have income over forty percent of SMI, you may be eligible for services on a sliding fee basis.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-1110, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1115 What income and resources are exempt when determining eligibility? The following income and resources, regardless of value, are exempt when determining whether you are eligible for SCSA-funded services:

- (1) Your home, and the lot it is upon;
- (2) Garden produce, livestock, and poultry used for home consumption;
- (3) Program benefits which are exempt from consideration in determining eligibility for needs based programs (e.g., uniform relocation assistance, Older Americans Act funds, foster grandparents' stipends or similar moneys);
- (4) Used and useful household furnishings, personal clothing, and automobiles;
- (5) Personal property of great sentimental value;
- (6) Personal property used by the individual to earn income or for rehabilitation;
- (7) One cemetery plot for each member of the family unit;
- (8) Cash surrender value of life insurance;
- (9) Real property held in trust for an individual Indian or Indian tribe; and
- (10) Any payment received from a foster care agency for children in the home.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-1115, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1120 What if I am not eligible to receive SCSA-funded services at no cost? (1) Even if your income is above the forty percent SMI limit to receive SCSA-funded services at no cost, you may receive SCSA-subsidized services. The department uses a sliding fee schedule to determine what percentage the department pays for the cost of your services. You pay the remaining amount, but not more than the usual rate paid for services, as negotiated by the AAA or the department. The formula for determining the department's share of the cost of the services is:

$$\frac{100\% \text{ State Median Income (SMI)} - \text{Household Income} \times 100}{100\% - 40\% \text{ SMI}}$$

- (2) Service providers must be responsible for collecting fees owed by eligible persons and reporting to area agencies all fees paid or owed by eligible persons.

(3) Some services are provided at no charge regardless of income or need requirements. These services include, but are not limited to, nutritional services, health screening, services under the long-term care ombudsman program, and access services. Note: Well adult clinic services may be provided in lieu of health screening services if such clinics use the fee schedule established by this section.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1120, filed 5/17/05, effective 6/17/05.]

RESPITE CARE SERVICES

WAC 388-106-1200 What definitions apply to respite care services? The following definitions apply to respite care services:

"Caregivers" means a spouse, relative, or friend who has primary responsibility for the daily care of an adult with a functional disability without receiving payment for services provided.

"Continuous care or supervision" means daily assistance or oversight of an adult with a functional disability.

"Functionally disability" means a condition requiring substantial assistance in completing activities of daily living and community living skills.

"Participant" means an adult with a functional disability who needs substantial daily continuous care or supervision.

"Service provider" means an individual, agency, or organization under contract to the area agency on aging (AAA) or its subcontractor.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1200, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1205 What are respite care services? Respite services relieve unpaid caregivers by providing temporary care or supervision to adults with a functional disability.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1205, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1210 Who is eligible to receive respite care services? (1) To be eligible to receive respite care services, the caregivers must:

- (a) Have primary responsibility for the daily continuous care or supervision of an adult with a functional disability;
- (b) Provide a minimum of an average of twelve hours per day for care or supervision;
- (c) Not be compensated for the care; and
- (d) Be assessed as being at risk of placing the participant in a long-term care facility if home and community support services, including respite care, are not available.

(2) An eligible participant is an adult who:

- (a) Has a functional disability;
- (b) Needs daily substantial continuous care or supervision; and
- (c) Is assessed as requiring placement in a long-term care facility if home and community support services, including respite care, are not available.

(3) The area agency on aging (AAA) determines how many hours of continuous care or supervision a day an unpaid caregiver must provide to a participant to become eligible for

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respite care services, as long as it is a minimum of twelve hours per day, as outlined in subsection (1)(b) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1210, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1215 Who may provide respite care services? Respite care providers include, but are not limited to the following:

- (1) Nursing homes (chapter 388-97 WAC).
- (2) Adult day services, which includes adult day care and adult day health.
- (3) Home health/care agencies.
- (4) Hospitals.
- (5) Licensed residential care facilities such as boarding homes, adult family homes, and assisted living facilities.
- (6) Providers such as volunteer chore workers, senior companions, and individual providers.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1215, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1220 How are respite care providers reimbursed for their services? The department reimburses:

(1) Respite care providers for the number of hours or days of services authorized and used. The rate that is established for the services is negotiated between the respite care program of the local area agency on aging and the respite care service provider.

(2) Medicaid-certified nursing homes and DDD-certified group homes providing respite services the medicaid rate approved for that facility. Contracted nursing homes must not charge more than the medicaid rate for any services covered from the date of eligibility, unless authorized by the department (see RCW 18.51.070). Participants must pay for services not included in the medicaid rate.

(3) Private nursing homes at their published daily rate.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1220, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1225 Are participants required to pay for the cost of their services? (1) There is no charge to the participant whose income is at or below forty percent of the state median income, based on family size.

(2) If the participant's gross income is above forty percent of the state median income, he or she is required to pay for part or all of the cost of the respite care services. The department will determine what amount the participant must contribute based on the state median income and family size.

(3) If the participant's gross income is one hundred percent or more of the state median income, the participant must pay the full cost of services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1225, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1230 Are there waiting lists for respite services? (1) The department must first consider requests for emergency respite care. An example of an emergency is when the caregiver becomes ill or injured to the extent that the caregiver's ability to care for the participant is impaired.

(2) In nonemergency situations, respite care is allocated based upon available respite funds at the local level. Respite

care must be provided on a first-come, first-served basis. If sufficient funds are not available when respite care is requested, services are made available using waiting lists and department-approved priority categories, developed by the AAA, including caregiver vulnerability and health condition, availability of other support systems, and whether other family members need care.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1230, filed 5/17/05, effective 6/17/05.]

CLIENT RIGHTS

WAC 388-106-1300 What rights do I have as a client of the department? As a client of the department, you have a right to:

- (1) Be treated with dignity, respect and without discrimination;
- (2) Not be abused, neglected, financially exploited, abandoned;
- (3) Have your property treated with respect;
- (4) Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for the department to offer some services if you do not give enough information;
- (5) Be told about all services you can receive and make choices about services you want or don't want;
- (6) Have information about you kept private within the limits of the laws and DSHS regulations;
- (7) Be told in writing of agency decisions and receive a copy of your care plan;
- (8) Make a complaint without fear of harm;
- (9) Not be forced to answer questions or do something you don't want to;
- (10) Talk with your social service worker's supervisor if you and your social service worker do not agree;
- (11) Request a fair hearing;
- (12) Have interpreter services provided to you free of charge if you cannot speak or understand English well;
- (13) Take part in and have your wishes included in planning your care;
- (14) Choose, fire, or change a qualified provider you want; and
- (15) Receive results of the background check for any individual provider you choose.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1300, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1303 What responsibilities do I have as a client of the department? As a client of the department, you have a responsibility to:

- (1) Give us enough information to assess your needs;
- (2) Let the social services worker into your home so that your needs can be assessed;
- (3) Follow your care plan;
- (4) Not act in a way that puts anyone in danger;
- (5) Provide a safe work place;
- (6) Tell your social services worker if there is a change in:
 - (a) Your medical condition;
 - (b) The help you get from family or other agencies;
 - (c) Where you live; or

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(d) Your financial situation.

(7) Tell your social services worker if someone else makes medical or financial decision for you;

(8) Choose a qualified provider;

(9) Inform the department and your home care agency if an employee assigned by the home care agency is related to you by blood, marriage, adoption, or registered domestic partnership.

(10) Keep provider background checks private;

(11) Tell your social services worker if you are having problems with your provider; and

(12) Choose your own health care. Tell your social services worker when you do not do what your doctor says.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 571, and Washington state 2009-11 budget, section 206(17). 10-06-112, § 388-106-1303, filed 3/3/10, effective 4/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-1303, filed 2/6/06, effective 3/9/06.]

WAC 388-106-1305 What if I disagree with the result of the CARE assessment and/or other eligibility decisions made by the department? You have a right to contest the result of your CARE assessment and/or other eligibility decisions made by the department. The department will notify you in writing of the right to contest a decision and provide you with information on how to request a hearing.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1305, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1310 When I request a fair hearing on my CARE assessment and another CARE assessment(s) is done between my fair hearing request and the fair hearing, which CARE assessment must the administrative law judge review? When you request a fair hearing on your CARE assessment and another CARE assessment(s) is done between your fair hearing request and the fair hearing, the administrative law judge must review the most recent CARE assessment.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1310, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1315 Do I have a right to an administrative hearing if my total in-home personal care hours approved as an exception to rule are reduced or terminated or if my increased residential payment rate approved as an exception to rule is reduced or terminated? Notwithstanding WAC 388-440-0001(3), you have a right to an administrative hearing regarding the department's exception to rule decision if:

(1) You receive services in your own home, and:

(a) The total number of in-home personal care hours you are currently receiving includes in-home personal care hours approved as an exception to rule in addition to the number of in-home care hours determined to be available to you by CARE; and

(b) The total number of in-home personal care hours you are currently receiving is reduced because of a reduction or termination in the number of in-home personal care hours approved as an exception to rule.

(2) You receive services in a residential facility, and:

- (a) You currently have an increased residential payment rate approved as an exception to rule; and
- (b) Your increased residential payment rate that was approved as an exception to rule is reduced or terminated.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. 07-01-046, § 388-106-1315, filed 12/14/06, effective 1/14/07.]

NEW FREEDOM CONSUMER DIRECTED SERVICES (NFCDS)

WAC 388-106-1400 What services may I receive under New Freedom consumer directed services (NFCDS)? (1) In order for services, supports, and/or items to be purchased under New Freedom, they must:

- (a) Be for your sole benefit;
 - (b) Be at a reasonable cost;
 - (c) Meet your identified needs and outcomes in the CARE assessment and address your health, safety, and welfare; and
 - (d) Be documented on your New Freedom spending plan.
- (2) Your consultant may require a physician or other licensed professional, such as an occupational or physical therapist to recommend a specific purchase in writing. This recommendation is needed to ensure the service, support and/or item will increase, maintain, or delay decline of functional abilities, and to ensure the purchase supports your health and welfare.

(3) You may use your individual budget to purchase services, supports, and/or items that fall into the following service categories:

(a) **Personal assistance services**, defined as supports involving the labor of another person to assist you to carry out activities you are unable to perform independently. Services may be provided in your home or in the community and may include:

- (i) Direct personal care services defined as assistance with activities of daily living, as defined in WAC 388-106-0010;
- (ii) Delegated nursing tasks, per WAC 246-841-405 and 388-71-05830. Providers of direct personal care services may be delegated by a registered nurse to provide nurse delegated tasks according to RCW 18.79.260 and WAC 246-840-910 through 246-840-970;
- (iii) Homemaking, or assistance with instrumental activities of daily living (essential shopping, housework and meal preparation);
- (iv) Other tasks or assistance with activities that support independent functioning, and are necessary due to your functional disability;
- (v) Personal assistance with transportation.

(b) **Treatment and health maintenance**, defined as treatments or activities that are beyond the scope of the medicaid state plan that are necessary to promote your health and ability to live independently in the community and:

- (i) Are provided for the purpose of preventing further deterioration of your level of functioning, or improving or maintaining your current level of functioning; and

(ii) Are performed or provided by people with specialized skill, registration, certification or licenses as required by state law.

(c) **Individual directed goods, services and supports**, defined as services, equipment or supplies not otherwise provided through this waiver or through the medicaid state plan; and

- (i) Will allow you to function more independently; or
- (ii) Increase your safety and welfare; or
- (iii) Allow you to perceive, control, or communicate with your environment.

(d) **Environmental or vehicle modifications**, defined as alterations to your residence or vehicle that are necessary to accommodate your disability and promote your functional independence, health, safety, and/or welfare.

(i) Environmental modifications cannot be adaptations or improvements that are of general utility or merely add to the total square footage of the home.

(ii) Vehicles subject to modification must be owned by you or a member of your family who resides with you; must be in good working condition, licensed, and insured according to Washington state law; and be cost effective when compared to available alternative transportation.

(e) **Training and educational supports**, defined as supports beyond the scope of medicaid state plan services that are necessary to promote your health and ability to live and participate in the community and maintains, slows decline, or improves functioning and adaptive skills. Examples include:

- (i) Training or education on your health issues, or personal skill development;
- (ii) Training or education to paid or unpaid caregivers related to your needs.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1400, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1400, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1405 What services are not covered under New Freedom consumer directed services (NFCDS)? Services, supports and/or items that cannot be purchased within New Freedom budgets, including, but not limited to:

- (1) Services, supports and/or items covered by the state plan, medicare, or other programs or services.
- (2) Any fees related to health or long-term care incurred by you, including co-pays, waiver cost of care (participation), or insurance.
- (3) Home modifications that merely add square footage to your home.
- (4) Vacation expenses other than the direct cost of provision of personal care services while on vacation (but you may not use New Freedom funds to pay travel expenses for your provider).
- (5) Rent or room and board.
- (6) Tobacco or alcohol products;
- (7) Lottery tickets.
- (8) Entertainment items such as television, cable, or DVD players.

(9) Vehicle purchases, maintenance or upgrades that do not include maintenance to modifications related to disability.

(10) Tickets and related costs to attend sporting or other recreational events.

(11) Routine household supplies and maintenance, basic food, clothing, and major household appliances.

(12) Pets and their related costs.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1405, filed 4/6/10, effective 5/7/10.]

WAC 388-106-1410 Am I eligible for New Freedom consumer directed services (NFCDS)-funded services? You are eligible for NFCDS-funded services if you reside in your own home and meet all of the following criteria. The department must assess your needs using CARE and determine that:

(1) You are in NFCDS HCBS waiver specified target groups of:

(a) Eighteen or older and blind or have a physical disability; or

(b) Sixty-five or older; and

(2) You meet financial eligibility requirements. This means the department will assess your finances, determine if your income and resources fall within the limits, and determine the amount you may be required to contribute, if any, toward the cost of your care as described in WAC 388-515-1505; and

(3) You:

(a) Are not eligible for medicaid personal care services (MPC); or

(b) Are eligible for MPC services, but the department determines that the amount, duration, or scope of your needs is beyond what MPC can provide; and

(4) Your CARE assessment shows you need the level of care provided in a nursing facility as defined in WAC 388-106-0355; and

(5) You live in your own home, or will be living in your own home by the time NFCDS start.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1410, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1415 When do New Freedom consumer directed services (NFCDS) start? Your eligibility for NFCDS begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1415, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1420 How do I remain eligible for New Freedom consumer directed services (NFCDS)? (1) In order to remain eligible for NFCDS, you must be in need of services in accordance with WAC 388-106-1410, as determined through a CARE assessment. The CARE assessment must be performed at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for NFCDS change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the

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changed eligibility requirements, the department will terminate your NFCDS services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1420, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1422 What happens to my New Freedom service dollar budget if I am temporarily hospitalized, placed in a nursing facility or intermediate care facilities for the mentally retarded (ICF/MR)? If you are admitted to a hospital, nursing home or ICF/MR, you cannot access your New Freedom service budget during your stay.

If you are institutionalized for forty-five days or less and you intend to return to New Freedom when discharged, your service budget will be suspended. Upon discharge home, your service budget will be reinstated.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1422, filed 4/6/10, effective 5/7/10.]

WAC 388-106-1425 How do I pay for New Freedom consumer directed services (NFCDS)? Depending on your income and resources, you may be required to pay participation toward the cost of your care, as described in WAC 388-515-1505. If you have nonexempt income that exceeds the cost of NFCDS services, you may keep the difference. Since you are receiving services in your own home, you are allowed to keep some of your income for a maintenance allowance.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1425, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1430 Can I be employed and receive New Freedom consumer directed services (NFCDS)? You can be employed and receive NFCDS, per WAC 388-515-1505.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1430, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1435 Who can direct New Freedom consumer directed services (NFCDS)? You, as an NFCDS participant, direct your services. You may also designate, or a court may appoint, a representative to assist you in directing your services, or to direct your services on your behalf. A New Freedom designated representative cannot also be your paid provider.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1435, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1435, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1440 What is an individual budget? An individual budget means the maximum amount of funding authorized by the department and allocated to the participant for the purchase of New Freedom consumer directed services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1440, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1445 How is the amount of the individual budget determined? The department will calculate your individual budget amount after you are assigned a classification resulting from completion of the comprehensive

assessment reporting and evaluation tool, CARE. The calculation will be based on:

(a) The hourly wage as determined by the collective bargaining agreement for individual provider personal care paid by the department multiplied by the number of hours generated by the assessment, multiplied by a factor of .95, plus an amount equal to the average per participant expenditures for nonpersonal care supports purchased in the COPES waiver. The average will be recalculated in July of each year.

(b) If you select a home care agency, an adjustment will be made for each hour of personal care identified in the NFSP for an amount equal to the difference between the published individual provider rate and home care agency rate.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1445, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1445, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1450 Is the individual budget intended to fully meet all of my needs? The program provides funds in an amount proportionate to the amount of resources you would receive through COPES, and gives you flexibility to self-direct the purchase of goods and services to meet your long-term care needs. The degree to which the budget meets your needs depends on the supports you identify and prioritize in your spending plan. Depending on your decisions, after your budget is exhausted, some of your needs may be unmet, or you may find other resources to address them.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1450, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1455 What happens to unused funds from my individual budget? (1) Unused funds, up to three thousand dollars, may be held in reserve for future purchases documented in the NFSP. Reserves in excess of three thousand dollars may be maintained for planned purchases with approval from the department.

(2) Unused funds, up to five hundred dollars, may be held in reserve for future purchases not yet identified as planned purchases in their NFSP.

(3) Unused funds will revert back to the department under the following circumstances:

(a) You have funds over five hundred dollars that are not identified for planned purchases in your NFSP;

(b) You disenroll from New Freedom;

(c) You lose eligibility for New Freedom;

(d) You are hospitalized and/or placed in a nursing home or ICM/FR for over forty-five days; or

(e) You have reserved funds in excess of three thousand dollars held in reserve for future purchases not approved by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1455, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1455, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1460 When can my New Freedom spending plan (NFSP) be denied? Your NFSP may be denied when the plan you develop does not:

(a) Include services in the New Freedom definition;

(b) Address your needs as it relates to performance of activities of daily living and instrumental activities of daily living;

(c) Include strategies and steps to address known critical risks;

(d) Identify the payment rate; or

(e) Adequately describe the service.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1460, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1465 Who can deny my New Freedom spending plan (NFSP)? Your plan can be denied by your New Freedom consultant, who assists NFCDS participants to develop and use a New Freedom spending plan to:

(a) Meet identified needs;

(b) Address health and safety needs;

(c) Develop options to meet those needs;

(d) Make informed decisions about their individual budget; and

(e) Obtain identified supports and services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1465, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1470 Are there waiting lists for New Freedom consumer directed services (NFCDS)? The department will create a waiting list for NFCDS in accordance with caseload limits determined by legislative funding. Participants on the waiting list will gain access in the following order:

(1) Nursing home residents who are returning home and are assessed for NFCDS waiver services will be ranked first on the waiting list by date of application for services;

(2) Individuals living in the community with a higher level of need, as determined by the CARE assessment, will be ranked higher on the wait list over participants with a lower level of need; and

(3) When two or more individuals on the waiting list have equal need levels, the individual with the earlier application for NFCDS will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1470, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1475 How do I end enrollment in New Freedom consumer directed services (NFCDS)? (1) You may choose to voluntarily end your enrollment from NFCDS without cause at any time. To do so, you must give notice to the department. If you give notice:

(a) Before the fifteenth of the month, the department will end your enrollment at the end of the month; or

(b) After the fifteenth, the department will end your enrollment the end of the following month.

(2) Your enrollment may also end involuntarily if you:

(a) Move out of the designated service area or are out of the service area for more than thirty consecutive days, unless you have documented the purpose of the longer absence in the NFSP; or

(b) Do not meet the terms for consumer direction of services outlined in the NFCDS enrollment agreement when:

(i) Even with help from a representative, you are unable to develop a NFSP or self-direct services or manage your individual budget or NFSP;

(ii) Any one factor or several factors of such a magnitude jeopardize the health, welfare, and safety of you and others, requiring termination of services under WAC 388-106-0047;

(iii) You become financially ineligible for medicaid services; or

(iv) You no longer meet the nursing facility level of care requirement as defined in WAC 388-106-0355.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 06-16-035, § 388-106-1475, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1480 What are my hearing rights to appeal New Freedom consumer directed services (NFCDS) actions? You have a right to a hearing under WAC 388-106-1300 through 388-106-1310, and under chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 06-16-035, § 388-106-1480, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1500 What is the department's chronic care management program? (1) The department of social and health services, aging and disability services administration's chronic care management program is designed to improve health outcomes, reduce medical costs, improve functional and self-care abilities and slow progression of disease or disability. The program:

(a) Offers care management and coordination activities for medical assistance-eligible clients who are also receiving medicaid long-term care services identified to be at risk for high medical costs;

(b) Provides education, training and coordination of services for program participants through providers contracted with the department to assist in achieving health action plans;

(c) Assists program participants in improving self-management skills and improving health outcomes; and

(d) The program provides education to better utilize health care services.

(2) The department's chronic care management program does not:

(a) Change the scope of services available to clients eligible under a Title XIX medicaid program;

(b) Interfere with the relationship between a client and a client's chosen providers;

(c) Duplicate or take the place of existing case management activities available to a client in the client's community; or

(d) Substitute for established activities, including case management, that are otherwise available to a client through programs administered by the department or other government agencies.

[Statutory Authority: RCW 74.08.090 and 74.09.520, 11-22-043, § 388-106-1500, filed 10/27/11, effective 11/27/11.]

WAC 388-106-1505 What services may I receive under the chronic care management program? You may be eligible to receive the following services under the chronic care management program:

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(1) Registered nurse care manager assistance with coordination of health care, support services, education, training and transitional care services.

(2) Registered nurse care manager assessment of your risk factors, health status, self-management skills and treatment plan.

(3) Registered nurse care manager development of a health action plan to identify your health-related problems, interventions and goals.

[Statutory Authority: RCW 74.08.090 and 74.09.520, 11-22-043, § 388-106-1505, filed 10/27/11, effective 11/27/11.]

WAC 388-106-1510 Who provides chronic care management services to medical assistance clients receiving long-term care services and supports? Chronic care management program services may be provided by department contracted organizations. Each contracted organization must meet the conditions of the contract between the department and the contractors, including:

(1) Meet all applicable state and federal requirements;

(2) Provide services according to the contract with the department;

(3) Document all chronic care management services as required by the contract with the department; and

(4) Submit timely and accurate invoices for payment.

[Statutory Authority: RCW 74.08.090 and 74.09.520, 11-22-043, § 388-106-1510, filed 10/27/11, effective 11/27/11.]

WAC 388-106-1515 Am I eligible to enroll in the chronic care management program? (1) You are eligible for chronic care management services if you are:

(a) Age twenty-one or older;

(b) Identified through predictive modeling as being at risk for having future high medical costs as a result of requiring medical treatment for multiple conditions;

(c) Agree to enroll in the chronic care management program;

(d) Are a recipient of the supplemental security income (SSI) program or general assistance with expedited medical categorically needy (GAX) program;

(e) Have a current CARE assessment as defined in WAC 388-106-0050;

(f) Assessed by CARE as meeting one or more of the following characteristics:

(i) Live alone in your own home;

(ii) Experience isolated moods and behaviors;

(iii) Rate your health as fair or poor;

(iv) Have deteriorating self-sufficiency; or

(v) Have more than 8 prescribed medications; and

(g) Receive home and community support services in your home; or

(h) Receive home and community support services in a licensed residential facility.

(2) As a long-term care services client, you are not eligible for enrollment in the chronic care management program if you do not meet the criteria described above, or if you are:

(a) Eligible for enrollment in the department's healthy options managed care program;

(b) Receiving hospice services;

(c) Receiving case management services for HIV/AIDS;

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(d) Receiving education, training and coordination services for another program due to pregnancy;

(e) Eligible for third party coverage that provides a comparable service;

(f) Eligible for medicare coverage;

(g) Enrolled in another managed care program or other chronic care management program; or

(h) Residing in an institution as defined in WAC 388-500-0005, for more than thirty days.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 11-22-043, § 388-106-1515, filed 10/27/11, effective 11/27/11.]

enrollment or disenrollment for chronic care management program services, you have a right to a fair hearing based on the rules outlined in WAC 388-106-1305.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 11-22-043, § 388-106-1535, filed 10/27/11, effective 11/27/11.]

WAC 388-106-1520 How do I enroll in the chronic care management program? Enrollment in the chronic care management program is voluntary. You must meet the eligibility criteria listed in WAC 388-106-1515. You may be referred by:

(1) The department's referral and enrollment process;

(2) The department's case managers;

(3) Providers in other settings; or

(4) You may also request to enroll by contacting your long-term care case manager.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 11-22-043, § 388-106-1520, filed 10/27/11, effective 11/27/11.]

WAC 388-106-1525 How long can I participate in the chronic care management program? (1) There is no required minimum or maximum duration of enrollment in the chronic care management program.

(2) The chronic care management program is a voluntary service and you may choose to disenroll at any time for any reason.

(3) Your registered nurse care manager shall disenroll you when:

(a) You are not actively participating in the chronic care management program; or

(b) You have met your goals and are sustaining self-management activities.

(4) You are required to be disenrolled when:

(a) You become medicare eligible;

(b) You enroll in hospice, PACE, Washington medicaid integration project, or a managed care program;

(c) You reside in an institution as defined in WAC 388-106-0010, for more than thirty days; or

(d) You become pregnant.

(5) At the time of disenrollment, you will continue to receive services for which you are eligible.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 11-22-043, § 388-106-1525, filed 10/27/11, effective 11/27/11.]

WAC 388-106-1530 Is there a cost to me for participating in the chronic care management program? There is no cost to participants enrolled in the chronic care management program.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 11-22-043, § 388-106-1530, filed 10/27/11, effective 11/27/11.]

WAC 388-106-1535 Do I have a right to a fair hearing while receiving chronic care management services? Yes. If you do not agree with a decision regarding eligibility,

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