

**Chapter 16:  
Home and Community-Based Services**

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## Chapter 16

### Home and Community Based Services

#### 16-1: Description of Home and Community Based Services

The goal of the Home and Community Based Services (HCBS) is to provide eligible adults age 60 and over and adults with physical disabilities who are at risk of entering long-term care facilities the option of receiving services in their homes or in a community setting. Home and community based services are state-funded (OPTIONS for Community Living) and federally-funded (Older Americans Act Title IIIB).

#### 16-1-.01: Home and Community Based Services

##### (1) OPTIONS for Community Living

OPTIONS for Community Living (referred to as OPTIONS) is a state-funded program created to provide home and community based services to adults age 60 and over and adults (18 years of age or older) with disabilities. OPTIONS is available through the local Area Agencies on Aging and Disability (AAAD). Services may include homemaker services, personal care services, and home delivered meals.

The authority for the Options program comes from *Tennessee Code Annotated 71-5-1416* as follows:

**Funding to increase access to home and community-based services in the state-funded options program.**

Subject to the availability of funding, the commissioner shall designate in each year's appropriations bill an amount of money that can be used to increase access to home and community-based services in the state-funded options program for persons who do not qualify for medicaid long-term care services. This funding may be used to provide services such as home-delivered meals, homemaker services and personal care, and to reduce the waiting list for these services under the options program, or to offer transportation services or assistance to non-medicad-eligible individuals.

##### (2) Older Americans Act (OAA) Title IIIB

The Older Americans Act as amended in 2006 authorizes grants to the States under State approved plans for supportive services. One directive under this act includes

providing “services designed to assist older individuals in avoiding institutionalization and to assist individuals in long-term care institutions who are able to return to their communities . . .” The services are designed to enhance the capacity of individuals age 60 and over to remain self-sufficient in their homes and to maximize the informal support provided by caregivers. The services may include homemaker services, personal care services, adult day services, and chore services.

The AAADs receive the OAA federal funding from the Tennessee Commission on Aging and Disability (TCAD) to provide the identified services. All individuals age 60 and over are eligible for services; however priority is given to those with greatest economic and social need.

**16-1-.02: Program Eligibility**

- (1) To be eligible for OPTIONS, the individual must:
  - (a) be a resident of Tennessee;
  - (b) be an adult age 60 and over and/or an adult age 18 and over with a documented assessment of a physical impairment;
  - (c) verify his/her age as 18 and over by utilizing any of the following documents: birth certificate, driver’s license, Medicare card, passport, employment identification card or badge, military/veteran’s identification card, U.S. census records, wedding or divorce decree, notarized affidavit. For individuals over the age of 60 who do not have access to necessary documents, they may complete and sign an Age Declaration statement.
  - (d) be assessed with a pre-defined level of limitations as determined by Independent Living Assessment (Appendix A);
  - (e) not found to be qualified for TennCare CHOICES; and
  - (f) have a residence that is a safe setting for the individual and any service provider(s).
- (2) To be eligible of OAA Title IIIB, the individual must:
  - (a) reside in Tennessee;
  - (b) be an adult age 60 or over
  - (c) verify his/her age as 60 and over by utilizing any of the following documents: birth certificate, driver’s license, Medicare card, passport, employment

identification card or badge, military/veteran's identification card, U.S. census records, wedding or divorce decree, notarized affidavit. For individuals over the age of 60 who do not have access to necessary documents, they may complete and sign an Age Declaration statement.

- (d) be assessed with a pre-defined level of limitations as determined by Independent Living Assessment (Appendix A); and
- (e) have a residence that is a safe setting for the individual and any service provider(s).

**16-1-.03: Steps to Obtaining Home and Community Based Services**

For the person contacting the AAAD for Home and Community Based Services (HCBS) and are eligible to receive services funded through OPTIONS or Title IIIB, the following outline the steps in the process to receive those services:

- (1) The AAAD will provide initial screening in order to determine the most appropriate referrals.
  - (a) When an individual appears to meet the functional and financial eligibility for TennCare CHOICES, the individual shall be referred to the TennCare CHOICES Counselor.
  - (b) All other individuals will be referred to other community services, and, if necessary, prioritized and placed on the waiting list for OPTIONS, Nutrition Services, or Title IIIB Supportive Services.
- (2) The AAAD will conduct an in-home assessment of those with ADL or IADL limitations to determine the need for in-home services.
- (3) The AAAD and the individual will develop an Action Plan to identify the services needed.
- (4) The AAAD with input from the individual will arrange for the delivery of HCBS either through an outside vendor or through the self-directed care component.
- (5) The AAAD will send authorization for services to the provider(s) selected.
- (6) Services identified in the Action Plan will begin within 5 working days of the receipt of the Service Authorization by the service provider.

**OPTIONS or Title IIIB funding for in-home services is limited. OPTIONS or Title IIIB funding is not intended to pay for services to meet all of the needs of the individual.**

**16-1-.04: Options Counselor**

Each individual shall have an assigned Options Counselor and shall be notified of the name, business address, and telephone number of the Options Counselor. The Options Counselor focuses on the personal goals of the individual for the long-term care supports needed for the individual to live as independently as possible in the setting of his/her choice. The Options Counselor assists the individual to make informed choices about long-term care supports; understand the home and community based services available; understand the resources available to help pay for the services; and encourage the effective and efficient use of home and community based services.

- (1) The Options Counselor must have the appropriate qualifications and competencies to work with adults age 60 and over and adults with disabilities utilizing a person-centered approach to making decisions about long-term supports and services as the alternative to nursing facilities or institutional placement.
  - (a) The minimum qualifications for the position of Options Counselor are as follows:
    - (i) A Bachelor's Degree in social work, psychology, gerontology, sociology, counseling, nursing, or equivalent degree; or
    - (ii) A minimum of completion of two (2) years attendance at an accredited college or university and a minimum of two (2) years experience in the field of social work or a related field.
- (2) The Options Counselor shall have the following competencies:
  - (a) Understand the individual's right to control, choice, self-direction, dignity of risk, and self-determination in the provision of home and community based long-term care supports and services.
  - (b) Understand how to adapt communication methods to the sensory, verbal, physical, and cognitive abilities of adults age 60 and over and adults with disabilities.
  - (c) Utilize communication skills to support the individual in the decision-making process such as, but not limited to, active listening, paraphrasing, effective ways to ask questions while providing resources, and decision support to engage the individual and/or family/caregiver during the process.

- (d) Understand the concepts of individual choice, self-determination, and participation in the selection of the long-term supports and services.
- (e) Able to identify and refer the individual to community programs, services, and/or resources, including, but not limited to, medical, nutritional, transportation, and self-directed programs, that are available to meet the needs of the individual.
- (f) Understand diversity and multicultural considerations that need to be considered during each step of the process and programs and services that are appropriate to the individual's cultural needs.
- (g) Assist the individual to understand the concept and implications of aging in place and identify available services and resources as well as barriers to aging in place.
- (h) Recognize the common mental health conditions that can affect adults age 60 and over and adults with disabilities and know the referral resources and organizations available to address their needs.

If the Options Counselor does not have all of the appropriate competencies listed, the competencies may be obtained through the on-line courses provided by Boston University's School of Social Work: The Center Aging Disability Education and Research (CADER) or other local education and training programs.

**16-1-.05: Service Coordination**

The Options Counselor will provide service coordination whether it is in the form of access to services or care coordination to the individual who is experiencing diminished functioning capacity, personal conditions, and other characteristics that require service and meet the eligibility requirements.

Service coordination supports information sharing among agencies/organizations, service providers, types and levels of service, service sites, and timeframes to ensure that the individual's needs and preferences are achieved and that services are efficient and of high quality. Activities of service coordination include assessing needs, developing Action Plans, authorizing services, arranging services, coordinating the provision of services, follow-up and reassessment. Service coordination ensures non-duplication of services by identifying the services and/or service providers, the informal supports, and resources that are currently being utilized and/or provided to the individual.

**16-1-.06: Action Plan**

The Options Counselor shall work with the individual and the family support system to develop the Action Plan. The Action Plan is a written document that specifies the types, frequency, and amount of in-home services provided to an individual based on a comprehensive assessment of the individual's needs. Service decisions shall always be made in the best interest of the individual. The Action Plan is the individual's plan of care. The individual (or his/her representative) will actively participate in the development of the Action Plan.

(1) Action Plan Components

During the development of the Action Plan, needed communication aids such as audio tapes, Braille material, or language interpreters shall be provided at no cost to the individual. All sections of the Action Plan must be completed and the Action Plan shall be written prior to obtaining the signature of the individual (or his/her representative) and the AAAD representative. The Action Plan shall describe in detail each of the following:

- (a) the needs of the individual;
- (b) the specific in-home support services needed and the frequency of each service in order to maintain his/her independence;
- (c) services currently being received from other providers in order to avoid duplication of services and use the funds more effectively;
- (d) informal support services, no cost or voluntary services provided by family and/or other individuals;
- (e) the cost of the in-home support services needed to maintain the individual's independence; and
- (f) specified amount of funding provided and the source of funding for each service provided. If the amount and/or source of funding changes, this must be noted in the Action Plan.

(2) Changes to Action Plan

Any changes to the Action Plan must be reviewed and approved by the individual (or his/her representative) during an in-home visit or by phone.

- (a) If the change is reviewed during an in-home visit, the individual (or his/her representative) shall sign the up-dated Action Plan.

(b) If the change is reviewed by telephone, the Options Counselor shall document (in the case notes) that the change was reviewed by the individual (or his/her representative) and the Options Counselor and the Supervisor shall initial and date the Action Plan.

(3) Annual Review of Action Plan

The Action Plan must be reviewed annually, but can be done more frequently as dictated by the individual's needs.

(a) The Action Plan should be updated when a service is either decreased or a new service is added. When a change is made, the individual must be advised. A face-to-face visit may be made at the discretion of the Options Counselor.

(b) An individual is considered in Interrupted Status if the individual does not receive services for thirty (30) days due to hospitalization or other causes. The Options Counselor must maintain regular contact with the individual during this time.

(c) The AAAD may terminate an individual from the program after the individual has been in Interrupted Status for thirty (30) days.

(4) Action Plan Not Developed

If any of the following conditions apply, an Action Plan shall not be developed:

(a) if the individual (and/or his/her representative) notifies/tells the Options Counselor that he/she does not want to proceed with the development of the Action Plan;

(b) if the individual (and/or his/her representative) refuses to release or provide information that is necessary to the development of the Action Plan; or

(c) if the resources are not available, within the available funds, to develop and carry out the Action Plan.

**16-1-.07: Services**

(1) Screening

For the initial screening for OPTIONS and OAA Title IIIB, the AAAD shall utilize a brief standardized questionnaire developed by TCAD. The screening questionnaire will collect information that will identify risk factors or conditions that indicate the need for long-term supports and services resulting in a referral for an assessment and/or for long-term support services for which the individual is potentially

eligible. All adults age 60 and over and adults with disabilities who contact the AAAD requesting in-home services will receive an initial screening for which there is no charge. Screened individuals who have at least one (1) ADL or IADL limitation may receive a full in-home assessment when an opening for services is available. All individuals shall be provided with current information on opportunities and services available within his/her community.

I&A staff will complete the Screening Prioritization Form (Appendix B) on each individual upon the completion of the initial screening. This form shall be used to rank the individuals on the wait list with individuals with the highest risk score at the top of the list. If more than one individual has the same score, he/she will be ranked by date with the individual with the earliest day going first.

(2) Assessment and Reassessment

The SAMS Independent Living Assessment developed by TCAD shall be used by the AAAD to assess the individual's risk of losing his/her independence and to assist in the development of an action plan, if appropriate. The assessment gathers information about health and nutritional status, financial status, Activities of Daily Living (eating, bathing, dressing, toileting, transferring/walking, and continence), Instrumental Activities of Daily Living (ability to use telephone, shopping, food preparation, housekeeping, laundry, transportation, responsibility for own medications, and ability to handle finances), physical environment, and social support system. All assessments shall be completed in a face-to-face interview with the individual and family support. A reassessment is required at least annually for all in-home services; however, the Options Counselor should be alert for changes in an individual's condition or circumstances that may warrant a reassessment at an earlier date. A six (6) month reassessment may be completed on an individual if the Options Counselor sees the need.

The individual may be functionally impaired as determined by the following for each of the services:

- (a) homemaker: a total score (ADL/IADL) of at least three (3) with one (1) being an IADL;
- (b) personal care: a total score (ADL/IADL) of at least three (3) with one (1) being an ADL;

- (c) home-delivered meals: a total score (ADL/IADL) of at least six (6) with two (2) being ADL and/or IADL limitations in addition to the following:
- (i) physically unable to access congregate meal site
  - (ii) inadequate informal supports
  - (iii) must be homebound based on the following:
    - Leaving home is not recommended due the condition of the individual.
    - The individual's condition keeps him/her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person).
    - Leaving home takes a considerable and taxing effort.
    - An individual may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services.
    - Homebound condition is documented on the assessment and/or in the Options Counselor case files.

(3) Funded Services

The services provided by the state-funded OPTIONS or through OAA Title IIIB include the following:

(a) Homemaker Services

The Homemaker Services provider completes household tasks that enable an individual to live in a clean, safe, and sanitary home environment, including those Instrumental Activities of Daily Living (IADL), such as:

- (i) shopping for groceries and personal items;
- (ii) meal preparation;
- (iii) managing money;
- (iv) using the telephone; and
- (v) light housework.

(b) Personal Care

The Personal Care provider provides personal assistance, stand-by assistance, or supervision for the individual having difficulty with one or more of the Activities of Daily Living (ADL). These ADLs include:

- (i) eating;
- (ii) dressing;
- (iii) bathing;
- (iv) walking;
- (v) toileting; and/or
- (vi) transferring in and out of bed or chair.

Homemaker Services and Personal Care must be provided in accordance with the Rules of the Department of Mental and Developmental Disabilities Office of Licensure Chapter 0940-5-38, Minimum Requirements for Personal Support Service Agencies.

(c) Home-delivered Meals

Home-delivered Meals are nutritionally-balanced and meet at least one-third (1/3) of the current Dietary Reference Intakes (DRI) and is delivered to the individual's house.

(d) Other Services

Other services may be provided if the Options Counselor sees there is a need to provide minimal services in order to maintain the individual within the home. Any other services provided by State allocation must have prior approval by the Director of the AAAD. These services may include Personal Emergency Response System (PERS), pest control, and limited home modifications.

(4) Home Environment and Safety

A Home Environment Checklist shall be completed by the Options Counselor to assess the safety and accessibility of an individual's homes prior to an individual receiving services. This checklist is a part of the SAMS ILA. The Options Counselor may use this checklist to determine the safety of both the individual and service providers. The checklist may also be used as an opportunity to talk with the individual about assistance that may be available to correct problems in and around the home and to offer the necessary referrals.

Each AAAD will be responsible for having a written policy to review the potential denial of services due to home environment and safety. An individual denied services due to home environment and safety has the right to make a grievance complaint, if desired. Grievance

complaints will be reviewed by the grantee agency in accordance with the agency's grievance policy.

(5) Individual's Right to Self-Determination

Each individual has the right to choose how they will live as well as where they will live, as long as he/she are competent to make that decision and are able to understand the consequences of their actions. All adult individuals are presumed legally competent unless deemed incompetent by a court. However, it is essential that the Options Counselor not approve in-home services for individuals who are in an environment or situation that is clearly unsafe for the individual or for the workers who come into the home.

Reports to Adult Protective Services (APS) are mandated by state law when "any person" has reasonable cause to suspect abuse, neglect (including self-neglect), or financial exploitation. This includes neighbors, friends, relatives, doctors, dentists, caregivers, agency personnel, etc. (Adult Protection Act T.C.A. 71-6-103(b)(1); [www.state.tn.us/humanserv/adfam/aps-act.pdf](http://www.state.tn.us/humanserv/adfam/aps-act.pdf))

(5) Follow-Up

The Options Counselor will contact the individual semi-annually following the implementation of the Action Plan to determine the following:

- (a) if the individual was able to follow through on the steps outlined in the Action Plan;
- (b) identify barriers experienced when implementing the Action Plan; and
- (c) determine if the home and community based services met the needs of the individual and the resulting impact.

**16-1-.08: Priority for Provision of Services**

In providing home and community based services, priority shall be given to Adult Protective Service (APS) clients and low-income individuals.

(1) Adult Protective Service

The following conditions apply:

- (a) Funding to provide services must be available.
- (b) The APS Referral for Priority HCBS Services form (Appendix C) must be approved and signed by the APS Unit Supervisor before the referral is submitted

to the AAAD. If a referral is submitted to the AAAD prior to APS Unit Supervisor's approval, the AAAD must return the referral.

- (c) The APS case will be kept open for at least 30 days following the date of the referral or from the date of the individual receiving OPTIONS services. This time period allows the Options Counselor and the assigned APS staff to communicate to assure that services are appropriate. The assigned APS staff must communicate the intent to close the APS care before it is closed.
- (d) The individual's needs must be determined by APS to be severe and without intervention to stabilize the home environment, there would be harm to the individual.
- (e) The Screening Prioritization Form will be completed by the I&A staff at the AAAD based on the information provided in the APS referral document. If the score and the level of need for the APS clients are comparable to non-APS individuals on the AAAD wait list, the APS client will be added to the existing program wait list. A Notice of Action will be provided to the APS staff informing them of this decision. Individuals with the highest score and are on the wait list the longest, will be pulled off first to be assessed when there is funding available.

(2) Low income individuals

The following conditions apply:

- (a) Must meet the Federal Poverty Guidelines that change annually. (Appendix G)
- (b) Funding to provide services must be available.

**16-1-.09: Administrative Requirements**

(1) TCAD shall:

- (a) designate a coordinator to oversee program development implementation of the home and home and community based services
- (b) develop and maintain consistent standards and mechanisms
- (c) provide technical assistance as needed
- (d) assume quality assurance responsibilities for all home and community based services programs to ensure compliance with standards, policies, and procedures of TCAD.

- (2) At a minimum, each AAAD shall:
- (a) coordinate HCBS with other program and service systems serving adults age 60 and over and adults with disabilities
  - (b) conduct competitive bid process and choose service providers for authorization
  - (c) conduct contract compliance monitoring with service providers annually and renew contracts based upon performance and satisfactory compliance with contract specifications and quality assurance monitoring
  - (d) apply Cost Sharing Plan
  - (e) compile and maintain a wait list for OPTIONS, OAA Title IIIB, and Nutrition
  - (f) ensure appropriate program/financial reporting, billing, and budget reconciliation.

**16-1-.10: Confidentiality**

Details and identity shall not be disclosed without the individual's informed consent, except in compliance with court orders or to report elder abuse as required by T.C.A. 71-6-101, The Tennessee Adult Protection Act. The following protocols cover day-to-day situations involving individual records and office procedures and the protection of the individual's right to confidentiality:

- (1) All individual files must be locked during non-working hours. During working hours, files may be unlocked if staff is present in the area. If staff is out of the office for more than one-half hour, even if in the building, the files should be locked.
  - (a) The key to the file cabinet should be controlled in each office.
  - (b) The original individual files must not leave the office.
  - (c) Copies of assessments that are done in individual homes must be secured in a locked file.
  - (d) Discretion in discussing individual information shall be employed at all times. Many staff share office space with program staff from other agencies. Files should not be left on desks in plain view. No lists of names are to be left in view on bulletin boards. Discussion of individual information shall not be held in hallways or with staff not authorized to be involved with the individual.
  - (e) Data that are transferred electronically must be adequately secured to avoid unauthorized access.

- (f) A confidentiality notice must accompany all facsimile (FAX) transmissions.
- (2) All electronic client data shall be maintained on agency controlled or authorized computers.
  - (a) All computers must be password protected.
  - (b) All electronic client data must be encrypted while stored on mobile or remote computing platforms and protected from unauthorized access, modification, and/or destruction at all times.
  - (c) AAAD shall have a written internal policy and procedure addressing the security of electronic client data that complies with HIPPA requirements.
- (3) The AAAD shall maintain the confidentiality of individual files and records at all times. Such files and records shall not be disclosed except:
  - (a) to the individual or his/her representative;
  - (b) to TCAD or other state agencies for purposes of monitoring and securing home and community based services;
  - (c) to Tennessee Department of Human Services/Adult Protective Services Division worker; and
  - (d) under court order.
- (4) The AAAD shall use individual records for purpose of the coordination of other related services only. Any disclosure of information in an individual's file for purposes of coordinating related services shall be limited to the information that is directly relevant to and required by the other related services.

**16-1-.11: Records**

- (1) Each AAAD shall maintain separate records for each individual who applies for or receives home and community based services. Records for each individual must include at a minimum the following:
  - (a) individual's name, address, and telephone number (cell number and email information, if available);
  - (b) individual's date of birth, gender, race/ethnicity;
  - (c) physician's name, address, and telephone number; (cell number and email information, if available);

- (d) name, address, and telephone number of a person, other than spouse or relative with whom the individual resides, to contact in case of emergency (cell phone and/or email, if available);
  - (e) ADL/IADL status;
  - (f) documented disability due to a physical impairment;
  - (g) rural status;
  - (h) living alone status;
  - (i) whether or not the individual has an income at or below the poverty level for intake and reporting purposes; and
  - (j) eligibility requirements for service authorization as determined by ADLs/IADLs.
- (2) Each individual's records shall be maintained by the AAAD for a minimum of three (3) years after the individual's termination from the program or other final action.

**16-1-.12: Funding**

The following guidelines apply to funding expenditures. Reimbursement rate for services is contained in Appendix E.

- (1) The in-home support services must relate directly and clearly to the individual's goals and Action Plan.
- (2) The allowable cost for each individual is the maximum amount of funds that can be used to provide services to the individual and is the amount identified in the Action Plan.
- (3) Funds cannot pay for services provided through or covered by any other provider or any other insurance or payment system.
- (4) It is recommended that contracted home and community based services provided under OPTIONS or Title IIIB not to exceed \$3,500 annually per individual enrolled after July 1, 2014, but shall not exceed a maximum of \$5,000 annually per individual. For individuals enrolled prior to July 1, 2014, it is recommended that contracted home and community based services provided under OPTIONS or Title IIIB not to exceed \$3,500, but shall not exceed a maximum of \$7,000 annually per individual.
- (5) Contracted home and community based services for individuals enrolled after July 1, 2014 shall not exceed \$5,000 annually per individual unless the individual has three (3) or more Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living

(IADL) limitations. Contracted services for those individual with the identified exception shall not exceed \$7,000 annually and **must** have prior approval by the AAAD Executive Director.

**16-1-13: Cost Sharing and Participant Contribution Requirements**

1) Administrative Requirements

Each AAAD shall:

- a) utilize a sliding fee scale with the following considerations:
  - i) Cost sharing shall be based solely on household income and the cost of delivering services to determine the cost share for HCBS.
  - ii) The AAAD shall determine eligibility for cost share by declaration of income with no requirement for verification.
  - iii) The AAAD shall not consider any assets, saving, or other property owned by the individual when defining low-income individual who is exempt from cost sharing, when creating a sliding scale for cost sharing or when seeking contributions.
  - iv) An example of a cost share computation form may be found in Appendix F.
- b) adhere to the cost sharing requirements for the individual funded in whole or in part by HCBS funding
- c) implement cost sharing for all HCBS services except for:
  - i) information and assistance, outreach, benefits counseling, or case management services;
  - ii) ombudsman, elder abuse prevention, legal assistance, or other individual protection services;
  - iii) congregate and home delivered meals; and
  - iv) any services delivered through tribal organizations.
- d) any funds received as the result of cost sharing must be:
  - (i) put back in the program as program income.
  - (ii) disbursed in a timely manner.
  - (iii) used to expand the service for which the income was given.
  - (iv) not be used for matching.

- e) use methods for receiving cost share payments and contributions that protect the privacy and confidentiality of each individual in declaration or non-declaration of income and to any share of costs paid or unpaid by the individual.
- f) invoice the individual for the cost share amount, issue a receipt of payment to the individual, and keep a record of accounts receivable for cost share payment.
- g) not deny OAA funding to any individual due to the income of the individual or the individual's failure to make cost sharing payment.
- h) make a good faith effort to collect cost sharing obligation above \$25 per month. TCAD may approve a waiver for the AAAD if:
  - (i) a significant proportion of persons receiving HCBS have low incomes below the threshold established by TCAD (See Appendix G for Federal Poverty Guidelines); or
  - (ii) cost sharing would be an unreasonable administrative or financial burden on the AAAD.

2) Cost Share Procedure

The following identify the steps in developing the cost share plan based on the individual's action plan for care and notifying the individual about the amount of cost share.

- a) During initial home visit, determine household income for the individual and/or spouse.
- b) The Options Counselor will determine an estimated cost share amount to be paid by the individual and will advise the individual of the estimated amount.
- c) The individual will receive an enrollment letter with the estimated amount of the individual's cost share.

**16-1-14: Cost Effectiveness and Non-Duplication of Services**

In order to ensure that all individuals eligible for HCBS can be served in a cost effective and efficient manner, three separate waiting lists will be maintained including one for Title IIIB Supportive Services, Nutrition, and OPTIONS.

- (1) All individuals who are screened and appear to be eligible for CHOICES will be referred directly to the CHOICES Counselor.

- (2) Individuals who are screened and appear to be eligible for Title IIIB Supportive Services, Nutrition Services, or OPTIONS will be placed on the appropriate waiting list.
- (3) Individuals who are qualified for CHOICES and declines CHOICES are not eligible to receive OPTIONS services; however, they may be placed on the Title IIIB Supportive Services waiting list, on the Nutrition waiting list, or may choose the private pay option.
- (4) When an individual receiving OPTIONS or Title III services is reassessed for services during the annual visit and is found to be eligible for CHOICES, the Options Counselor will make a referral to CHOICES. Options or Title III services may continue for up to 10 days from the CHOICES date of enrollment to ensure that the individual retains services until CHOICES services begin.
- (5) If the individual who is receiving OPTIONS is found to be qualified for CHOICES but declines CHOICES, the AAAD may move the individual to Title IIIB Supportive Services.

**16-1-.15: Reduction in Services**

The AAAD shall reduce services in any of the following circumstances:

- (1) The assessed level of need diminishes as established by an updated Action Plan.
- (2) The AAAD's funds are insufficient to meet the service commitment to current individuals; all reasonable efforts have been made to secure resources to avoid services reductions; the AAAD has stopped performing new assessments and Action Plans; and the AAAD has adopted a fair and equitable policy for distributing service reductions among individuals. The fair equitable policy should be based upon the following criteria:
  - (a) The agency will suspend new enrollment.
  - (b) Upon the discharge or death of an individual, the agency will not fill the vacant slot.
  - (c) The Options Counselors will reduce all Action Plans not to exceed \$2,500 per plan.
  - (d) If necessary, the AAAD will terminate individuals from the program on a case-by-case basis.

**16-1-.16: Termination of Services**

The AAAD shall terminate services in any of the following situations:

- (1) The individual currently receiving OPTIONS or OAA Title IIIB services is re-assessed and qualifies for CHOICES, OPTIONS/Title IIIB funding will continue until the individual begins receiving services from CHOICES.
- (2) The current individual becomes eligible for HCBS from other sources for which the individual was not previously eligible and is now receiving those services.
- (3) The individual's health or personal circumstances have improved so that the person no longer needs HCBS to maintain his/her independence in a safe, non-institutional environment.
- (4) Other resources become available in the community and the individual begins receiving those services that were not available at the time of the development of the previous Action Plan.
- (5) The health, welfare, or safety of the individual or providers can no longer be reasonably assured.
- (6) The individual (or his/her representative) has fraudulently obtained or misused HCBS funded services.
- (7) The individual is in the hospital for longer than thirty (30) days or has a permanent placement in a nursing facility.
- (8) The individual receiving services passed away.
- (9) The individual (or his/her representative) voluntarily requests termination.
- (10) The individual (or his/her representative) refuses service necessary for his/her health and well-being.
- (11) No service providers are willing to provide services or no service providers are available in the area.

**16-1-.17: Missed Visits**

“Missed visit” is the term used when the provider fails to keep the scheduled appointment for services or the individual receiving services fails to be available for a scheduled appointment. “Missed visit” applies to both the provider and individual. Any missed visit by either the provider or individual should be reported to the Options Counselor and be recorded in the missed visit log. If a service provider misses three (3) visits within a year without notifying the individual and the individual is available to receive services, the individual will be advised to change providers. If the individual fails to be available to receive services three (3) times within

a year without notifying the provider of the change in schedule, the individual will receive a letter from the AAAD advising him/her that services may be terminated.

**16-1-.18: Quality Assurance**

The AAAD will monitor the following:

(1) Individual Satisfaction Surveys

The program should conduct individual satisfaction surveys on an annual basis. The results of the surveys shall be analyzed and a report produced that documents the evaluation of provider efforts.

(2) Provider Review

The AAAD shall conduct an annual review of service providers to ensure that all services are in compliance with the provider contract and to track the performance of the service provider. The review can be conducted by another AAAD that also contracts with the service provider.

(a) Complaints and Incidents

A complaint may be any verbal or written communication that expresses dissatisfaction with something or someone. An incident is an occurrence that caused or had the potential to cause harm and/or a breach of security and/or confidentiality. Complaints and/or incidents should be promptly noted in the Complaint and Incident Log. The Log should document and detail the nature of the complaint and/or incident, the individuals involved, and the resolution of the complaint and/or incident. It should also be noted and corrected whenever providers consistently show up on the Complaints and Incidents list.

(b) Missed Visits

The Missed Visit Report will be checked to ensure that both the provider and the individual receive services as scheduled and that action has been taken to resolve the impact on the provider and/or the individual. The Missed Visit Report shall include the date(s) of the missed visit, the reason(s) for the missed visit, and the action taken to resolve the situation.

**16-1-.19: Reporting Requirements**

The data shall be entered into SAMS no later than the 20<sup>th</sup> of the month following the month being reported. When the due date falls on a weekend or holiday, the report will be due

on the following business day. TCAD will review the SAMS data on a monthly basis. As required by the State Budget Office, the AAAD will submit monthly statistical data regarding OPTIONS that includes monthly enrollment, overall monthly expenditures, contracted services expenditures, and number of individuals on the waiting list.

**16-1-.20: Background Checks**

This program must be in compliance with Background Check Chapter of the TCAD Program and Policy Manual.

**16-1-.21: Individual Transfers Between AAADs**

Current individuals who move from one region to another region within Tennessee shall continue to receive services maintaining a seamless system. The individual shall be transferred to the AAAD that serves the county to which the individual moved. If there is an open slot, then the receiving AAAD would place the individual into that open slot. If the receiving AAAD has no open slot available, the receiving AAAD would not deny services, but would arrange for services to be provided to the individual and would bill the transferring AAAD the cost to provide services to the individual. The receiving AAAD would continue to bill the transferring AAAD on a monthly basis until an open slot becomes available. The receiving AAAD shall provide the transferring AAAD with written notice of the available slot and final billing.

**16-1-.22: OPTIONS for Community Living: Self Directed Care**

If an individual meets all of the eligibility requirements for OPTIONS but would like more control over his/her services and providers than offered by the previously described OPTIONS program, the individual may select OPTIONS: Self-Directed Care, often referred to as “consumer directed”. The individual has the decision-making authority over his/her services and providers and takes direct responsibility for managing his/her services. The individual (or his/her authorized representative) will work with the OPTIONS Counselor to:

- 1) identify his/her needs;
- 2) determine how and when those needs will be met;
- 3) select the providers, such as family, friends, agency, etc.;
- 4) develop a spending plan for use of the funds; and
- 5) evaluate the quality of services he/she receives.

The individual will be responsible for providing training to and supervising those providing the services. A fiscal intermediary service provides assistance to the individual to ensure all the fiscal requirements are met by the individual as the employer.

TCAD has contracted with a provider of fiscal intermediary services. An individual assessed by the AAAD as eligible for self-directed services can hire his/her own personal assistant or other help whose job duties might include housekeeping, laundry, cooking, personal care, and transportation. The goal of the program is to avoid institutionalization and related higher costs.

For OPTIONS: Self-Directed Care, general program policies include the following:

- (1) The individual will not be able to have the fiscal intermediary service pay employees and/or providers on his/her behalf until:
  - (a) the individual enrollment paperwork is complete;
  - (b) the provider employee paperwork is complete;
  - (c) the provider training and background checks are complete; and
  - (d) the fiscal intermediary service receives an approved authorization from the Options Counselor.

The fiscal intermediary service's standard method of paperwork distribution is for the Options Counselor to download provider packets from the program website.

However, packets can be mailed upon request.

- (2) The individual will be the employer of record (EOR) unless the family determines that he/she needs a representative to serve in this capacity or the individual has an existing Employer Identification Number (EIN).
- (3) If the individual has a conservator/Power of Attorney, conservatorship paperwork must be sent to the fiscal intermediary service.
- (4) All documents for individuals and providers will be stored in the document management system for viewing on the Web Portal.
- (5) Spouses and conservators of participants/employers/authorized representatives may not provide services in this program.
- (6) There is no limit to the number of providers a consumer may hire; however, providers may only be on staff for more than one consumer if they have a Personal Support Service Agency (PSSA) license.

(7) Background and registry checks are conducted for all employees.

For further specifics regarding the program, the complete document can be found in Appendix H.

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**Social Assistance Management System  
Independent Living Assessment  
(Nutrition Screening Initiative) 2012**

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# SAMS ILA (NSI) 2012

## 0. Cover Sheet

### 0.A. Client Identification

1. What is the date of the assessment?

\_\_\_\_/\_\_\_\_/\_\_\_\_

2. Specify the type of assessment, or the reason for the assessment.

- 1 - Initial assessment  
 2 - Reassessment

3. Where was the client interviewed?

- 1 - Home  
 2 - Hospital  
 3 - Nursing facility  
 4 - Other

4. Describe where the client was interviewed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What is the name of the person conducting this assessment?

\_\_\_\_\_

6. What is the name of the agency the assessor works for?

\_\_\_\_\_

7. What is the client's last name?

\_\_\_\_\_

8. What is the client's first name?

\_\_\_\_\_

9. What is the client's middle initial?

\_\_\_\_\_

10. Enter the client's name suffix.

\_\_\_\_\_

11. Enter the client identifier for the client.

12. Enter the client's 'also known as' name.

\_\_\_\_\_

13. What is the client's ethnicity?

- 1 - Hispanic or Latino  
 2 - Not Hispanic or Latino  
 3 - Unknown

14. What is the client's race?

- 1 - American Indian/Native Alaskan  
 2 - Asian  
 3 - Black/African American  
 4 - Native Hawaiian/Other Pacific Islander  
 5 - Non-Minority (White, non-Hispanic)  
 6 - Hispanic/Latino - White  
 7 - Other

15. Enter the client's telephone number.

\_\_\_\_\_

16. What is the client's Social Security Number?

\_\_\_\_\_

17. What is the client's date of birth?

\_\_\_\_/\_\_\_\_/\_\_\_\_

18. Enter the age of the client in years.

19. What document was used to verify the client's age?

- Birth certificate  
 Driver's license  
 Employment identification card  
 Military/veteran's identification card  
 Notarized affidavit  
 Passport  
 Self Declaration (Must Complete Age Declaration on Signature Page)  
 Social Security or Medicare card  
 U.S. census records  
 Wedding or divorce decree  
 Other (Answer Next Question if this is chosen)

20. What other document was used to verify the client's age?

\_\_\_\_\_

21. What is the client's gender?

- M - Male  
 F - Female

22. Enter the client's residential street address or Post Office box.

\_\_\_\_\_

23. Enter the client's residential city or town.

\_\_\_\_\_

24. Residential zip code.

\_\_\_\_\_

25. What county does the client reside in?

\_\_\_\_\_

26. If different from residential address, enter the client's mailing street address or Post Office box.

\_\_\_\_\_

27. If different from residential address, enter the client's mailing city or town.

\_\_\_\_\_

28. If different from residential address, enter the client's mailing state.

\_\_\_\_\_

29. If different from residential address, enter the client's mailing ZIP code.

\_\_\_\_\_

30. What is the name of the client's caregiver?

\_\_\_\_\_

31. What is the relationship of the primary helper to the client?

- Daughter/Daughter-in-law  
 Grandparent (55+)  
 Husband  
 Non-relative  
 Other elderly non-relative (60+)

- Other elderly relative (60+)  
 Other relative  
 Relationship Missing  
 Son/Son-in law  
 Wife

**0.8. Emergency Contact Information**

1. What is the name of the client's primary care physician?

\_\_\_\_\_

2. What is the work phone number for the client's primary care physician?

\_\_\_\_\_

3. Name of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

\_\_\_\_\_

4. Relationship of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

\_\_\_\_\_

5. Address of Friend or Relative (other than Spouse/Partner) to contact in an Emergency.

\_\_\_\_\_

6. Work Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

\_\_\_\_\_

7. Home Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

\_\_\_\_\_

8. Cell Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

\_\_\_\_\_

9. What is the name of a second relative or friend of the client?

\_\_\_\_\_

10. What is the work phone number of the second relative or friend of the client?

\_\_\_\_\_

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**11. What is the home phone number of the second relative or friend of the client?**

\_\_\_\_\_

---

**12. What is the e-mail address of a Family Member?**

\_\_\_\_\_

**0.C. Directions to Client's Home**

**Directions on how to get to the client's home.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**1. Intake**

**1.A. Standard Data**

1. Did someone help the client or answer questions for the client?

- Y - Yes
- N - No

2. What is the name of the person that helped the client during this assessment?

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3. What is the helper's relationship to the client?

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4. Was communication/language assistance needed for this assessment?

- Y - Yes
- N - No

5. Specify the client's primary language.

- English
- Spanish
- French
- Italian
- German
- Russian
- Other

6. What type of communication/language assistance was needed for this assessment?

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**1.B. Legal Representative**

1. Does the client have a power of attorney?

- Y - Yes
- N - No

2. What is the name of the client's power of attorney?

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3. Enter the work phone number of the client's power of attorney.

---

4. Enter the home phone number of the client's power of attorney.

---

5. Does the client have a DPOA for health care?

- Y - Yes
- N - No

6. What is the name of the client's DPOA for health care?

---

7. Enter the work phone number of the client's DPOA for health care.

---

8. Enter the home phone number of the client's DPOA for health care.

---

9. Does the client have a DPOA for finances?

- Y - Yes
- N - No

10. What is the name of the client's DPOA for finances?

---

11. Enter the work phone number of the client's DPOA for finances.

---

12. Enter the home phone number of the client's DPOA for finances.

---

13. Does the client have a representative payee?

- Y - Yes
- N - No

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14. What is the name of the client's representative payee?

\_\_\_\_\_

15. Enter the work phone number of the client's representative payee.

\_\_\_\_\_

16. Enter the home phone number of the client's representative payee.

\_\_\_\_\_

17. Does the client have a legal guardian?

Y - Yes  
 N - No

18. What is the name of the client's guardian?

\_\_\_\_\_

19. Enter the work phone number of the client's guardian.

\_\_\_\_\_

20. Enter the home phone number of the client's guardian.

\_\_\_\_\_

21. Does the client have a living will?

Y - Yes  
 N - No

22. Name of person holding copy of DPOA/Living Will.

\_\_\_\_\_

23. Telephone number of person holding copy of DPOA/Living Will.

\_\_\_\_\_

24. Address of person holding second copy of DPOA/Living Will.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

25. If the client does not have a living will, was information provided about advanced directives?

Y - Yes  
 N - No

### 1.C. Assessment Information

1. Select the client's current marital status.

A - Single  
 B - Married  
 C - Separated  
 D - Widowed  
 E - Divorced  
 F - Unavailable

2. Indicate the type of residence that the client currently resides in.

A - House/mobile home  
 B - Private apartment  
 C - Private apartment in senior housing  
 D - Residential care home  
 E - Nursing home  
 F - Unavailable  
 Z - Other

3. Is the client NSIP eligible for home delivered meal reimbursement? (Regardless of whether or not they need meals, if they are over the age of 60 or meet one of the conditions on the next question, you will generally check yes.)

Yes  
 No

4. For what reason is the client NSIP eligible for home delivered meals?

Disabled individual residing in an elderly housing which serves congregate meals  
 Age 60+ or Tribal Age  
 Spouse of someone who is NSIP eligible

### 1.D. Social Screening

1. Select the client's current living arrangement.

A - Lives Alone (3)  
 B - With spouse/partner  
 C - Lives with spouse and child  
 D - With child/children  
 F - With others (2)

2. If b, c, or d is checked: Ask if any of the person(s) that live with you are able to assist with your care? (If No, score 2)

No (2)  
 Yes

**3. What is the name of the client's spouse/partner?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. How many people are there in the client's household?**

- A - One person
- B - Two people
- C - Three people
- D - Four or more people

**5. Does the client have any children nearby?**

- Y - Yes
- N - No (2)

**6. Does the client have contact with family often enough?**

- Y - Yes
- N - No (3)

**7. Does the client have contact with friends often enough?**

- Y - Yes
- N - No (2)

**8. Is there a friend or relative that could take care of the client for a few days?**

- Y - Yes
- N - No (3)

**9. When the client makes a decision about something, how does s/he do it?**

- A - Independently and alone
- B - Independently after talking to family/friends (1)
- C - Follow advice of family/friends (2)
- D - Dependent (3)
- E - Information unavailable (Choose only if consumer not able to answer score 3)

**10. Is the client currently employed?**

- Yes
- No
- Full time

**11. Is the client participating in any of the following services or programs?**

- Statewide Medicaid Waiver/CHOICES
- Homemaker program
- Home Health Aide
- Nursing
- Speech therapy

- Occupational therapy
- Physical therapy
- Home delivered meals
- PERS - Personal Emergency Response System
- Senior companion
- Weatherization
- Congregate meals
- Adult day services
- Food stamps
- Fuel Assistance
- Telephone lifeline
- Medicaid
- SSI
- QMB/SLMB
- QI-1
- Personal care
- Respite care
- Minor Home Repairs
- Assistive Devices
- Private Duty
- 504 USDA program
- Extra help for Part D Medicare
- Other

**12. Does the client want to apply for any of the following services or programs?**

- B - Medicaid waiver
- C - Homemaker program
- I - Home delivered meals
- J - Emergency lifeline
- L - Weatherization
- M - Congregate meals
- O - Adult day services
- R - Fuel Assistance
- T - Medicaid
- U - SSI
- 1 - Personal care
- 2 - Respite care
- 3 - Minor Home Modifications
- 4 - Assistive Devices
- 5 - Private Duty
- O - Other

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Enter Social Score

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**1.E. Health Screening**

**1. How does the client rate his/her health?**

- A - Excellent
- B - Good
- C - Fair (2)
- D - Poor (3)
- E - Information unavailable

---

**2. In the past year, how many times has the client stayed overnight in a hospital?**

- 1 - Not at all (0)
- 2 - Once (1)
- 3 - 2 or 3 times (2)
- 4 - More than 3 times (3)

---

**3. In the past 6 months has the client stayed in a nursing home, residential care home, or other institution?**

- Y - Yes (2)
  - N - No
-

**4. Indicate which of the following conditions/diagnoses the client currently has.**

- Addiction
- Alcoholism/substance abuse
- Allergies
- Alzheimer's disease
- Anemia
- Ankle/leg swelling
- Anxiety disorder
- Any psychiatric diagnosis
- Aphasia
- Arteriosclerosis heart disease (ASHD)
- Arthritis/rheumatic disease/gout
- Asthma
- Blood-related problems
- Breathing disorders
- Bruises
- Cancer
- Cardiac dysrhythmias
- Cataract
- Cerebral palsy
- Chronic pain
- Chronic weakness/fatigue
- Congestive heart failure
- Contractures
- Coronary artery disease
- Decubitus
- Deep vein thrombosis
- Depression
- Developmental disability
- Diabetes
- Diabetic retinopathy
- Dialysis
- Digestive problems
- Drug resistance (MRSA/VRE)
- Edema
- Emphysema/COPD/asthma
- Expressive communication
- Fibromyalgia
- Frailty
- Frequent falls
- Gastritis or related condition
- Glaucoma
- Hearing impairment
- Heart problems
- Hemiplegia/Hemiparesis
- High cholesterol
- Hip fracture
- HIV

- Hypertension
- Hyperthyroidism
- Hypotension
- Hypothyroidism
- Immune system disorders
- Incontinence, bladder
- Incontinence, bowel
- Incontinent
- Liver disease
- Macular degeneration
- Manic depression (bipolar disease)
- Memory Loss
- Missing limb (e.g., amputation)
- Multiple sclerosis
- Muscle or bone problems
- Nausea/vertigo
- Neurological condition
- Non-Alzheimer's dementia
- Osteoporosis
- Other cardiovascular disease
- Other eye condition
- Other fracture (except hip/spine)
- Other neurological
- Other significant illness
- Paralysis
- Paraplegia
- Parkinson's disease
- Pathological bone fracture
- Peripheral vascular disease
- Pneumonia
- Post Traumatic Stress Syndrome
- Quadriplegia
- Receptive communication
- Renal failure
- Respiratory disease
- Schizophrenia
- Seizure disorder
- Speech impairment
- Stroke
- TB
- Thyroid disease
- Transient ischemic attack (TIA)
- Traumatic brain injury
- Tremors
- Urinary problems
- Urinary tract infection
- Vision problems
- None of the Above

5. Enter any comments regarding the client's medical conditions/diagnoses.

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6. Is the client limited in what s/he can do because of this health problem?

Y - Yes (3)  
 N - No

7. How often does bad health, sickness, pain, or disability stop the client from doing things s/he would like to do?

A - Never  
 B - Sometimes (1)  
 C - Often (2)  
 D - Always (3)

8. Has the client fallen in the past three months?

Y - Yes (3)  
 N - No

9. In a typical week, during the last 30 days, how often did the client go outside of their residence (no matter for how short a period of time)?

A - Two or more days a week  
 B - One day a week or less (2)

10. Does the client use a walker/cane to get around?

Y - Yes (3)  
 N - No

11. Does the client use a wheelchair to get around or is bedbound?

Y - Yes (3)  
 N - No

12. Does the client have problems with hearing that are NOT corrected with aids/devices?

Y - Yes (1)  
 N - No

13. If the client has hearing aids/devices, are they in working order?

Y - Yes  
 N - No

14. Does the client have problems with vision that are not corrected with aids/devices?

Y - Yes (1)  
 N - No

15. If the consumer uses vision aids/devices, are they in working order?

Y - Yes  
 N - No

16. Does the client have problems with speech that are not corrected with aids/devices?

Y - Yes (1)  
 N - No

17. Describe any aids/devices used by the client to correct speech problems.

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18. If the consumer uses speech aids/devices are they in working order?

Y - Yes  
 N - No

19. Does the client often feel sad or blue?

Y - Yes (3)  
 N - No

20. Expressions of lack of pleasure in life (e.g. I do not enjoy anything anymore)

Content  
 Happy  
 Hopeless  
 Lonely

21. Has the consumer had Suicidal thoughts?

Yes  
 No

22. How many prescription medications does the client take?

23. Is the number of Medications the client is taking 3 or more?

Y - Yes (1)  
 N - No

24. Does the client have a history of alcohol or drug abuse or history of mixing medications/alcohol?

Yes  
 No

25. Is there evidence that the client has problems with substance abuse?

- Yes  
 No

26. Describe any history of alcohol or drug abuse as it relates to the question above.

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27. What was the client's response when asked, 'What year is it?'

- A - Correct answer  
 B - Incorrect answer

28. What was the client's response when asked, 'What month is it?'

- A - Correct answer  
 B - Incorrect answer

29. What was the client's response when asked, 'Where are we now?'

- A - Correct answer  
 B - Incorrect answer

30. Indicate worker's judgment of client's overall mental clarity/cognitive functions.

- 1 - Good  
 2 - Fair (2)  
 3 - Poor (3)

31. In the past six months, has the client lost more than 10 pounds without trying?

- Yes (2)  
 No

Enter Health Screening Score.

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**1.F. Nutrition Screening**

1. Has the client made any changes in lifelong eating habits because of health problems?

- Y - Yes (2)  
 N - No (0)

2. Does the client eat fewer than 2 meals per day?

- Y - Yes (3)  
 N - No (0)

3. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?

- Y - Yes (1)  
 N - No (0)

4. Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?

- Y - Yes (1)  
 N - No (0)

5. Does the client have 3 or more drinks of beer, liquor or wine almost every day?

- Y - Yes (2)  
 N - No (0)

6. Does the client have biting, chewing or swallowing problems that make it difficult to eat?

- Y - Yes (2)  
 N - No (0)

7. Does the client sometimes not have enough money to buy food?

- Y - Yes (4)  
 N - No (0)

8. Does the client eat alone most of the time?

- Y - Yes (1)  
 N - No (0)

9. Does the client take 3 or more different prescribed or over-the-counter drugs per day?

- Y - Yes (1)  
 N - No (0)

10. Without wanting to, has the client lost or gained 10 pounds in the past 6 months?

- Y - Yes (2)  
 N - No (0)

11. Is the client not always physically able to shop, cook and/or feed themselves (or able to get someone to do it for them)?

- Y - Yes (2)  
 N - No (0)

Total score of Nutritional Risk Questions.

---

**What is the client's nutritional risk score rating?**

- High risk (6 or more)
- Moderate risk (3-5)
- No risk (0-2)

**2. Functional Assessment**

**2.A. Activities of Daily Living (ADL)**

**1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (include shower, full tub or sponge bath, exclude washing back or hair)?**

- 0 - Independent
- 1 - Supervision (1)
- 2 - Requires assistance sometimes (1)
- 3 - Mostly dependent (1)
- 4 - Totally dependent (1)
- 5 - Activity does not occur (1)

**Is the help the client receives bathing enough?**

- Y - Yes
- N - No

**2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?**

- 0 - Independent
- 1 - Supervision (1)
- 2 - Limited Assistance (1)
- 3 - Extensive Assistance (1)
- 4 - Total Dependence (1)
- 5 - Activity did not occur (1)

**Is the help the client receives dressing enough?**

- Y - Yes
- N - No

**3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?**

- 0 - Independent
- 1 - Supervision (1)
- 2 - Sometimes dependent (1)
- 3 - Mostly dependent (1)
- 4 - Totally dependent (1)
- 5 - Activity does not occur (1)

**Is the help the client receives using the toilet enough?**

- Y - Yes
- N - No

**4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform getting out of bed/chairs/transferring?**

- 0 - Independent
- 1 - Supervision (1)
- 2 - Minimal assistance required (1)
- 3 - Mostly dependent (1)

- 4 - Totally dependent (1)
- 5 - Activity does not occur (1)

**Is the help the client receives getting in and out of bed/chairs enough?**

- Y - Yes
- N - No

**5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?**

- 0 - Independent
- 1 - Supervision (1)
- 2 - Sometimes dependent (1)
- 3 - Mostly dependent (1)
- 4 - Totally dependent (1)

**Is the help the client receives eating enough?**

- Y - Yes
- N - No

**6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?**

- 0 - Independent
- 1 - Supervision (1)
- 2 - Limited Assistance (1)
- 3 - Extensive Assistance (1)
- 4 - Total Dependence (1)
- 5 - Activity did not occur (1)

**Is the help the client receives getting around the home enough?**

- Y - Yes
- N - No

**How many ADL impairments does the client have (Count or Total)?**

**2.B. Instrumental Activities of Daily Living (IADL)**

**1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?**

- 0 - Independent
- 1 - Sometimes dependent (1)
- 2 - Mostly dependent (1)
- 3 - Totally dependent (1)
- 4 - Activity does not occur (1)

---

**Is the help the client receives preparing meals enough?**

- Y - Yes  
 N - No
- 

**2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?**

- 0 - Independent  
 1 - Somewhat dependent (1)  
 2 - Mostly dependent (1)  
 3 - Totally dependent (1)  
 4 - Activity does not occur (1)
- 

**Is the help the client receives shopping enough?**

- Y - Yes  
 N - No
- 

**3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?**

- 0 - Independent  
 1 - Needs reminders (1)  
 2 - Somewhat dependent (1)  
 3 - Totally dependent (1)  
 4 - Activity does not occur (1)
- 

**Is the help the client receives taking medication enough?**

- Y - Yes  
 N - No
- 

**4. Specify the client's ability to MANAGE MONEY.**

- 0 - Completely independent  
 1 - Needs assistance sometimes (1)  
 2 - Needs assistance most of the time (1)  
 3 - Completely dependent (1)  
 4 - Activity does not occur (1)
- 

**Is the help the client receives managing money enough?**

- Y - Yes  
 N - No
- 

**5. Rank the client's ability to use the TELEPHONE.**

- 0 - Independent  
 1 - Able to perform but needs verbal assistance (1)  
 2 - Can perform with some human help (1)  
 3 - Can perform with a lot of human help (1)  
 4 - Cannot perform function at all without human help (1)
- 

**Is the help the client receives using the telephone enough?**

- Y - Yes  
 N - No
- 

**6. Specify the client's ability to perform HEAVY HOUSEWORK CHORES.**

- 0 - Independent  
 1 - Needs assistance sometimes (1)  
 2 - Needs assistance most of the time (1)  
 3 - Unable to perform tasks (1)  
 4 - Activity does not occur (1)
- 

**Is the help the client receives performing heavy household chores enough?**

- Y - Yes  
 N - No
- 

**7. Specify the client's ability to perform LIGHT HOUSEKEEPING.**

- 0 - Independent  
 1 - Needs assistance sometimes (1)  
 2 - Needs assistance most of the time (1)  
 3 - Unable to perform tasks (1)  
 4 - Activity does not occur (1)
- 

**Is the help the client receives doing housework enough?**

- Y - Yes  
 N - No
- 

**8. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?**

- 0 - Independent  
 1 - Somewhat dependent (1)  
 2 - Mostly dependent (1)  
 3 - Totally dependent (1)
- 

**Is the help the client receives using transportation enough?**

- Y - Yes  
 N - No
-

---

**9. Does the client have any of the following devices or equipment used to help perform the above ADL/IADL?**

- Artificial limb
- Bath stool
- Bedside commode
- Cane
- Dentures
- Extended shower head/Hand held shower
- Eyeglasses
- Grab bars
- Hearing aid
- Hospital bed
- Lift chair
- Nebulizer
- Oxygen
- Raised toilet seat
- Ramp
- Walker
- Wheelchair
- Other

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**10. Any of Other devices or equipment not listed, if other.**

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**How many IADL impairments does the client have (Count or Total)?**

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**Total Score (Social + Health+ADL/IADL)**

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**3. Financial Resources**

**3.A.i. Client Resources**

1. Specify the client's monthly social security income.

\$

2. Specify the client's monthly SSI income.

\$

3. Specify the client's monthly retirement/pension income.

\$

4. Specify the client's monthly interest income.

\$

5. Specify the client's monthly VA benefits income.

\$

6. Specify the client's monthly wage/salary/earnings income.

\$

7. Specify the client's other monthly income.

\$

**3.A.ii. Spouse Resources**

1. Specify the monthly social security income of the client's spouse.

\$

2. Specify the monthly SSI income of the client's spouse.

\$

3. Specify the monthly retirement/pension income of the client's spouse.

\$

4. Specify the monthly interest income of the client's spouse.

\$

5. Specify the monthly VA benefits income of the client's spouse.

\$

6. Specify the monthly wage/salary/earnings income of the client's spouse.

\$

7. Specify other monthly income of the client's spouse.

\$

**3.A.iii. Total Resources**

1. Specify the client's MONTHLY income.

\$

2. What is the client's monthly income?

- \$931 or less
- \$1,261 or less
- \$1,591 or less
- \$1,921 or less
- \$2,251 or less

3. How many people in the household does the client support on his/her income?

4. What is the client's TOTAL MONTHLY HOUSEHOLD income?

\$

5. Based on the Range, Is the CLIENT'S income level below the national poverty level?

- Yes
- No

**3.B. Monthly Housing Costs**

1. Specify the client's monthly rent.

\$

2. Specify the client's monthly mortgage.

\$

3. Specify the client's monthly property tax.

\$

4. Specify the client's monthly heat bill.

\$

5. Specify the client's monthly utilities bill.

\$

6. Specify the client's monthly house insurance cost.

\$

7. Specify the client's monthly telephone bill.

\$

8. Specify the client's other monthly costs.

\$

9. What is the consumer's estimated total medical monthly expenses(e.g. health insurance premiums, hospital and doctor bills, prescription costs)?

\$

10. Enter the client's total monthly housing expenses.

\$

**3.C. Savings/Assets**

1. What is the client's savings account/CD/investments balance?

\$

2. What is the client's checking account balance?

\$

**3.D. Health Insurance**

1. Enter the client's Medicare number.

2. Does the client have Medicare A health insurance?

Yes  
 No

3. Does the client have Medicare B health insurance?

Y - Yes  
 N - No

4. Does the client have Medigap health insurance?

Y - Yes  
 N - No

What is the name of the client's Medigap health insurer?

5. Does the client have Medicare D health insurance?

Y - Yes  
 N - No

What is the name of the client's Medicare D company/plan?

6. Does the client have LTC health insurance?

Y - Yes  
 N - No

What is the name of the client's LTC health insurer?

7. Does the client have other health insurance?

Y - Yes  
 N - No

What is the name of the client's other health insurer?

3 Comments

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**Comment on the client's current financial situation.**

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**5. Mental Health/Behavior/Cognition**

**5.A. Mental Health Services**

**1. In the past year, has the client received (or is the client currently receiving) mental health treatment or counseling?**

- Y - Yes
- N - No

**2. What kinds of services has the client received, or what kinds of services is the client receiving now?**

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**5.B. Behavior**

**1. Does spouse, partner, caregiver or other person, including this assessor, suggest that the client has memory or emotional problems?**

- Y - Yes
- N - No

**2. How often does the client get lost or wander?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**3. How often is the client physically abusive to him/herself?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**4. How often is the client physically abusive to others?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**5. How often is the client verbally abusive to him/herself or others?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**6. How often does the client exhibit socially inappropriate/disruptive behavior?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**7. How often does the client experience hallucinations/delusions?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**5.C. Cognition**

**1. How often does the client have problems with his/her short term memory?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**2. How often does the client have problems making him/herself understood?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**3. How often does the client have problems with long term memory?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**4. How often does the client have problems understanding others?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**5. How often does the client have problems with decision making?**

- 1 - Less than daily
- 2 - Daily
- 3 - Multiple times per day
- 4 - Never

**6. Home Environment**

**6.A. Environmental Checklist**

**1. Does the client have problems with dangerous stairs or floors in his/her home?**

Y - Yes  
 N - No

**2. Is it difficult for the client to get to the entrance of his/her home?**

Y - Yes  
 N - No

**3. Is it difficult for the client to get to the bathroom or bedroom in his/her home?**

Y - Yes  
 N - No

**4. Does the client have problems with the major appliances or toilet in his/her home?**

Y - Yes  
 N - No

**5. Does the client have problems with the heating or cooling in his/her home?**

Y - Yes  
 N - No

**6. Does the client have problems getting water or hot water in his/her home?**

Y - Yes  
 N - No

**7. Does the client have difficulties keeping his/her home free from odor or pests?**

Y - Yes  
 N - No

**8. Does the client need a smoke alarm in his/her home?**

Y - Yes  
 N - No

**9. Does the client have problems with electrical hazards in his/her home?**

Y - Yes  
 N - No

**10. Does the client have problems with poor lighting in his/her home?**

Y - Yes  
 N - No

**11. Does the client have problems with an unsafe stove in his/her home?**

Y - Yes  
 N - No

**12. Does the client have problems with loose slippery rugs in his/her home?**

Y - Yes  
 N - No

**13. Does the client have problems with inadequate locks on the doors and/or windows in his/her home?**

Y - Yes  
 N - No

**14. Does the client have problems keeping his/her home clean and free of clutter?**

Y - Yes  
 N - No

**15. Does the client have any other environmental problems in his/her home?**

Y - Yes  
 N - No

**16. Describe any other environmental problems.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**17. In the case of an emergency, would the client be able to get out of his/her home safely?**

Y - Yes  
 N - No

**18. In the case of an emergency, would the client be able to summon help to his/her home?**

Y - Yes  
 N - No

**19. Comment on the client's home environment in general and establish a safety evacuation plan if necessary.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Title :

Date

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Title :

Date

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# **Screening Prioritization**

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## SCREENING PRIORITIZATION

**Individual's Name:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Individual's Age:** \_\_\_\_\_

**Program:**  Title III-B  Meals  OPTIONS  CHOICES

**Is this an APS Referral?**  Yes  No **Total ADL/IADL Score:** \_\_\_\_\_ **ADL** \_\_\_\_\_ **IADL**

	<b>Low</b>	<b>Moderate</b>	<b>High</b>
ADL/IADL Deficits	1 (1-3 ADL/IADL)	2 (4-9 ADL/IADL)	3 10-14 ADL/IADL
Informal/Formal Support	1 (well supported in the home)	2 (support available but changing, inconsistent or inadequate)	3 (very little or no support in the home)
Health	1 (minimal with little impact on quality of life)	2 (chronic with moderate impact on quality of life)	3 (severe acute or chronic health problems with severe impact on quality of life)
Income	1 (more than 200% poverty level and/ resources of \$2000 or more)	2 (up to 200% poverty level and/or resources of less than \$2000)	3 (at Poverty level or lower and resources of less than \$2000)

**Other Factors:**

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**Total:** \_\_\_\_\_

**Low Risk (Less than 5 points)**      **Moderate Risk (6-8 points)**      **High Risk (9-12 points)**

**I&A Counselor/Options Counselor Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Adult Protective Services (APS)  
Referral for Priority HCBS Form**

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# APS REFERRAL FOR PRIORITY HCBS SERVICES

(Please Print)

Date of Referral:		
<b>APS INFORMATION</b>		
Name of APS Unit Supervisor Making Referral:		
Unit Supervisor Phone:	Unit Supervisor Cell:	Unit Supervisor Email:
Name of APS Field Worker:		
Field Worker Phone:	Field Worker Cell:	Field Worker Email:
APS Fax Number:		

<b>CONSUMER INFORMATION</b>			
Consumer Last Name:	First:	MI:	Date of Birth: / /
Home Address:			City:
County:	Zip Code:		Home Phone No.:
Does the consumer have dementia or any other condition that prevents him/her from participating in the screening? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Who do we contact for the initial screening? (Primary and Secondary)			
<b>Primary Name:</b>		Home Phone No.:	Cell Phone No.:
Relationship to Consumer (Please check one box): <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Caregiver <input type="checkbox"/> Neighbor <input type="checkbox"/> Professional <input type="checkbox"/> Other _____			
<b>Secondary Name:</b>		Home Phone No.:	Cell Phone No.:
Relationship to Consumer (Please check one box): <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Caregiver <input type="checkbox"/> Neighbor <input type="checkbox"/> Professional <input type="checkbox"/> Other _____			
What HCBS services are needed? (Please check all applicable boxes): <input type="checkbox"/> Homemaker <input type="checkbox"/> Personal Care <input type="checkbox"/> Home-delivered Meals <input type="checkbox"/> Other _____			
What referrals to other services have been made by APS?			
What current services are in the home? (Identify service and end date):			

What is the **risk of harm** to the consumer?

Is there anyone who might try to prevent services to the consumer? If so, specify the person and their relationship.

Provide any symptoms/situations the HCBS Worker needs to be aware of when visiting the consumer.

Current location of consumer:

Phone No:

**Signature of APS Field Worker** (Sign and Date):

**Signature of APS Unit Supervisor Making Referral** (Sign and Date):

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# Action Plan

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Individual Name:		Individual Id:	
<b>INFORMAL SUPPORT AND OTHER COMMUNITY SUPPORTS TO INDIVIDUAL</b> <i>(This section should detail services that are being provided by informal supports and other community supports. Support service may include services that already exist and/or services they are willing to provide in order to meet the needs of the individual.)</i>			
Type of Support to be Provided	Name of Person or Community Resource to Provide	Support	Frequency
Next Review: 6 Months	12 Months	Other:	Date:
Effective Date:			
Cost Share Required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>I, the Individual or Authorized Representative, have been involved in developing this action plan. I understand that it may be revised as my preferences and needs change and that I will be notified in advance of changes to the service plan. I have been given the option to choose my providers for services.</b>			
Signature of Individual or Authorized Representative:			Date:
Signature of Options Counselor:			Date:
Signature of AAAD Authorized Designee:			Date:

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## Reimbursement Rate for Services

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## Reimbursement Rate

### OPTIONS for Community Living (State-Funded) Older Americans Act – Title III (Federally Funded)

Service	Reimbursement Rate
Personal Care – OAA Title III	<i>The lesser of \$20.32 per hr. or usual and customary charges*</i>
Personal Care – State Funds	<i>The lesser of \$20.32 per hr. or usual and customary charges*</i>
Homemaker Services – OAA Title III	<i>The lesser of \$20.32 per hr. or usual and customary charges*</i>
Homemaker Services – State Funds	<i>The lesser of \$20.32 per hr. or usual and customary charges*</i>
In-home Respite – OAA Title III	<i>The lesser of \$16.12 per hr. or usual and customary charges*</i>
Hot Home-Delivered Meals – OAA Title III	<i>The lesser of \$6.93 per meal or usual and customary charges*</i>
Hot Home-Delivered Meals – State Funds	<i>The lesser of \$6.93 per meal or usual and customary charges*</i>
Frozen Home-Delivered Meals – OAA Title III	<i>The lesser of \$5.94 per meal or usual and customary charges*</i>
Frozen Home-Delivered Meals – State Funds	<i>The lesser of \$5.94 per meal or usual and customary charges*</i>

*\*For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service. The same requirements are to be applied in the above noted programs. Thus, only the lesser of the maximum rate as specified above or the usual and customary charges for each service should be billed.*

These are the maximum rates which may **not** be exceeded; a lesser amount should be billed and reimbursed, if the provider's usual and customary charge to persons not participating in these programs is lower. Reimbursement rates for OAA and State-Funded services shall not exceed the TennCare reimbursement rates.

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**OPTIONS Cost Share Computation Worksheet**

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# COST SHARE WORKSHEET

OPTIONS, OAA

Name \_\_\_\_\_  
 DOB \_\_\_\_\_

Date: \_\_\_\_\_  
 Id#: \_\_\_\_\_

1

Household Size	1	2
Declared Monthly Income	\$0.00	\$0.00
200% of FBR ( <i>Update yearly</i> )	\$1,442.00	\$ 2,164.00
<b>Income Subject to Cost Share</b>	<b>-\$1,442.00</b>	<b>-\$2,164.00</b>

2 Action Plan Estimation (HDM is subject to donation only)

	Units/Month or Year	Unit Cost	Total
Homemaker	0	\$ -	\$ -
Personal Care	0	\$ -	\$ -

Monthly or Yearly Cost Estimate for Service

\$ -

3 **Cost Share Rate** (Income subject to Cost Share divided by the amount given for the appropriate number in the household)

Cost Share Rate:	-50.00%		
	-50.00%	1	\$ 2,884.00
		2	\$ 4,328.00

(Update yearly with FBR x 4)

(Update yearly with FBR x 4)

4 **Cost Share**

\$0.00
\$0.00

Household 1  
 Household 2

Options Counselor \_\_\_\_\_

Date \_\_\_\_\_

Note: The amount of cost share cannot exceed 45% of their declared income

Note: If cost share is less then \$25/month, the Individual will not be required to pay

If assessed a cost share, 1 copy for Fiscal and original for file

## FINANCIAL RESOURCES-INCOME

**Name:** \_\_\_\_\_ **Id:** \_\_\_\_\_

### Income

INCOME	Individual	Spouse (if applicable)
Social Security		
SSI		
Retirement/Pension		
Interest from Savings, CDs, etc		
VA Benefits		
Wages/Salaries/Earnings		
Other (specify)		
<b>TOTAL</b>	0	0

### Savings/Assets

Type of Asset	Amount	Comments
Checking		
Savings		
CDs		
Other		

### Monthly Living Cost

SOURCE	AMOUNT PER MONTH	COMMENTS
Rent/Mortgage		
Heat		
Electric		
Water/Garbage		
Telephone		
Cable		
Property Tax		
Home Insurance/Rental Insurance		
Medical Insurance		
Medications		
Transportation		
Other (specify)		
<b>TOTAL</b>	0	

**Available Income** \_\_\_\_\_ **0**

**Fee Waived:**  Yes  No

Options Counselor \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

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**Federal Poverty Guidelines**

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## HHS 2014 POVERTY INCOME GUIDELINES

### 100% POVERTY LEVEL

Persons in family/household	Poverty guideline
1	\$11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090
<i>For families/households with more than 8 persons, add \$4,060 for each additional person.</i>	

The poverty guidelines in this table were published in the **FEDERAL REGISTER** on January 22, 2014. These figures are to be used by Area Agencies and Service Providers receiving funds under Title III and/or Title VII of the Older Americans Act in determining “greatest economic need: for reporting and targeting purposes.

These poverty guidelines do change each year. Updated Poverty Income Guidelines can be found through the United States Department of Health and Human Services by viewing the following website, <http://aspe.hhs.gov/poverty>.

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**TCAD Options Program/Self-Directed  
Care Program, Public Partnerships,  
LLC (PPL) Financial Administration  
Services**

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**TCAD Options Program  
Self-Directed Care Program  
Public Partnerships, LLC Financial Administration Services**

**PROGRAM BUSINESS RULES**

**Contents**

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## **Introduction**

The Tennessee Commission on Aging and Disability (TCAD) and the nine Area Agencies on Aging and Disability (AAADs) have created an opportunity to serve consumers of any age that are at risk of nursing home placement and their family caregivers. Through the TCAD Options program, consumers will receive home and community based services to enable them to continue to live in their homes and communities.

The Tennessee Commission on Aging and Disability selected Public Partnerships, LLC to be a provider of financial intermediary services in their Consumer-Directed Home and Community-based Services Program. The program, called Options, was developed in partnership with the federal Agency on Aging (AoA) and Tennessee's nine Area Agencies on Aging and Disabilities (AAADD).

Consumer direction is a model of service delivery which affords participants more choice and control in the delivery of home and community-based services. Supported by PPL, a person assessed by an AAADD as eligible can hire their own personal assistant or other help, whose job duties might include housekeeping, laundry, cooking, personal care, and transportation. The goal of the program is to avoid institutionalization and related higher costs. PPL performs functions related to the performance of payroll, accounts payable, and related tasks. AAADs provide support brokerage. TCAD provides administrative and programmatic oversight.

The following is a list of core business rules for the TN Options Self-Direction as of the date of signature. This list may be updated as rules are added, clarified or omitted during the course of the program. The document will be updated and signed by the program stakeholders each time changes occur.

## **General Program Policies**

1. Consumers must be 18 years of age or older
2. Consumer must be a resident of Tennessee.
3. Consumer must meet functional eligibility requirements for the Options program.
4. Consumers will not be able to have PPL pay providers on their behalf until the consumer enrollment paperwork is complete, provider employee paperwork is complete, provider training and background checks are complete and PPL receives an approved authorization.
5. The consumer will be the employer of record unless the family determines that he/she needs a representative to serve in this capacity or the consumer has an existing EIN. It is acceptable for the EOR to be the consumer's conservator. If it is the conservator, the Supports Broker will obtain a copy of the legal paperwork and provide it to PPL.
  - a. If the identified employer has an active Employer Identification Number, another employer will need to be identified, unless the EOR can obtain an IRS transcript that says that the EIN is inactive and has no liabilities.
6. If the consumer has a conservator/Power of Attorney, conservatorship paperwork must be sent to PPL.
7. All documents for consumers and providers will be stored in the document management system for viewing on the Web Portal.
8. Spouses and conservators of participants/employers/representatives may not provide services in this program.
9. Authorized representatives cannot be employees.
10. If a Veteran opts to assign a new EOR in their place they will need to complete a Change of EOR form to PPL. Forms will be made available through the PPL Web Portal. Employer of Record changes must coincide with a fiscal quarter end, unless a significant circumstance is demonstrated.
11. There is no limit to the number of providers a consumer may hire, however, providers may only be on staff for more than one consumer if they have a PSSA license.
12. PPL's standard method of paperwork distribution is for support brokers and EORs to download provider packets from the program website. However, packets can be mailed upon request.
13. Background and registry checks for providers are good for life. However, any EOR can request checks to be re-run, and all EORs should be aware of any fail/approves.

## **Consumer Enrollment**

1. At the point of home assessment, the AAAD support broker will ask the consumer if s/he is interested in self-direction. The support broker will also provide options counseling services, determine a budget level, and create an approved Care Plan. If appropriate, this conversation can happen telephonically.
2. If the person is interested in self-direction, the support broker will schedule a follow up appointment at which the employer of record and worker will all be present to sign paperwork. If appropriate, this can happen at the same time as the home assessment.
3. Prior to going to the home to review paperwork, the AAAD support broker will enter consumer information in the Web Portal. This will include all required fields to become an employer:
  - a. First & last name
  - b. Address line 1 (must be street address)
  - c. Address line 2 (can be PO Box)
  - d. City, state, zip
  - e. Gender
  - f. Date of Birth
  - g. SSN
  - h. Phone
  - i. Email (if any)
  - j. Participant ID as assigned by AAAD (DOB + last for SSN)
  - k. Employer name, address, phone, and social security number
  - l. Authorized representative contact information (if any)
  - m. AAAD association
  - n. Support broker name
4. The support broker will then print out the pre-populated EOR packet. The support broker will have access to the standard general enrollment documents. The support broker should bring the following:
  - a. Pre-populated EOR packet
    - i. IRS SS-4
    - ii. IRS 2678
    - iii. IRS 2848
    - iv. IRS 8821
    - v. TN LB-0441
    - vi. TN LB-0927
    - vii. Representative Form
  - b. AAAD docs – tracked by the AAADs
    - i. Participant Signature Page
    - ii. Consumer Direction Rights & Responsibilities
    - iii. Medical Release form
  - c. Employer Information Packet
    - i. Explanation of all employer documentation
    - ii. Pay schedule
    - iii. Timesheet instructions (for Web Portal & fax submission)
    - iv. Provider Change Termination Form
  - d. Employer Poster Packet (required employment posters)

- e. Employee application & instructions (*see provider enrollment*)
  - f. Vendor packet & instructions (*see vendor enrollment/invoice payment*)
5. The support broker reviews the PPL documents with the consumer/EOR and worker and helps them complete the enrollment paperwork.
  6. Consumer/support broker/employee sends enrollment paperwork back to PPL via mail, fax, or email.
  7. PPL enters the packet into the Web Portal, obtains EIN, and follows up until the packet is fully completed. PPL's standard processing time is 3-5 business days for paperwork processing. (Obtaining EINs is dependent upon current IRS processing time.)
  8. PPL Customer Service is available to help with questions.
  9. All paperwork receipt and status will be documented in the PPL Web Portal in support tickets.

## **Consumer Disenrollment**

1. Upon learning of a consumer becoming disenrolled from Options, the AAAD Supports Broker will mark the consumer inactive on the consumer profile in the PPL Web Portal and enter the date in the Enrollment End Date field in the consumer profile. [This will pend any payments or invoices submitted past the Enrollment End Date.]
2. There are situations where TCAD, the AAAD, or PPL may recommend that a consumer disenroll from the program because of extenuating circumstances (such as fraud, consistent underutilization, home environment unsafe, needs change, etc). The oversight committee makes the final decision as a group.

## Employee Enrollment

1. The support broker will bring and review the employee paperwork and requirements with the consumer. The consumer will provide employees with the paperwork and train the employee on providing him/her with care.
2. Paperwork will include:
  - i. Employee Application & Criminal background release
  - ii. Service agreement
  - iii. Rate agreement
  - iv. I-9 & instructions
  - v. W-4
  - vi. Tax Exemption Information
  - vii. Direct Deposit Enrollment
3. The employees will send paperwork to PPL.
4. PPL will enter all paperwork into the PPL Web Portal and establish provider IDs. AAAD support brokers can view good-to-go status in the PPL Web Portal.
5. PPL staff will run the following registry checks on all providers and document the results in the PPL Web Portal. If the employee fails any of the registry checks, the provider cannot work in this program.
  - i. Felony offender list
  - ii. Sexual offender list
  - iii. Health abuse registry
6. If the employee passes the registry checks, PPL will run a criminal background check using Kroll. This will be paid out of the consumer's budget.
  - i. Failing criteria for the background check:
    - Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug.
    - Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held.
  - ii. Criteria for waiving background check results:
    - Exceptions to disqualifications may be granted at the consumer's discretion and only if all of the following conditions are met:
      - Offense is a misdemeanor;
      - Offense occurred more than five (5) years ago;
      - Offense is not related to physical or sexual or emotional abuse of another person;
      - Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and
      - There is only one disqualifying offense.
7. PPL staff will mark the background check:
  - i. Pass
  - ii. Fail
    - i. PPL will notify the support broker and the EOR.
  - iii. Fail—approved

- i. PPL will notify the support broker. The support broker will then go in and look at the documents in the Web Portal to ensure that the consumer's safety is not at risk.
8. It is the employer's responsibility to hire, fire, train, and manage his/her employees. Firings require a provider change termination form prior to the next immediate pay period.
9. Employees can begin working upon the first date where all background and registry check is complete and all provider/consumer paperwork is complete, provided an authorization has been established for the consumer. PPL will notify the EOR when all employee paperwork is complete and confirm good-to-go (GTG) status.
10. Directly-hired employees will be able to provide all hourly services. They will only be able to provide transportation if they provide auto insurance information and valid driver's license.
11. PPL will be checking the OIG List of Excluded Individuals/Entities on a monthly basis. If a provider is found to have been added to the list and continued to provide services to an Options consumer, PPL will immediately report the provider to the Tennessee Bureau of Investigation and the Office of the Inspector General. PPL will also invoice the provider for any services provided since the last clean run of the OIG List of Excluded Individuals/Entities. Passing the OIG registry check is required for provider good-to-go.

## **Independent Contractors/Vendors/Agency Provider Enrollment**

1. Independent contractors and agency providers must hold a PSSA (or other appropriate) license. License expiration dates will be tracked in the Web Portal as part of each provider's profile. Out of state licenses will be reviewed on a case-by-case basis.
  - i. Independent Contractor is an individual who holds a PSSA (or other appropriate) license.
  - ii. Agency provider is an organization that holds a PSSA license (or other appropriate) .
  - iii. Vendor is a commercial store that does not hold a PSSA license (or other appropriate) (i.e., a Walmart).
2. Vendor information packet
  - i. W-9 – required for all
  - ii. License – required for independent contractors and agency providers (but not for vendors, as they are stores).
  - iii. *Information sheet about presenting checks*
  - iv. *Invoice submission instructions*
  - v. *Warning against fraud*

## **Good to Go Requirements**

1. Consumer
  - a. All EOR documentation
  - b. Obtained EIN
2. Employee
  - a. All background/registry checks passed (including the OIG registry check)
  - b. All employee/employer paperwork complete
3. Independent Contractor
  - a. License
  - b. W-9
4. Agency
  - a. License
  - b. W-9
5. Vendor
  - a. W-9

## Service Authorizations

1. The AAAD support broker will enter the spending plan into the Web Portal. Authorization can be entered at any time once the consumer has been referred.
2. Spending plans are authorized for one year, broken down by month. There is a soft cap of \$5,000, with a maximum of \$7,000 (approved by the AAAD).
  - a. Administrative funds will be deducted from the consumer's budget in advance of other services.
  - b. Consumers will only be able to view their budget after administrative funds have been deducted.
3. The service matrix is as follows:

Service Name	Code	Unit	Daily/ Hourly	High Pay Rate	Low Pay Rate	Additional Limits/Notes
<b>Attendant Care Services</b>	DHS1	15 min	Hourly	\$15	Min Wage (\$7.25)	Timesheet
<b>Homemaking</b>	DHS2	15 min	Hourly	\$15	Min Wage (\$7.25)	Timesheet
<b>Transportation - Mileage</b>	FCS1	1 mile	Unit/mile	\$0.47 (state rate as of March 2012)		Invoice
<b>Transportation – Cab</b>	FCS2	1 trip	Unit/trip			
<b>Daily Respite</b>	FCS5	1 day	Daily	\$63.50, \$195, or \$231		Timesheet: One rate for the day, must be 8 hours or more. Day cannot be crossed.
<b>Hourly Respite</b>	FCS6	15 min	Hourly	\$15	Min Wage (\$7.25)	Timesheet: Max 8 hours
<b>Other Consumable Goods</b>	MSG6	1 item	Unit			Invoice
<b>Durable Medical Equipment</b>	MSG1	1 item	Unit			Invoice
<b>Personal/Home Monitoring (PERS)</b>	ATEV4	1 item	Unit			Invoice
<b>Criminal Background Check Fees</b>	ADM4	1 item	Unit			Invoice
<b>Home Delivered Meals</b>	FCS4	1 item	Unit			Invoice

4. Rate rules:

- a. Billable rate for hourly services is the pay rate plus any employer taxes. If the employer has no tax obligation for a given employee, the bill rate will be equal to the pay rate.
5. The support brokers will establish, maintain and revise consumer budgets.
6. If a consumer under-spends, the under-spent amount can be made accessible to the consumer in later months through an authorization amendment by the support broker.
7. Authorizations will be entered in terms of dollars.
8. A support broker can amend an authorization at any time. S/he cannot retro-actively change an authorization to an amount less than what has already been purchased.

## **Timesheets**

1. Standard rules:
  - i. Timesheets must be signed by both the employee and employer (or the representative). If a timesheet is not signed, it needs to be returned and resubmitted before payment.
  - ii. In the case of a legal guardian being the representative, the legal guardian will be responsible for signing the timesheets. In the case of Designated Representative, the Designated Representative may sign the timesheet. It is always acceptable for the consumer to sign the timesheet.
  - iii. PPL will round time to the closest 15 min. increment (7 min, round down – 8 min. round up)
  - iv. Providers may not be compensated for the provision of services in excess of 40 hours per employer per workweek (Monday through Sunday).
  - v. Consumers cannot be served by more than one provider at a time. Providers cannot serve more than one individual at a time. Shifts may not overlap.
  - vi. If a timesheet is received for more hours that are left on a consumer's authorization, PPL will issue payment up to the available units and pend the exceeding amount. The pended amount will be paid out only if an amended authorization is submitted by the support broker. If denied, the employer is responsible for paying the provider the remaining funds.
  - vii. Providers must select the appropriate service code when completing a timesheet.
2. Timesheets can be submitted by fax, mail, or via the Web Portal.
3. Workers will be required to keep daily notes of services provided. The Daily Notes will be kept in the home or in the Web Portal. Workers will record services provided and unusual activity related to the individual.
4. Timesheets and invoices must be submitted within one month of the payroll schedule timesheet deadline.
5. PPL will mail checks directly to the provider or transmitted via Electronic File Transmission/Direct Deposit (EFT/DD). The posted Pay Date will be the day checks are mailed and EFTs are posted to the PPL corporate account. PPL cannot guarantee mailing times or when local bank branches pick up EFT transmissions, and therefore cannot guarantee a payment receipt date, however PPL ensures the payments are paid within the state labor law limits.
6. Timesheets submitted 60 days or more after the last day of the pay period will be denied for payment unless authorized by the AAAD Supports Broker.
7. Expense Account Requests submitted 60 days or later after the last day of a given pay period will not be paid unless authorized by the AAAD Supports Broker.
8. PPL will not make payments that are outside the budget start or end dates or exceed authorization dollars.

## **Invoice Process**

1. All goods or services must be documented in the consumer's spending plan, either under goods or services or in planned savings. The consumer is responsible for covering all purchases s/he makes which are not in his/her budget. The Supports Broker is responsible for authorizing purchases in the web portal.
2. The EOR will submit an invoice (either by paper or via the Web Portal) to the AAAD. The invoice will contain detailed information regarding the item, its exact cost, and its purpose.
  - a. If the vendor for the item is not in PPL's system, the EOR will submit a W-9 form capturing the vendor's tax identification number (TIN). PPL has the TIN for big box stores and chains on file.
  - b. Providers will need to submit a mapquest (or comparable document) along with their transportation form when requesting transportation reimbursement.
3. The AAAD support broker will approve/not approve the item (either by paper or via the Web Portal).
  - a. While the AAAD support broker must approve all requests, there are no specific limits on purchases (other than the general cap).
4. PPL will cut a check made out to the vendor and send it to the consumer.
5. If the good or service is a different price than the check, the EOR/consumer must call PPL to address the issue at the point before purchase.
6. Consumers will not receive cash stipends.

## **Payment Schedule**

1. The pay period will be the 1<sup>st</sup> through the 15<sup>th</sup> and the 16<sup>th</sup> through the end of the month.
2. Payroll schedule is twice monthly. Timesheets can be faxed or mailed to PPL any time after the work for the pay period has been completed up until the timesheet due date.
3. Timesheets will be due at 5:00 pm EST two business days following the end of the pay period. PPL cannot guarantee normally scheduled payment for timesheets submitted after the due date. Any timesheets received after the deadline will be processed in an off cycle check run scheduled for one week after the primary pay cycle.
4. Any timesheets received after the deadline will be processed in an off cycle check run on Friday of the following week.
5. The Payment Schedule will account for pay days that fall on a weekend day or holiday and make payment on the business day after to the weekend day or holiday.
6. PPL will mail checks directly to the providers (or remittance advices, in the case of direct deposit).
7. Tennessee final paycheck laws require that whenever an employee quits or is fired, the final paycheck must be given on the next scheduled payday or within 21 days, whichever is later. As payroll is done twice a month, PPL will automatically comply with this.

## **Reporting**

1. PPL will manage, track and provide reports in the receipt and disbursement of funds on behalf of the participants monthly. AAADs and TCAD will be able to view this information via the PPL Web Portal.
2. PPL will provide TCAD and the EOR with a monthly utilization report.
3. TCAD staff will have privileges to retrieve a multitude of customizable reports through Web Portal on the PPL Universal Reports Server.

## **Worker's Compensation**

1. Workers compensation will not be offered in this program. As a result, no employer may have more than 4 employees associated to him/her at a time.

## **Administrative and Service Billing**

1. PPL will bill TCAD directly for both administrative and services billing.
2. The PMPM for each person is \$95/person/month. The criterion for billing is consumers enrolled during the given month.
3. Upon completion of the payroll processing (i.e. verifying timesheets and testing submitted time again allocations as well as entering and testing payment request forms for self directed goods and services), PPL will transmit (via secure email) to TCAD an invoice for total service payments.

## **Advance for Service Payments**

1. TCAD will calculate and pay PPL a 1 month service advance prior to the first check run.
2. Services begin for Month 1
3. TCAD will calculate and pay PPL an advance for month 2 of services prior to the second month.
4. PPL will invoice TCAD for month 1's actual services on or around the 15th of month 2.
5. TCAD will process actual service invoice for month 1 then send to Finance and Administration Department (F&A) around the 21st of the second month. F&A will process the invoice; then PPL will receive payment thru ACH in 3 to 7 business days.
6. PPL will invoice TCAD for month 2's actual services on or around the 15th of month 3.
7. TCAD will process actual service invoice for month 2 then send to F&A no later than the 21st of month 3. F&A will process invoice; then PPL will receive payment thru ACH in 3 to 7 business days.
8. At the end of the contract, PPL & TCAD will reconcile advance with actual.

## **Web Portal User Management and Role Based Security Model**

1. EORS will have roles configured with access to functionalities that support usage and prohibit access to other EORs' information as well as privileges to modify authorization and payroll information.
2. Other read/write privileges for project staff will be defined during program start up based on defined roles.

## **Customer Service**

1. PPL will maintain a U.S. based toll free customer service line available from 9:00 a.m. to 5:00 p.m. Eastern Standard Time Monday through Friday excluding state holidays.
2. PPL will also maintain a program administrative fax and email account.
3. All voice mails, faxes, and emails will be responded to within one business day.

**Signatures**

\_\_\_\_\_  
Public Partnerships, LLC

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tennessee Commission on Aging & Disability

\_\_\_\_\_  
Date

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## Missed Visit Report

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# MISSED VISIT REPORT

Individual's Name: \_\_\_\_\_ Id#: \_\_\_\_\_

If NFCSP, Care Recipient Name: \_\_\_\_\_ Id#: \_\_\_\_\_

Provider Agency: \_\_\_\_\_ County: \_\_\_\_\_

Program (check one):  OPTIONS  NFCSP (Caregiver, Title III-E)  OAA (Title III)

Dates of Missed Visit: \_\_\_\_\_  
\_\_\_\_\_

### Type of Visit:

- Personal Care       Home Delivered Meals       In-Home Respite  
 Homemaker       Other: \_\_\_\_\_

### Reason for Missed Visit:

- Individual/Care Recipient had unscheduled appointment  
 Individual/Care Recipient hospitalized  
 Individual/Care Recipient refused services  
 Individual/Care Recipient refused alternate staff member services  
 Individual/Care Recipient unavailable:  Hospital  Nursing Home  Other:  
\_\_\_\_\_  
 Knocked – No Response: Contact Person Notified/Response: \_\_\_\_\_  
 Called – No Answer: Contact Person Notified/Response: \_\_\_\_\_  
 Scheduling error  
 Hazardous weather  
 Holiday scheduling –  Provider canceled  Individual/Care Recipient canceled  
 Provider unable to provide service because: \_\_\_\_\_  
\_\_\_\_\_

Additional Provider Comments: \_\_\_\_\_  
\_\_\_\_\_

Signature of Agency Representative: \_\_\_\_\_ Date: \_\_\_\_\_

AAAD Use Only:  Provider Liable       Consumer Liable       No Fault

**FAX/SCAN WITHIN 5 BUSINESS DAYS OF MISSED VISIT TO AAAD**

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**Provider Authorization/Notification of Change**

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**PROVIDER AUTHORIZATION/NOTIFICATION OF CHANGE**

Service Start     Service Change     Change of Information     Service End

Hold as of: \_\_\_\_\_  Resume Services as of: \_\_\_\_\_

**I. Individual's Information**

Name:		DOB:	Id#:	County:
Street Address:			City/Zip Code:	
Phone #:	Emergency Contact:		EC Phone #:	
If Title III-E (NFCSP), Name of Care Recipient:			Care Recipient Id#:	

**II. Service Authorization**

Service	Date Service Authorized	Provider Name	Funding Source	Units/Frequency	Unit Cost	End Date
Homemaker						
Personal Care						
Home Delivered Meal						
Chore						
In-Home Respite						
Adult Day Care						
Other:						

Special Frequency Instructions: \_\_\_\_\_

Comments/Considerations: \_\_\_\_\_

Options Counselor: \_\_\_\_\_ Phone: \_\_\_\_\_

Date Faxed: \_\_\_\_\_ If Change of Services, Date Individual Notified: \_\_\_\_\_

**III. Service Provider**

Accepted     Declined    Service Start Date: \_\_\_\_\_ Date Ended: \_\_\_\_\_

Authorized Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAX/SCAN REPLY WITH START DATE WITHIN 5 WORKING DAYS TO AAAD**

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**Provider Checklist**

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**PROVIDER CHECKLIST**

Date: \_\_\_\_\_ County: \_\_\_\_\_

Individual's Name: \_\_\_\_\_ Id#: \_\_\_\_\_

If NFCSP, Care Recipient: \_\_\_\_\_ Id#: \_\_\_\_\_

**PERSONAL CARE**

Type of Bath:

- Tub Bath
- Shower
- Complete bed bath
- Complete sponge bath
- Partial sponge bath

Hair Care:

- Shampoo in shower
- Shampoo in sink
- Shampoo in bed
- Brush hair
- Shave
- Other \_\_\_\_\_

Dressing:

- Dressing Assistance

Ambulation:

- Assist to ambulate
- With assistive device
- Do not ambulate

Foot Care:

- Foot soak
- Lotion Feet
- Other \_\_\_\_\_

Mouth Care:

- Brush teeth
- Clean dentures
- Swab mouth

Skin Care:

- Lotion massage
- Other \_\_\_\_\_

Other Duties:

- Assist with eating
- Assist with toileting

Nail Care:

- Clean nails
- Other \_\_\_\_\_

**HOMEMAKER**

- Straighten/Pick up
- Vacuuming
- Mop
- Laundry/Laundromat
- Dusting
- Empty trash
- Prescription pickup

- Shopping
- Grocery shopping

Bedroom:

- Change bed linen
- Straighten bed linen
- Other \_\_\_\_\_

Bathroom:

- Clean tub/shower
- Clean bath basin
- Clean commode
- Other \_\_\_\_\_

Kitchen:

- Clean stove
- Clean countertop
- Clean refrigerator
- Clean dishes
- Meal preparation
- Other \_\_\_\_\_

Special Instructions:

Safety needs identified:

Signature of Individual or Authorized Representative

Date

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**Signature Page**

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**SIGNATURE PAGE**

**Individual's Name:** \_\_\_\_\_ **Individual's ID:** \_\_\_\_\_

**AGE DECLARATION** – I am unable to provide proof of age and I declare that I am 60 years of age or older and that my date of birth, \_\_\_\_\_ (Month/Day/Year), is correct to the best of my knowledge.

**ASSESSMENT** – I certify that the information provided to the Options Counselor regarding my medical, social and financial circumstances is accurate and complete. I understand that if it is determined at a later date that the information collected is incorrect, my eligibility for services may be affected.

**CHOICE OF PROVIDERS** – I have been offered a choice of service providers from a list of available companies in my county for each service I am authorized to receive. I understand that it is my choice as to whom I want to provide the in-home services.

**PRIVACY PRACTICES AND INDIVIDUAL RIGHTS AND RESPONSIBILITIES** – By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and a copy of the Individual Rights and Responsibilities. I also acknowledge that I understand the information provided in the Notice of Privacy Practices and the Rights and Responsibilities.

**RELEASE OF INFORMATION FOR STATISTICAL REPORTING** – I understand that the information collected will not be identified with me personally. It may be used in statistical reports. I give my permission to use the information for statistical reporting.

**REQUEST FOR INTERAGENCY INFORMATION SHARING** – I receive services for more than one program funded through the Tennessee Commission on Aging and Disability and the Area Agency on Aging and Disability. I request the information from my assessment be shared with agencies that would otherwise have to interview me again to collect the same data.

**SERVICES POLICY** – I understand that initiating/continuing services is based upon the availability of funding from State/Federal sources. Additionally, change(s) in Individual circumstances may determine eligibility for an increase or decrease in services.

**TITLE VI** – I understand that I have the right not to be discriminated against on the ground of race, color, or national origin. I understand the procedures for filing a complaint if I feel that I have been discriminated against.

**VOLUNTARY CONTRIBUTIONS** – I understand how to make a voluntary contribution to help pay for the cost of my services paid for by the AAAD. I understand that my contribution can be made anonymously and/or confidentially if that is my preference.

\_\_\_\_\_  
Initials of Individual/Authorized Representative    Date

**Individual's Name:** \_\_\_\_\_ **Individual's ID:** \_\_\_\_\_

**COST SHARING** – I understand there is a possibility that I will have cost share and that I will be receiving a letter informing me about my cost sharing responsibilities if my income exceeds 200% of the Federal Benefit Rate. I understand that prior to my services starting, I will be informed of my costs, if any.

**RECEIPT OF ADVANCED DIRECTIVE INFORMATION** – I have received written information on my right to formulate advanced directives.

**PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)** – I understand that if I have PERS equipment and I am no longer receiving PERS services that the equipment will be removed from the home at the discontinuation of the service.

**NUTRITION COUNSELING** – I understand that due to identified nutritional risk factors, I have been referred for Nutrition Counseling.  Accept or  Deny

**AUTHORIZATION FOR REFERRAL FOR SERVICES** – I give permission for the Area Agency on Aging and Disability to contact, on my behalf, the agencies or persons listed below and/or on my Action Plan and to release only such information to them as may be needed to determine the level and types of services that I may need. I also grant permission to the receiving agencies to report back regarding services that I may or may not receive and/or any additional information that may significantly reflect on my need for services. This authorization may be revoked at any time by my written statement, and is automatically revoked at my transfer from the agency or at notification of death to include a period of six (6) months.

AGENCY

PURPOSE

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**CLIENT AGREEMENT** – By my signature, I affirm that I have read, or have had explained to me, the above statements. The telephone number I need for questions or complaints has been left with me, and I do give the authorization for release of information as listed above. Unless otherwise stated, this expires in one year.

\_\_\_\_\_  
Signature of Individual or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Options Counselor

\_\_\_\_\_  
Date