



# Personal Choice Program

## Provider Manual

***Please Note:*** This manual is a guide for Personal Choice program provider agencies. Please refer to EOHHS Policy and consult your Medicaid contact person with any particular questions not covered in the manual.

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# Chapter 1

## Introduction

Welcome to the Personal Choice Program. Personal Choice is designed to give Long Term Care Medicaid eligible individuals more control over how they receive personal care services. This manual is designed to give you basic information about the program, assist you in managing your caseload, and help to answer your questions.

## Overview

Personal Choice is:

- A Long Term Care Service for people with disabilities over the age of (18) eighteen or elders aged (65) or older.
- For individuals who meet either a high or highest level of care.
- For individuals who want to either return home or remain at home.
- For individuals who want to purchase their own care and services from a budget based on their individual functional needs.
- For individuals who have the ability to self-direct care or who have a representative who is able to direct care for the participant.
- Provide assistance to the participant by a Service Advisor and a Fiscal Intermediary.

The goal of the Personal Choice Program is to provide a home and community-based program where individuals who are eligible for Long Term Care services have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) individuals who provide their personal care, and to exercise choice and control over a specified amount of funds in a participant-directed budget. Participants choose a service advisement agency and a fiscal agent to assist in making informed decisions that are consistent with their needs and that reflect their individual circumstances.

## Definitions

**Assessment:** A meeting between the participant, and/or representative and the Service Advisor. The assessment evaluates Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) to determine participant needs. Assessments also help to identify services, equipment, home modifications and other services in the community that may help the participant to increase their independence within the community. Assessments occur at the beginning of the program and then annually as long as the participant is enrolled in Personal Choice. Either the participant or their representative may request an assessment sooner if their situation has changed and there is either an increased or decreased need for assistance.

**Budget Amount:** Medicaid funds set aside for the participant's personal care services. The budget is based on the amount of assistance the participant requires to meet his/her personal care needs.

**Participant (Consumer) Direction:** An approach to long-term care where participants manage their own personal care services. Participants assess needs, decide how their needs are to be met, and monitor the quality of the services they receive.

**Fiscal Intermediary Services:** Services designed to assist the participant in allocating funds as outlined in the Individual Service and Spending Plan and to facilitate employment of personal assistance staff by the participant. Personal Choice financial matters are maintained by the fiscal agency and a portion of the participant's monthly budget is set aside to pay the agency for the services it provides.

**Home Modifications:** Equipment and/or adaptations to a participant's residence to enable the participant to remain in his/her home or place of residence, and ensure safety, security, and accessibility.

**Individual Service and Spending Plan (ISSP):** A written plan describing the participant's personal care needs and how he/she will meet them by hiring personal care attendants (PCA). The ISSP also includes a plan for handling emergencies. Allocation for other goods and services and savings are also included in the plan.

**Participant:** A person who is a Medicaid recipient and has chosen to receive his/her personal care services through the Personal Choice Program.

**Participant Directed Goods and Services:** Services, equipment, or supplies not otherwise provided through this program or through the Medicaid State Plan that address an identified need in the ISSP (including improving and maintaining the individual's opportunities for full membership in the community).

**Personal Care Attendant (PCA):** A person who provides personal care services to the Personal Choice participant.

**Personal Care Services:** Services provided in the home or community providing direct support to individuals in performing tasks that due to their illness and/or disability they are functionally unable to complete independently.

**Representative:** A person designated by the Personal Choice participant to assist him/her in managing some or all of the requirements of the program. A Representative *cannot* be paid to provide this assistance.

**Service Advisement Services:** An advisement team consisting of the Service Advisor, an RN, and a Mobility Specialist whose focus is on empowering participants to define and direct their own personal assistance needs and services. The Service

Advisor guides and supports, rather than directs and manages the participant through the service planning and delivery process. A portion of the participant's monthly budget is set aside to pay the agency for the services it provides.

**Taxes:** Fees deducted from the participant's monthly budget that are required to be paid on behalf of employees (PCAs):

- FICA (Federal Insurance Contributions Act): Finances care for the aging, disabled, and survivors. Including funding for Medicare for people who cannot afford medical insurance.
- FUTA (Federal Unemployment Tax Act): Finances employment programs at the federal level.
- SUTA (State Unemployment Tax Act): Finances employment programs at the state level.
- RITDI (Rhode Island Temporary Disability Insurance): Provides income to employees who cannot work for a period of time due to illness or injury.

**Worker's Compensation Insurance:** Funds that provide for monetary awards paid to individuals who are injured, disabled or killed on the job. Worker's Compensation Insurance is a cost of employment paid by the participant from his/her monthly budget.

## **Roles**

The Personal Choice Program is designed for a participant to have maximum control over the services received while adhering to the requirements of Medicaid, which fund Personal Choice services. Two types of agencies provide participant's with assistance:

- 1) Service Advisement Agency
- 2) Fiscal Advisement Agency

Their roles in assisting participants are as follows:

### **The Service Advisement Agency:**

- Assesses participant needs.
- Identifies which services a participant may need.
- Develops and writes out an Individual Service and Spending Plan.
- Assists in determining amount of assistance needed, how much to pay Personal Care Attendants, and how to find and interview Personal Care Attendants.
- Monitors program by conducting regular home visits and reassessments.

### **The Fiscal Advisement Agency:**

- Assists the participant in obtaining Worker's Compensation Insurance
- Completes annual criminal background checks on all potential PCAs and Representatives.
- Assists the participant with procedures and forms to use when hiring or changing PCAs.

- Advises PCAs of their rights as employees.
- Help the participant to understand the procedures and forms to use for reporting the hours worked by theirPCAs (timesheets).
- Reviews the PCA timesheet to make sure they agree with the approved ISSP.
- Completes a monthly check of the List of Excluded Individuals and Entities (LEIE) and Federal General Services Agency(GSA) data bases as specified in the CMS Federal Code of Regulations.
- Makes payments to PCAs based on participant instructions and approved ISSP.
- Will perform all necessary payroll functions.
- Reviews all payments for items and services to make sure they are a part of the approved ISSP.
- Pays for items or services that a participant purchases based on the approved ISSP.
- Tracks how the participant is spending their budget by providing the participant with spending reports every 6 – 8 weeks.

## **Participant Rights and Responsibilities**

The following is a brief list of the rights and responsibilities of a Personal Choice participant.

### **A participant has the right to:**

- Be treated as an adult, with dignity and respect at all times.
- Privacy in all interactions with the agency and freedom from unnecessary intrusion.
- Make informed choices based upon appropriate information provided to them, and have those choices respected, while respecting the rights of others to disagree with those choices.
- Freely choose between approved providers for both Service Advisement and Fiscal Advisement Agencies.
- Feel safe and secure in all aspects of life, including health and well being; be free from exploitation and abuse; and not be overprotected.
- Realize the full opportunity that life provides by not being limited by others, by making full use of the resources the program provides, and by being free from judgments and negativity.
- Live as independently as they choose.
- Have their individual ethnic background, language, culture and faith valued and respected.
- Be treated equally and live in an environment that is free from bullying, harassment and discrimination.
- Voice grievances about care or treatment without fear of discrimination or reprisal.
- Voluntarily withdraw from the program at any time.
- Ask questions until they understand.

- Manage PCAs by:
  - Deciding who to hire to assist you.
  - Deciding what special knowledge or skills the PCA must possess.
  - Training each PCA to meet your individual needs.
  - Replacing PCAs who do not meet your needs.
- Request a new assessment if their needs change.
- Create an Individual Service and Spending Plan (ISSP) to meet needs within the Personal Choice program guidelines, and to change the plan as needs or goals change.
- Know about all service advisement and fiscal advisement agency fees.
- Receive a report on how they have spent their monthly budget.
- Appeal any decision made by the Service Advisement Agency, Fiscal Advisement Agency, or Medicaid Agency and expect a prompt response.

**A participant has the responsibility to:**

- Manage and maintain their health and access medical help as needed, or seek assistance in order to do so. Do not make decisions or act in such a way that would place their health and safety at risk.
- Demonstrate the required skills and abilities needed to self-direct PCAs without jeopardizing health and safety, or designate a representative to assist them..
- Act as a supervising employer by:
  - All staff and/or representative must submit to a criminal background and abuse registry screening, to be facilitated by the Fiscal Intermediary.
  - Deciding wages and schedules for PCAs.
  - Completing hiring agreements with each PCA.
  - Following all employment laws and regulations.
  - Following all requirements of the Fiscal Advisor/IRS for hiring and paying PCAs including: completing all necessary forms, reviewing timesheets for accuracy and submitting them in a timely manner, and paying PCAs promptly.
  - Treating all employees with dignity and respect.
- Manage personal care services by:
  - Meeting and cooperating with the Service Advisor as required for completing all needed assessments and monitoring.
  - Developing and monitoring an ISSP to address personal care service needs within the requirements of Personal Choice.
  - Hiring and supervising PCAs, and ensuring they are performing their duties as needed.
  - Tracking expenses so that the budget is not exceeded.
  - Notifying the Service Advisement Agency of any changes in medical status or admissions to hospitals or other medical facilities.
  - Ensuring a safe working environment for PCAs.
  - Developing an emergency back-up plan.
  - Provide orientation and training to PCA staff.

- Schedule PCA staff and ensure that PCA(s) do not work over 40 hours per week.
- Terminate PCA staff if necessary and notify the fiscal intermediary when termination occurs.
- Contact the fiscal intermediary in the event of a billing or payment complaint.
- Only make purchased of items that are included in the Individual Service and Spending Plan.

## **Involuntary Disenrollment from Personal Choice Program**

The service advisement agency can remove a participant from the Personal Choice program if either the participant or representative does not comply with program policy. The service advisement agency must notify the participant/representative in writing stating that they intend to remove them from the Personal Choice Program, the reason for disenrollment, and inform the participant/representative that services will be provided through Medicaid Long Term Care via a home health agency.

Involuntary disenrollment may occur when:

- The loss of eligibility, either Medicaid financial eligibility, or level of care eligibility will result in disenrollment.
- The participant proves to be unable to self-direct purchase and payment of long-term care.
- A representative proves incapable of acting in the participant's best interest.
- The participant/representative fails to comply with legal/financial obligations as an employer of domestic workers and/or is unwilling to participate in advisement training or training to remedy lack of compliance.
- The participant/representative is unable to manage the monthly spending as evidenced by repeatedly submitting time sheets for unauthorized budgeted amount of care, underutilization of the monthly budget, which results in going without personal care assistance, and continual attempts to spend budget funds on non-allowable items and services.
- Failure of the participant to maintain health and well-being through the actions and/or inaction of participant/representative may result in disenrollment.
- An inability to maintain a safe working environment for personal care assistants' may result in disenrollment.
- The receipt of substantiated complaints of self-neglect, neglect or other abuse on either the part of the participant or representative will result in disenrollment.
- A refusal by either the participant or representative to cooperate with minimum program oversight activities, even when staff has made efforts to accommodate the participant/representative will result in disenrollment.
- Your representative can no longer assist the participant, and no replacement representative is available.
- The failure by the participant/representative to pay the amount determined in the post eligibility treatment of income as described in section 0392.15, which is

- commonly referred to as the client share, to the fiscal agency will result in disenrollment.
- The Service Advisement agency determines they are unable to provide proper service to the participant.
  - Evidence that Medicaid funds were used improperly/illegally in accordance with local, state or federal regulations will result in disenrollment.
  - The participant/representative must notify both the Service Advisement agency and the Fiscal Intermediary of any change of address and/or telephone number within 10 days of change occurring, failure to do so will result in disenrollment.

### **Disenrollment Appeal**

The Service Advisement Agency and the Fiscal Intermediary Agency will inform the participant/representative in writing of an involuntary disenrollment with the reason and will provide you with a Medicaid appeal procedure and request forms. You have the right to appeal utilizing the Medicaid standard appeal process.

## **Chapter 2**

### **Screening, Acceptance and Admission**

Each advisement agency shall define the population it intends to service under Personal Choice as follows: A long term care service for people with disabilities over the age of (18) eighteen or elders aged (65) or older who do not meet the developmental disability criteria of BHDDH, meet either a high or highest level of care, want to remain or return home, and have the ability to purchase and direct own care and services from a budget based on individual functional needs.

The Service Advisement agency will have a mission and philosophy statement that reflects the needs of the participant, the services, and supports it is committed to provide, and a commitment to the philosophy of Consumer Direction and personal choice. Keeping this philosophy in mind, the Service Advisement agency will provide the applicant with information about not only Personal Choice, but also other available Home and Community based care in order to assist the applicant in making an informed choice.

Basic eligibility criteria for the Personal Choice program include, but are not limited to:

- A disability affecting either cognitive or physical capacity to complete ADL's /IADL's in a safe or timely manner.
- Eligible for Medical Assistance through the Medicaid Long Term Care eligibility rules.
- Meet either a high or highest level of care as determined by the Medicaid Office of Medical Review.
- Posses the ability to self-direct and manage all aspects of their personal care and community living needs.

### **Self Direction Assessment**

The participant self-assessment is designed to assist the Service Advisor in determining if the applicant possesses the ability to self-direct and manage his/her own care. The questions are intended to elicit information needed for the Service Advisor to determine eligibility for the program and/or the need for a representative to assist the participant.

Since Personal Choice participants will be responsible for overseeing the day-to-day provisions of services it is important that they possess the ability and the desire to be involved in this process. The participant must have the ability to make choices, set goals, be aware of what is adequate or inadequate care, and make changes as to how their care is provided if necessary. A key component in ensuring that each individual Personal Choice participant is receiving high quality care in this type of consumer directed program is to assure that he/she has the ability to recognize and monitor his/her program independently.

The applicant should be asked all of the questions. The inability to answer one or two questions may not necessarily indicate the inability to self-direct their own care, but may indicate the need for more guidance, education, and training in those areas in question. The Service Advisor should also rely on observation of the applicant, and how they respond and answer each question.

The purpose of this tool is to determine if the applicant is capable of managing the Personal Choice program after they receive information and training. This tool is also intended to show the applicant areas of deficit and issues of concern that may prevent them from operating the program safely and efficiently. Finally, it is designed to assist the applicant in deciding whether or not a representative may be needed to assist them in managing some or all aspects of the program that they may have difficulty in doing independently.

The questions can be found in the appendix section of this manual. This assessment will be filed in the participant case record.

### **Participant Management Criteria**

A Service Advisor prior to the start of a self-directed program should determine if the applicant possesses the requisite skills to manage a self-directed Home and Community-Based assistance program. This tool is different from the Self-Direction Assessment in that this is more of a hands-on program assessment, giving the Service Advisor information as to whether the participant/representative understands how the program works.

The questions will be asked of all prospective participants/representatives, and the Service Advisor will record the answers to the questions which will be filed in the participant case record. All of the questions are designed to elicit answers that should indicate the participant's/representative's ability and/or readiness to take part in the program. Some of the questions (#'s 2, 12, 13 and 14 specifically) do not necessarily have a right or wrong answer, but rather are meant to determine if the participant/representative understands the concepts and philosophy of the program as well as their ability to recognize their responsibilities in the area of quality management.

It is up to the Service Advisor to determine if the participant/representative possesses the skills required to manage a self-directed program, and to provide guidance, support and training in areas where assistance is indicated. The questions can be found in the appendix section of this manual.

## Chapter 3

### Assessment Criteria

Assessment criteria will include, but not necessarily be limited to the following:

- A Case Manager from the Service Advisement agency will conduct an initial assessment as detailed below.
- An environmental accessibility and health/medical assessment are to be conducted as part of the intake process once the initial assessment has been completed.

### Assessments

An assessment measuring Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IADLS) is conducted to determine participant needs. A budget is developed based on the amount and level of assistance required, frequency of the task, and presence of any secondary conditions that would require a need for more time to complete the task. There are six (6) levels of assistance for each activity (refer to chart below). In addition to medical information and self-reporting, the assessor may observe or request the participant to demonstrate their ability to complete a task.

Independent	Participant is independent in completing the task safely.
Set-Up	Participant requires brief supervision, cueing, reminder and/or set-up assistance to perform the task.
Minimum	Participant is actively involved in the activity, requires some hands-on assistance for completion, thoroughness or safety. Needs verbal or physical assistance with 25% of the task.
Moderate	Participant requires extensive hands-on assistance, but is able to assist in the process. Needs verbal or physical assistance with 50% of the task.
Extensive	Participant requires verbal or physical assistance with 75% of the task.
Total Assistance	Participant cannot participate or assist in the activity, and requires 100% assistance with the task.
Not Applicable	This task does not apply to this participant.

During the assessment the Medicaid Agency or its contracted agency will assess the assistance a participant requires to complete tasks. These tasks can be broken down into two areas: Personal Care tasks such as bathing, toileting, dressing, etc, and Non-Personal Care tasks such as housekeeping and meal preparation. **Participants are not assessed for general supervision, watching, or companionship as these services are not covered under the Personal Choice Program.** Figuring out how to meet these needs

involves coming up with a plan of hiring people to do the tasks, or purchasing goods or services that will allow the participant to complete the task themselves.

## **How the Personal Choice Budget is Calculated**

### **Overview**

Personal Choice monthly budgets are based upon an assessment of participant need for hands on assistance or supervision in the following Activities of Daily Living (ADL's) which include: bathing, toileting, dressing, grooming, transfers, mobility, skin care, and eating; and Instrumental Activities of Daily Living (IADL's) which include: communication, shopping, housework, and meal preparation.

The assessment of need rates the level of assistance required to complete each task, and the number of times the task is performed. If a participant has a particular condition or characteristic in addition to their disability, it may require the need for more time to complete a particular task. These conditions/characteristics do not apply to all ADL/IADL tasks listed above; they only apply if the condition would have a direct impact on the performance of the task. Those conditions may include: balance problems, behavioral issues, cognitive deficits, decreased endurance, fine motor deficits, hearing loss, limited range of motion, open wound, pain, seizures, shortness of breath, spasticity/muscle tone, use of oxygen, limited vision, and living alone.

The Service Advisor will take into consideration care being provided by a non-paid formal or informal caregiver. For example, if a spouse is cooking dinner for herself, and her spouse is a diabetic, the expectation would be the spouse would provide that meal for the participant. Personal care provided multiple times per day must show documentation of need. For example, if a participant is incontinent they may require bathing or showering more than once a day, but if there is no medical need, a single shower/bath should suffice.

### **Process Used to Determine Monthly Budget**

Each Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) has an amount of time allowed to complete the task.

The unit time is the amount of time allowed to complete the task if the participant is unable to participate and require total assistance with the task.

The functional time is the amount of time allowed to complete the task if the participant is unable to participate and require total assistance with the task and certain conditions or characteristics are present. Those characteristics are listed in functional characteristic table below.

The times, in minutes, are as follows:

<b>Activity</b>	<b>Unit Time</b>	<b>Functional Time</b>
Sponge Bath	20	35
Shower	20	30
Tub Bath	30	45
Dressing	15	20
Eating	20	40
Mobility	5	10
Urinary/Menses	10	15
Transfers	5	10
Grooming	5	8
Skin Care	5	10
Bowel	20	40
Meal Preparation	20	20
House Work	12.5	25
Communications	10	10
Shopping	45	45

The functional characteristics for each ADL/IADL are as follows:

<b>ADL/IADL</b>	<b>Functional Characteristics</b>
Bowel	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Dressing	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Eating	Behavioral Issues, Fine Motor Deficit, Spasticity/Muscle Tone
Grooming	Cognitive, Limited ROM, Spasticity/Muscle Tone
Mobility	Balance Problems, Decreased Endurance, Pain, Spasticity/Muscle Tone
Shower	Balance Problems, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Skin Care	Open Wound
Sponge Bath	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Transfers	Balance Problem, Limited ROM, Spasticity/Muscle Tone
Tub Bath	Balance Problem, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Urinary/Menses	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Communications	No Functional Characteristics
Housework	Participant Lives Alone
Meal Preparation	No Functional Characteristics
Shopping	No Functional Characteristics

A participant's Level of Assistance need determines the amount of time allowed for hands on assistance or supervision for each task. Times allotted for each task are determined by multiplying the Unit Time (or Functional Time) by the Level of Assist Multiplier. The ADL Multipliers are:

Level of Assistance	Sponge Bath	Shower	Tub Bath	Dressing	Eating	Mobility	Urinary Menses	Transfers	Grooming	Skin Care	Bowel
Total Assist	1	1	1	1	1	1	1	1	1	1	1
Maximum Assist	.75	.75	.75	.75	.75	1	.75	1	.75	1	.75
Moderate Assist	.5	.5	.5	.5	.5	.75	.5	.75	.5	.75	.5
Minimum Assistance	.25	.25	.25	.25	.25	.75	.25	.75	.25	.25	.25
Set-Up Assistance	.15	.15	.15	.15	.15	.2	.15	.2	.15	.2	.15
Independent	0	0	0	0	0	0	0	0	0	0	0

The IADL Multipliers are:

Level of Assistance	Meal Preparation	Housework	Communications	Shopping
Total Assist	1	1	1	1
Maximum Assist	1	1	1	1
Moderate Assist	.75	.75	.75	1
Minimum Assistance	.5	.5	.5	1
Set-Up Assistance	.25	.25	.25	1
Independent	0	0	0	0

- **Example #1:** Mrs. M. requires an extensive level of assist in dressing and does not have any functional characteristics.

Time Allowed: 15 minutes x .75 (multiplier) = 11.25 minutes per occurrence

11.25 X 2 (per day) = 22.5 min/day x 7 (days/wk) = 157.50 (min/wk)

157.50 x 4.333 (wks/mo) = 682.44 (min/mo) divided by 60 (min) = 11.37 hours per month are required for assistance in dressing

11.37 x \$17.17 (The dollar amount per hour used in Personal Choice to calculate budget which is based on current reimbursement rates for Certified Nursing Assistants minus a 15% discount.) = \$195.31 per month for dressing.

- **Example #2:** Mr. O requires total assistance with eating and also has a functional characteristic.

Time Allowed: 40 minutes x 1 (multiplier) = 40 minutes per occurrence  
40 x 3 (per day) = 120 min/day x 7 (days/wk) = 840 (min/wk)  
840 x 4.333 (wks/mo) = 3639.72 (min/mo) divided by 60 (min) = 60.66 hours per month  
are required for assistance in eating.  
60.66 X \$17.17 = \$\$1,041.53 per month for eating

- **Example #3:** Ms. A requires set-up assistance with her shower and has no functional characteristics.

Time Allowed: 20 minutes x .15 = 3 minutes per occurrence  
3 x 1 (per day) = 3 min/day x 7 (days/wk) = 21 (min/wk)  
21 x 4.333 (wks/mo) = 90.99 (min/mo) divided by 60 (min) = 1.52 hours per month are  
required for assistance in showering.  
1.52 x \$17.17 = \$26.10 per month for showering

Task times for all ADL's and IADLs are calculated in this manner. The monthly figures for each ADL/IADL are added together to form a monthly budget. The Personal Choice Program is a self-directed program, as such; worker's compensation insurance and administrative costs do get deducted from the monthly budget. **Also a PCA cannot be paid for duties that require a professional license.** See the appendix section page 36. Budget calculations are subject to change at the discretion of the State Medicaid agency.

## **Chapter 4**

### **Individual Service and Spending Plan**

#### **Budgeting**

The budget is the amount of Medicaid funds available to a participant to purchase services to meet personal care needs. The budget is based on what the Medicaid agency would normally spend to purchase services from a Home Health Agency for the services necessary to allow a participant to live at home. The Medicaid agency sets the amount of the monthly budget based on participant need for personal care assistance. The hourly wage for a PCA can range from minimum wage up to \$15.00 per hour.

The budget amount is based solely on tasks such as bathing, dressing, toileting, etc., and is determined based on the amount of assistance the individual needs to complete the task, and time allotted for each task. The budget does not allow for companionship, watching, or general supervision of a participant. The amount of the budget may change at the discretion of the Medicaid agency.

#### **Budget Appeal Process**

An opportunity for a hearing is granted to an applicant/recipient or his/her designated representative, when a person is aggrieved by an agency action resulting in suspension, reduction, discontinuance, termination of a person's service or budget or a requested adjustment to the budget is denied.

A Notice of Agency Action will be forwarded to the applicant/recipient. The Notice will indicate the effective date of the action, the reason for the action, and notify the applicant/recipient of his/her rights to appeal. A sample appeal request form can be located in the appendix section of this manual.

#### **Participant Directed Goods and Services**

A participant may also set aside a specified amount of your budget each month to purchase services, equipment and supplies not otherwise provided through the Medicaid State Plan that address an identified need, are in the approved Individual Service and Spending Plan (ISSP), and meet the following requirements:

- Alternative funding sources are not available, AND
- The item or service would decrease the need for other Medicaid services; and/or
- The item or service would promote inclusion in the community; and/or
- The item or service would increase the individual's ability to perform ADLs/IADLs; and/or
- The item or service would increase the person's safety in the home environment

Limitations:

- Some items or services that are medical in nature require a physician's order.
- Items must be necessary to ensure the health, welfare and safety of the individual, or must enable the individual to function with greater independence in the home or community, and to avoid institutionalization.
- Items for entertainment purposes are not covered.
- Items cannot duplicate equipment provided under Medicaid-funded primary and acute care system or through other sources of funding (i.e. Medicare, private insurance).

**Items purchased whose goal is to lessen the need for assistance from a caregiver will result in a redetermination of need for caregiver assistance.**

If the above criteria are met, a request for participant-directed goods and services must be completed by the service advisor and sent to the Office of Community Services and Supports for review and disposition. There is not a specific list of allowable goods/services, as what may be beneficial to one participant, may not be of any assistance to another. The good or service must meet a specific goal, and help in promoting independence. A sample request for goods and services form is located in the appendix section of this manual.

There is a list of items that participants are specifically *not allowed* to purchase under any circumstance, and are listed below.

**Things a participant may not buy (disallowed purchases)**

The Personal Choice budget MAY NOT be used for:

- Gifts for workers, family, or friends;
- Loans to workers;
- Rent or mortgage payments;
- Payments to someone to be your Representative;
- Clothing;
- Groceries;
- Lottery tickets;
- Alcoholic beverages;
- Tobacco products;
- Entertainment activities;
- Televisions, stereos, radios, DVD players, GPS systems, electronic game systems, e-readers, etc;
- Utility payments (electric, gas, sewer, oil);
- Services which will meet your needs and are available without charge from community organizations;
- Cell phones;
- Items covered by another insurance agency or through Medicaid outside of the budget.

## **Writing an Individual Spending and Service Plan (ISSP)**

The Individual Spending and Service Plan (ISSP) have several purposes:

- It describes how a participant plans to spend the Personal Choice budget to meet personal care needs.
- It helps the participant understand how much money they have to spend each month.
- It prevents the participant from overspending by listing the items they may purchase.
- It gives the Service Advisor and the Personal Choice program office an understanding of how a participant's personal care needs will be met.
- It tells the Service Advisor and the Personal Choice program office what plans are in place for when a worker is not available and a participant need alternate services (emergency back-up plan).

When writing the ISSP, keep in mind that every purchase made and every wage paid has to be included in the ISSP, or it will not be paid by the Fiscal Advisor. To write an ISSP, participants will need to find workers at the rate of pay they decide to offer and will need to know the cost of any goods or services they may wish to purchase.

The Service Advisor will check to make sure the ISSP conforms to Personal Choice rules. The ISSP will become effective once approval is received from the Personal Choice program office.

The Service Advisor will give the participant a copy of the ISSP, and will also keep a copy of the ISSP in the case file.

### **An ISSP needs updating if:**

- The participant wants to make a big change, such as increasing a PCAs rate of pay, or adding an additional PCA.
- The participant wants to add a new need or new service.
- The participant's monthly budget amount changes.
- The participant just used their savings to make a special purchase. That money is no longer needed for the purchase and now may be used for more hours, emergency back-up, etc.

In any of these circumstances, the Service Advisement agency and the participant will need to write a new ISSP.

## Writing and Submitting the Individual Service and Spending Plan

### Step 1 – Writing out goals

Examples of some goals are: Be more independent in dressing, hire someone to assist with housework, etc.

Goals must be included in the case record with each ISSP.

Details to include in setting goals:

- The date the goal is set.
  - The date the goal is achieved.
  - Persons Responsible – Write down who will be involved in achieving the goal.
- Budget Funds Utilized – If the monthly budget will be used to pay for something that will allow the participant to achieve their goal, enter a “Y” in the space allotted. If the monthly budget will not be used to achieve the goal, enter an “N”.
- For example: If one goal is “to get assistance with personal care” and the participant will be hiring a PCA with the budget, you would enter a “Y”. If one goal is “to get an overhead lift system”, Medicaid will pay without having to use the budget, so “N” would be entered.

### Step 2 – Completing the ISSP Form

#### Section I – Direct Hire Services

**Service Type/Description:** List all the services the participant would like to receive from individuals that they will hire and supervise directly. Do not write in names, but rather use an identifier such as PCA#1, PCA#2, Housekeeper#1, etc.

**Goal #1** – List which goal this purchase or service will allow the participant to achieve.

**Hours Per Week** – Indicate the number of hours per week the PCA(s) is expected to work.

**Hourly Wage** – Indicate the hourly wage for each worker.

**Total Taxes per Hour** – Taxes are automatically calculated in the CDM

**Sum of Hourly Wages and Taxes** – Add up the hourly wage and the hourly tax expense for each worker and enter the total where indicated.

- Example: If Mr. P. is paying PCA#1 \$12.00 per hour in wages, and the taxes for \$12.00 per hour are \$1.32 per hour, you would enter the amount of \$13.32.

**Number of Hours per Month** – Take the number of hours each PCA will work every week and multiply that number by 4.33. This figure will equal the number of hours worked each month.

- Example: PCA#1 works 20 hours per week. Multiply 20 x 4.33, which equals 86.6 hours per month.

**Total Monthly Cost** – The total monthly cost will be automatically calculated.

**Total Direct Hire Services** – The sum of all workers' costs will be automatically calculated in the CDM.

### **Section IA – Emergency Back-Up Plan for Personal Care**

Personal Choice participants must make a plan for how their personal care needs will be met in the event that one (or more) of their PCAs become unavailable. This can be done in several ways, such as using unpaid volunteers (i.e. family members, friends), paying existing PCAs to cover for each other, or hiring a Home Health Agency.

**Back-Up Provider** - Indicate who will provide care in the event that a regularly scheduled PCA cannot work.

**Paid Y/N** - Indicate here if the back-up PCA(s) will be paid (Yes) or unpaid (No) for the assistance they will provide.

**Additional Cost per Month (if any)** – If the participant will be paying for back-up services and it will cost more than what is normally paid for a PCA in hourly wages indicate this here.

- Example – If a PCA earns \$12.00 per hour, but it will cost \$14.00 per hour for emergency back-up. The cost is an additional \$2.00 per hour.

If the Emergency Back-up Plan does not involve using a paid PCA, you do not have to enter this information.

**If Unused, Funds to be Saved For** – Indicate here how the participant wants to use unused back-up funds.

**Total Monthly Cost** – The total monthly cost will be automatically calculated.

**Total Monthly Cost for Emergency Back-Up** – The total monthly cost for emergency back-up will be automatically calculated.

### **Section II – Other Purchased Services**

**Service Type/Description** – List all of the services purchased directly from providers or agencies.

**Goal #** - Indicate which goal this purchase or service will allow the participant to achieve.

**Provider Name** – Enter the name of the agency or provider that will supply the service.

**Frequency** – Indicate how often the participant will be using the service during the month.

- Example – If the participant will be sending out their laundry to the “Fluff and Fold” once a week, you would enter (4) four (for 4 weeks) in the frequency box.

**Unit Cost** – Indicate the unit cost for each service the participant will purchase.

- Example – If the participant will be sending their laundry to the “Fluff and Fold” and they charge \$2.00 per pound, you would enter \$2.00/pound.

**# of Units per Month** – Indicate the number of units of the service the participant will be purchasing in a month.

- Example – If the participant sends out 10 pounds of laundry every week, you would enter 40 in this box. 10 pounds per week x 4 weeks per month.

**Total Monthly Cost** – This is the cost of the service for the entire month. The total monthly cost is automatically calculated in the CDM.

**Total Monthly Services Cost** – This is the total cost of all purchased services for the entire month. This is automatically calculated in the CDM.

### **Section III – Purchase of Items/Goods**

Please review process in section on Participant Directed Goods and Services in Chapter 2

**Description of Item or Good** – List all purchase of items or goods in this section.

Describe the item and its use.

- Example – If Ms. D has arthritis and is unable to safely use her stove/oven. She would like to purchase a microwave so she can prepare some of her own meals. She would enter “Microwave to prepare meals”.

**Goal #** - Indicate which goal this purchase or service will allow the participant to achieve.

**One-Time Purchase** – Indicate if item will be purchased once. (Note: Once the item is purchased revise the ISSP so funds can be used elsewhere.)

**Vendor Purchased From** – Indicate the name of the vendor that the participant will be purchasing the item from.

**Proposed Purchase Date** – Indicate the month and year the participant intends to purchase the item.

**Estimated Cost** – Indicate the approximate cost of the item(s) the participant is purchasing.

**Estimated Months Needed to Save** – Indicate how many months it will take to purchase expensive items. If the participant does not have to save to make the purchase enter “N/A”

- Example – If the microwave Ms. D wants to purchase costs \$100.00 and she wants to save \$25.00 per month to buy it, she would enter 4 months ( $\$25.00 \times 4 \text{ months} = \$100.00$ )

**Total Cost of Monthly Savings** – Indicate the amount the item costs (for items the participant does not have to save for) or the amount the participant wants to set aside each month (for more expensive items that you cannot purchase immediately).

**Financial Management Monthly Fee** – Enter the amount the Fiscal Agent charges for their services every month.

**Advisement Agency Monthly Fee** – Enter the amount the Service Advisement Agency charges for the services they provide.

**Worker’s Compensation Fee** – The Worker’s Compensation Insurance premiums required for PCA(s) is an amount charged to each employer, regardless of the number of workers or payroll. This amount is entered under “Worker’s Comp Fee”.

## Chapter 5

### Advisement Services

The Service Advisement agency will provide at a minimum, the following services to all participants enrolled in the Personal Choice program:

- Assess all participants for appropriateness for program.
- Complete in-depth assessments to determine participant need and budget amount.
- Facilitate participant directed services by assisting participants in developing and implementing their spending plan (ISSP).
- Monitor program implementation, ongoing service delivery, and participant health and safety.
- Provide initial and ongoing training to the participant and/or designated representative in order to ensure that all program requirements are met.
- Assess the participant's community integration needs and assist in accessing services as needed.

Additionally Mobility and Environmental Accessibility and Health Management and Education services are to be made available to all participants in Personal Choice. These services will include, but will not be limited to the following:

- Assisting the participant by assessing the need for Adapted Equipment, Home Modifications and/or Assistive Technology, both high and low tech that will improve the participant's independence and safety in their home environment and in accessing the community.
- Assisting in identifying, and applying for, funding to purchase identified equipment or modifications, separate from participant's monthly budget funds, if possible.
- Training and education in the use of adapted equipment that will increase participant independence or increase the safety and efficiency of caregivers.
- Assessing the participant's current medical condition and how it relates to and interacts with their disability and/or chronic condition(s).
- Provide to the participant educational and training opportunities that will help the participant better manage the effects of their disability and/or chronic medical condition(s) and prevent development of additional medical conditions, either personally or through existing community resources.
- Assist participants in identifying, applying for and accessing available community resources in the areas of wellness and health promotion or maintenance.

## **Program Monitoring**

Each Service Advisement agency will monitor participants enrolled in the Personal Choice Program to ensure health and safety satisfaction, adequacy of the current spending plan, and progress made toward participant identified goals.

### **Service Advisement Agency**

The advisement agency will have a system in place to monitor the services it provides to Personal Choice participants in the following domains:

- Participant access to services
- Participant-centered service planning and delivery
- Agency capacity and capabilities
- Participant safeguards
- Participant rights and responsibilities
- Participant outcomes and satisfaction
- Overall system performance

### **Minimum Monitoring Standards**

- Home visit will take place quarterly, and as requested by the State Medicaid agency. At least one quarterly home visit must be unannounced.
- Phone contact with the participant during the months in which no home visit is made.
- Separate logs in case record for required face-to-face contact and telephone contact that can be verified by State Medicaid agency.
- A full team reassessment after the 12<sup>th</sup> month of enrollment which will include a case management assessment, environmental accessibility assessment, and health and medical assessment.
- ISSP to be completed by the Service Advisor within 60 days of approval of budget.

A participant satisfaction survey is to be conducted annually by the service advisement agency. They will compile the results and provide the State Medicaid agency with a report summarizing their findings.

The Service Agency case records are required to be current and include the following:

- Current Level of Care
- Annual Service Advisor Functional Assessment
- Annual Nursing Health Assessment
- Annual Mobility Specialist Mobility and Environmental Assessment
- Current approved CDM Assessment
- Current approved Individual Service and Spending Plan (ISSP)
- Personal Choice Designation of Agency form.

- Signed Freedom of Choice
- Personal Choice Waiver Referral Form
- Monthly call logs.
- Quarterly visit logs
- Request for Participant Goods and Services (if any)
- Incident reports (if any)

The Service Advisement agency will have policy regarding corrective action measures and will implement corrective action plans with participants to ensure the participant's health and safety needs are being met in the spending plan (ISSP) implementation prior to initiating any adverse action or discharge from the personal choice program.

### **State Medicaid Agency**

Service Advisement agency case records will be reviewed by the State Medicaid agency. This review will, at a minimum, consist of the following components:

- A random sampling will be pulled from each service advisement agency.
- The advisement agency will, at the most, receive a one day notice of cases to be reviewed, and at the least will be given the cases upon the reviewer's arrival.
- The reviewer will process the case records of the selected sample to see if all required information is current and up to date.
- The review will compile the results and provide the service advisement agency with a written summary of the findings.
- The State Medicaid agency will provide the service advisement agency with a written statement indicating any corrective action and provide a time frame for compliance.
- The review process described above will also be used for the Fiscal Agency case record review and Long Term Care case record review.

The State Medicaid agency will work in conjunction with the Service Advisement agency to ensure the health; safety and well-being of Personal Choice participants are being met. The Medicaid agency will also provide the Service Advisement agency with assistance and support with problems and issues that may arise with the Personal Choice program.

## Chapter 6

### Medicaid Fraud

#### Personal Choice and Medicaid Fraud

**Medicaid Fraud** is defined as making a false statement, representation of material fact, submitting a claim or causing a submission to obtain some benefit or payment involving Medicaid money for which no entitlement would otherwise exist. This can be done for the benefit of oneself or another party and includes obtaining something of value through misrepresentation, concealment, omission or willful blindness of a material fact.

#### Who is responsible for reporting Medicaid Fraud?

- The Fiscal Intermediary Agency
- The Service Advisement Agency
- The Personal Choice Recipient or the Representative
- The Personal Care Attendant
- The Medicaid Recipient

#### Medicaid Fraud Referral Process

If Medicaid Fraud is either known or suspected:

1. An agency either receiving a report or discovering an incidence of Medicaid Fraud will complete a Medicaid Fraud Referral.
  - a. If reported to the agency by an outside person, the agency will provide as much reporter information as possible.
  - b. The agency will indicate if the reporter wishes anonymity.
  - c. Provide as much detail as possible in nature of complaint and indicate documentation. (Please do not provide physical documentation at this time)
  - d. If the report is internal from either the contractor or the PI, the Personal Choice staff must complete the referral form with the date, and attach emails/documentation/call log.
2. Fiscal agencies and service advisement agencies filing a report will retain a copy for their record, and fax the completed form to EOHHS Personal Choice Program Manager at 462-4266.

3. The Personal Choice Program Manager will email the Program Integrity (PI) Director and copy EOHHS Legal contact with referral information.
4. The PI Director will advise Personal Choice Program Manager of next steps and copy EOHHS Legal.
5. The Personal Choice Program Manager will file a copy of referral in a Fraud Referral Log. An excel copy of the document will be sent to PI Director and the Chief Medical Care Specialist for Claims and Contracts for inclusion in the Quarterly Medicaid Fraud Control Unit (MFCU) Meetings.
6. The Personal Choice Program Manager will forward a copy of the referral form to the RI Attorney General Medicaid Fraud Unit when directed by the PI Director, and will copy EOHHS legal.
7. Within five (5) business days of the referral, the MFCU must notify the PI Director and the Personal Choice Program Manager if they will accept the referral. The MFCU must at that time notify the PI Director and the Personal Choice Program Manager in writing (email or letter) if the MFCU will invoke the law enforcement good cause exception to request payments **not** be suspended to the Personal Choice Assistant.
8. If the MFCU does **not** invoke the law enforcement good cause exception then the PI Director in conjunction with the Personal Choice Program Manager must determine within one (1) business day whether payments should be suspended or not to the Personal Choice Assistant and/or whether mandatory or permissive exclusion of the provider is required.
9. Upon completion of investigation, the RI Attorney General Medicaid Fraud Unit will send the completed form with disposition to the PI Director, EOHHS Legal and the Personal Choice Program Manager.
10. The Personal Choice Program Manager will forward copies of the disposition to the appropriate Service Advisement and Fiscal Agencies.
11. The Personal Choice Program Manager will change case from an active Fraud Referral and file in completed Medicaid Fraud Investigations file. The case will be retained for five (5) years according to Federal Law, seven (7) years by State Law, and ten (10) years if case resulted in a criminal conviction.
12. All underlying documents must be retained for State records law and Federal audits.

## Chapter 7

### Critical Incident

#### Critical Incident - General Definition

A “Critical Incident” is any actual or alleged event or situation that creates a significant Risk of substantial or serious harm to the physical or mental health, safety or well being of a waiver participant.

#### Reportable Critical Incidents Defined

1. Abuse
2. Exploitation
3. Neglect/Self Neglect
4. Unexpected Hospitalizations
5. Serious Injury
6. Involvement with Criminal Justice System
7. Natural Disaster
8. Missing Person
9. Death
10. Suicide Attempt

#### Who is supposed to report a critical incident?

- Any person who becomes aware of a critical incident as defined on this form.
- Any person who may be directly affected by a critical incident as defined on this form.
- Qualified Service Providers that are enrolled with the Department of Humans Services.

#### How do you report a critical incident?

Individuals wishing to report an incident should call:

- a. **RI Division of Elderly Affairs** - For abuse, neglect and exploitation of persons 60 and Over **401-462-0555**
- b. **RI Department of Health** - Facility Based and Provider complaints **401-222-5200**
- c. **RI Department of Behavioral Health, Developmental Disabilities and Hospitals** - For abuse, neglect or exploitation of persons under 60 and disabled **401-462-2629**
- d. **The Alliance for Better Long Term Care** - Facility based, Home Care Provider and Assisted Living Provider complaints. **401-785-3340**

**OR**

**The Service advisement agency assigned to the individual.**

## **Reporting Process**

- Participant and/or other party contacts the appropriate state agency and/or the Service Advisement Agency.
- If aware of the incident, Service Advisement agency will complete the Critical Incident Reporting form and submit to The Office of Health and Human Services, Personal Choice Program within 48 hours of the reported incident.
- OHHS, Personal Choice Program staff will review the incident with the Service Advisement Agency to determine feasibility of continuing participation in the Personal Choice Program.

## **Critical Incident Definitions**

“Willful” means intentional, conscious and directed towards achieving a purpose.

“Caregiver” means a person who has assumed the responsibility for the care of the elderly or disabled person voluntarily, by contract or by order of a court of competent jurisdiction, or who is otherwise legally responsible for the care of the person.

### **Abuse**

Abuse means physical abuse, sexual abuse, and/or emotional abuse of an elderly or disabled person by a caregiver.

- a. Physical abuse means the willful infliction of physical pain or injury ( e.g. slapping, bruising or restraining).
- b. Sexual abuse means the infliction of non-consensual sexual contact of any kind upon and elderly or disabled person. Sexual abuse includes, but is not limited to, sexual assault, rape, sexual misuse or exploitation of an elder or disabled person, as well as threats of sexual abuse where the perpetrator has the intent and the capacity to carry out the threatened abuse.
- c. Emotional abuse means a pattern of willful infliction of mental or emotional harm upon and elder or disabled individual by threat, intimidation, isolation or other abusive conduct.

### **Exploitation**

Exploitation means the fraudulent or otherwise illegal, unauthorized or improper act or process of an individual, including, but not limited to, a caregiver or fiduciary, that uses the resources of an elder or disabled individual for monetary or personal benefit, profit, gain or that results in depriving an elder of rightful access to, or use of, benefits , resources, belongings, or assets by use of undue influence, harassment, duress, deception, false representation or false pretenses.

### **Neglect**

Neglect means the willful failure by a caregiver or other person with a duty of care to provide goods and services necessary to avoid physical harm, mental harm, or mental illness to an elderly or disabled individual, including, but not limited to,

“abandonment”(withdrawal of necessary assistance) and denial of food or health related services.

### **Self Neglect**

Self –Neglect means a pattern of behavior in an elderly or disabled individual that directly, imminently and significantly threatens his/her own health and/or safety. Self-Neglect includes, but is not limited to, an inability or an incapacity to provide self with food, water, shelter, or safety to the point of establishing imminent risk of any of the harm(s)described in the immediately preceding sentence.

### **Unexpected Hospitalization**

Any admission to the hospital that was unexpected or unplanned. A planned hospitalization would include scheduled surgeries, procedures or treatments. An unexpected hospitalization would only include when the patient is admitted overnight and would not include nursing home visits.

### **Serious Injury**

Reported, regardless of the cause or setting in which it occurred, when an individual sustains:

- o A fracture
- o A dislocation of any joint
- o An internal injury
- o A contusion larger than 2.5 inches in diameter
- o Any other injury determined to be serious by a physician, physician assistant, registered nurse, licensed vocational nurse/licensed practical nurse.

### **Involvement with Criminal Justice System**

Any involvement with the criminal justice system, including police being called to the individual residence for any reason.

### **Natural Disaster**

Any natural disaster (fire, flood, etc.) that results in housing displacement

### **Missing Person**

Any time a Personal Choice Participant is unexpectedly absent from their residence or cannot be accounted for through family, caregivers or neighbors.

### **Death**

The death of an individual is reported, regardless of the cause or setting in which it occurred.

### **Suicide Attempt**

The intentional attempt to take one’s own life. A suicide attempt is limited to the actual occurrence of an act and does not include verbal suicidal threats by a person receiving services.

## Appendix

### Personal Choice PCA and Representative Disqualifying Criminal Convictions

All Personal Care Assistants and Participant Representatives that have direct contact with Personal Choice program participants must submit to a National Criminal Background Check and a RI Bureau of Criminal Identification (BCI) screening prior to being allowed to provide assistance to a program participant.

For the purposes of the Personal Choice program, if the following **convictions** appear on the individuals BCI screen, they shall not be allowed to provide care or assistance to the consumer:

- Murder
- Voluntary Manslaughter
- Involuntary Manslaughter
- First, Second, or Third Degree Sexual Assault
- Assault on Persons sixty (60) years of age or older
- Assault with intent to commit specified felonies (murder, robbery rape, burglary or the abominable and detestable crime against nature)
- Felony Assault
- Patient abuse
- Neglect or mistreatment of patients
- Abuse, neglect and/or exploitation of adults with severe impairment
- Exploitation of elders
- Burglary
- First Degree arson
- Robbery
- Any felony involving the illegal manufacture, sale or delivery of a controlled substance, or possession with intent to manufacture, sell or deliver a controlled substance
- Felony Drug Possession
- Felony obtaining money under false pretenses
- Felony Embezzlement
- Larceny
- Abuse, Neglect and/or exploitation of adults with severe impairments
- Fraud and False dealings
- Theft
- Embezzlement
- False Pretenses and misappropriations
- Impersonation and identity Fraud
- Exploitation of Elders
- Felony banking law violations

In addition **recent** convictions for the following crimes will result in the individual being disqualified from providing care or assistance:

- Prostitution
- Driving While Impaired (DWI), (if PCA is providing transportation to participant)
- Theft
- Drug Offenses

## Self-Direction Assessment

Personal Choice allows you to decide how your personal care needs will be met by letting you choose how you are helped and by whom.

1. What services do you want and need?
2. What other things would help you be more independent. (i.e. equipment, other services) that you can't get now?

You decide who will help you and what things to buy to help you live in the community.

1. How will you find and select people to help you in your home?
2. How do you plan on making the purchases you need to make?
3. How do you plan to train and supervise the people who work in your home?
4. How will you tell your workers about what you like and don't like about their work?
5. If you are not happy with the work done by your worker, how will you handle the situation?
6. If your regularly scheduled worker could not help you (called in sick, didn't show up, etc.) How would you get your needs met?

A Service Advisor will be available to help you learn how to find workers; learn how to hire, train and manage workers; figure out how much to pay them; and manage your Medicaid resources. Service Advisors will also check in with you periodically to see how you are doing and answer any questions you may have.

1. Are you willing to accept this help from the Service Advisor on a regular basis, and ask for any additional help, as you need it?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_

A Representative is someone who can help you make decisions and also help run the program if you want or need help. A Representative can be a family member or friend who is willing to check in on you regularly and also meet with Personal Choice staff when they meet with you.

1. Do you want to appoint someone as your Representative? Yes \_\_\_\_\_ No \_\_\_\_\_
2. If yes, who do you want to appoint as your Representative?

## **Personal Choice Participant Management Skills Assessment**

1. How is Personal Choice different from other types of Home Care programs?
2. How do you plan to use your monthly budget?
3. What will the Service Advisement agency do to assist you in the program?
4. What will the Fiscal Intermediary do to assist you in the program?
5. List at least (3) rights and at least (3) responsibilities you as the participant have in Personal Choice?
6. What is the difference between a Complaint/Grievance and an appeal?
7. What are the pros and cons of hiring a Personal Care Attendant you don't know?
8. What are the pros and cons of hiring a family member or a friend as a Personal Care Attendant?
9. Describe how you will develop your Individual Service and Spending Plan (ISSP).
10. What is your Emergency Back-up plan?
11. Describe how you will go about finding and hiring a Personal Care Attendant?
12. What are (3) questions you CANNOT ask a potential Personal Care Attendant in an interview?
13. How do you plan on training your Personal Care Attendant?
14. How will you define high quality Personal Care Services?
15. What part of the Personal Choice program will be the most challenging to you, and how will you deal with it?

## Request for Participant-Directed Goods and Services

**Item:** \_\_\_\_\_

**Cost:** \_\_\_\_\_

**Goal/Need:** \_\_\_\_\_

\_\_\_\_\_

The item or service will decrease the need for other Medicaid services.      YES    NO

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

The item or service will promote independence within the community.      YES    NO

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

The item or service will increase the participant's ability to perform      YES    NO

ADLs and/or IADLs and will decrease the need for Personal Care Assistance.

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

The item or service will increase the participant's safety in the home      YES    NO

and will decrease the need for Personal Care Assistance.

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Participant (Printed Name): \_\_\_\_\_

Case Management Agency: \_\_\_\_\_

Service Advisor: \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach physician's order if applicable**

**Approved**                      **Denied**                      **Date:** \_\_\_\_\_

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

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_



**INSTRUCTIONS FOR COMPLETING DHS-121**

This form is used by both the client and the agency representative to:

1. Identify in writing by the client the cause of his/her appeal; and
2. Identify, by the agency representative, the policy on which the decision causing the appeal was based.

The client receives this form at the time of notification of an Agency decision.

**For Food Stamps (FS):** A client has 90 days from the date of the Notice of Agency Action to request a hearing.

**For General Public Assistance (GPA):** A client has 10 days from the date of the Notice of Agency Action to request a hearing.

**For All Other Programs:** A client has 30 days from the date of the Notice of Agency Action to request a hearing.

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**Sections I and II**

These two sections can be filled out by the client alone, or by the client and agency representative, if the client needs help in completing the form. The person requesting an appeal signs this section and returns the completed form to the appropriate regional or district office.

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**Section III**

After Sections I and II are completed, the agency representative completes Section III, citing the agency policy(ies) with reference to the particular manual section(s) that was the basis for making the decision. This section is signed by the agency representative and supervisor. The area identifying the local office is completed. The form is routed promptly to the hearing office at Central Office.

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**NOTE:** When the DHS-121 is completed by the client and mailed directly to Central Office, without being routed through the regional or district office, the hearing office makes a copy of the DHS-121. The original is sent to the regional or district office for completion of Section III. The DHS-121 must be returned to the hearing office at Central Office within seven (7) days.

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**Legal Help**

At the scheduled hearing, you may represent yourself, or be represented by someone else such as a lawyer, a relative, a friend, or another person. If you want free legal help, call Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

## **Personal Choice Program**

### **Excluded from the Duties of a PCA**

A nursing assistant/PCA shall not perform functions that otherwise require a professional license, certification or registration by state law and shall not perform the following duties that include but are not limited to:

- Sterile dressing application
- Injections
- Gastric lavage or gavage, including any tube feeding
- Cutting toenails or fingernails for diabetic
- Vaginal Irrigations
- Giving advise on medical/nursing matters
- Changing a Foley catheter
- Tracheostomy tube care
- Cutting toenails
- Any treatment to non-intact skin
- Oxygen application
- PCA's cannot administer medications

***Taken from the Rhode Island Department of Health Rules and Regulations Pertaining to Rhode Island Certificates of Registration for Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs (R23-17.9-NA)***

SAMPLE

### Personal Choice Quarterly Visit Log

Name: \_\_\_\_\_

Representative Name: \_\_\_\_\_

Initial Assessment Date: \_\_\_\_\_ Annual Assessment Date: \_\_\_\_\_

Participant Visit Date: \_\_\_\_\_

Has Participant had any hospitalizations since last visit? \_\_\_\_\_yes \_\_\_\_\_no.

If yes, please explain: \_\_\_\_\_

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Has Participant had any ER visits since last visit? \_\_\_\_\_yes \_\_\_\_\_no.

If yes, please explain: \_\_\_\_\_

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Does Participant need any adaptive equipment or home modifications? \_\_\_\_\_yes \_\_\_\_\_no

If yes, please explain: \_\_\_\_\_

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Do you have any concerns regarding safety or with self-direction being an appropriate program for Participant? \_\_\_\_\_yes \_\_\_\_\_no.

If yes, please explain: \_\_\_\_\_

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Additional Notes/Comments: \_\_\_\_\_

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SAMPLE

### Personal Choice Monthly Call Log

Participant Name: \_\_\_\_\_

Representative Name: \_\_\_\_\_

Initial Assessment Date: \_\_\_\_\_ Annual Assessment Date: \_\_\_\_\_

Call Date: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

**RI Attorney General Medicaid Fraud Unit  
Personal Choice Program Referral**

Date of Complaint: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Participant Address: \_\_\_\_\_

\_\_\_\_\_

Participant SSN: \_\_\_\_\_

Reporting Agency: \_\_\_\_\_

Reporter Information: (name, address, telephone number, relationship to participant)

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

Nature of Complaint: \_\_\_\_\_

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

*\*Do Not Write Below this Line – Fraud Unit Response Only\**

\_\_\_\_\_

Referral Date to PI Director: \_\_\_\_\_

Date of Referral to Medicaid Fraud Control Unit: \_\_\_\_\_

Disposition, Date of Notice from MFCU: \_\_\_\_\_

Notes: \_\_\_\_\_

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

Copies to be sent to:

EOHHS Legal

EOHHS Personal Choice Program Manager

PI Director

Fiscal Agency

Service Advisement Agency



## PERSONAL CHOICE CRITICAL INCIDENT REPORT FORM

This form is to be used for any critical incident involving a Personal Choice participant.

A “Critical Incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a Money Follows the Person or waiver participant. **Please refer to the Critical Incident Reporting Policy and the Critical Incident Reporting Fact Sheet for more detailed information regarding types of critical incidents and definitions.**

### Section 1. General Information

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Participant name: \_\_\_\_\_

Today’s Date: \_\_\_\_\_

Date and time of incident: \_\_\_\_\_

Location of incident: \_\_\_\_\_

Address and phone number of participant:  
\_\_\_\_\_

Person reporting incident: \_\_\_\_\_

Contact information of person reporting incident: \_\_\_\_\_  
\_\_\_\_\_

Type of relationship of person reporting incident: \_\_\_\_\_

### Section 2: Type of Incident

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Type of event:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Abuse                      | <input type="checkbox"/> Neglect         | <input type="checkbox"/> Exploitation |
| <input type="checkbox"/> Serious Injury             | <input type="checkbox"/> Self Neglect    | <input type="checkbox"/> Death        |
| <input type="checkbox"/> Unexpected Hospitalization | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Law Enforcement Contact    |  |                                       |

**Section 3: Describe Incident and Cause**

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**Section 4: Interventions and Outcomes**

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Names and roles of all involved in incident:

Names of witnesses to incident:

Action take, by whom, and outcome:

Police or other investigator authorities (Describe involvement, provide contact information, and attach any reports from listed authorities.):

Medical treatment provided to person involved in incident:

Facility providing treatment: \_\_\_\_\_

Physician providing treatment: \_\_\_\_\_

Address: \_\_\_\_\_

City/state/zip: \_\_\_\_\_

Telephone number: \_\_\_\_\_

**Section 5: Other Parties or Agencies Contacted**

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- |   |   |
|---|---|
| <input type="checkbox"/> Appropriate State Agency           | <input type="checkbox"/> HCBS Provider: _____ |
| <input type="checkbox"/> Family/Caregiver                   | <input type="checkbox"/> Guardian             |
| <input type="checkbox"/> Hospital                           | <input type="checkbox"/> Police               |
| <input type="checkbox"/> PCP/other health care practitioner | <input type="checkbox"/> Ombudsman            |
| <input type="checkbox"/> Other: _____                       |   |

**Section 6: Describe Corrective Action Taken to Prevent Future Incidents**

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**Section 7: Signature**

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*I certify that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge.*

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_