

SECTION V.5. Changes & Start Date Procedures

I. Change in Services Procedures

The procedure for reporting changes is determined by the following Choices for Care (CFC) settings:

A. Home-Based (fee for service) Service Changes

1. The case manager shall complete a Service Plan change when the individual has a significant change in physical or cognitive function that may increase or decrease the need for CFC services prior to the annual reassessment.
2. The case manager shall ensure that an RN or LPN has completed and signed the ILA health assessment if applicable.
3. The case manager, together with the individual, shall review the person centered plan focusing on the individual's strengths, capacities, preferences, needs and desired outcomes.
4. The case manager shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.
5. The case manager shall identify, if any, the informal/family supports that will continue.
6. The case manager shall review the service options and service limitations with the individual, surrogate, and/or guardian.
7. The case manager shall select services and develop a comprehensive Service Plan appropriate to the identified needs, and in compliance with existing CFC service definitions, standards, procedures, and limitations.
8. The case manager shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.
9. The case manager shall sign the Service Plan.
10. The case manager shall compile and submit the complete Service Plan change package to the Department of Disabilities, Aging and Independent Living (DAIL) regional office. The case manager shall ensure that the package is complete, containing the following documents:
 - a. Proposed Service Plan
 - b. Personal Care Worksheet (for changes in personal care and adult day)
 - c. Justification for change (e.g. ILA health, or functional assessment, etc.)
 - d. Assistive Device/Home Modifications addendum (if applicable)
 - e. Employer Certification Form (if changing to Participant/surrogate-directed only)
 - f. Variance request (if personal care time exceeds worksheet maximums)
 - g. A copy of the hospice plan for Dual Participation in Hospice & CFC (if applicable)
11. DAIL shall return incomplete change packets to case manager.

12. The case manager shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or Participant) when applicable.
13. DAIL shall complete Utilization Review (UR).
14. DAIL shall authorize the Service Plan, including any adjustments as determined in UR process.
15. DAIL shall mail approved Service Plan to the individual and providers and FAX to payroll agent when applicable.

B. Flexible Choices Allowance & Budget Changes

Allowance:

1. The consultant shall complete an allowance change when the individual has a significant change in physical or cognitive function that may increase or decreased need for CFC services prior to the annual reassessment.
2. The consultant shall ensure that an updated ILA and allowance is completed and sent to the local DAIL LTCCC for review.
3. DAIL shall complete Utilization Review (UR).
4. DAIL shall authorize the allowance, including any adjustments as determined in UR process.
5. DAIL shall send the approved allowance to the individual and consultant agency.

Budget:

The consultant will forward all budget and allowance allocation changes to the Fiscal ISO and the participant. Budget changes occur in two forms:

1. Budget changes that come about because the participant's needs have changed. This requires a new needs assessment to determine a new allowance amount and that process is detailed in "Determining the Allowance." A new budget would then be developed as laid out in the section "Budget Development."
2. Budget changes that come about not because of a change in participant needs. These changes reflect a change in participant priorities, or a new approach to meet existing goals. They do not require a new needs assessment but require a modification of all relevant sections of the Budget Form, including goals. These require only steps 8 – 11 listed in the "Initiation of Services" section.

C. Adult Family Care Home Service Changes

1. The AFC Coordinator will complete a reassessment when the participant has a significant change in physical or cognitive function.
2. The AFC Coordinator shall complete an AFC ILA when the individual has a significant change that may increase or decrease the need for CFC services prior to the annual reassessment.
3. The AFC Coordinator shall ensure that an RN or LPN has completed and signed the AFC ILA health section if applicable. The health section should be updated when there is a significant change in an individual's health and medical status.
4. The AFC Coordinator, together with the individual, shall develop a person centered plan focusing on the individual's strengths, capacities, preferences, needs and desired outcomes.
5. The AFC Coordinator with the participant (and care team when possible) shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.
6. The AFC Coordinator shall identify, if any, unpaid family supports that will assist in meeting the individual's needs.
7. When the change in needs affects the AFC Tier the AFC Coordinator will complete the AFC tier score sheet and AFC Service Plan.
8. The AFC Coordinator will obtain the necessary signatures on the AFC Service Plan.
9. The AFC Coordinator will submit all required documents (AFC ILA, AFC Tier Score sheet & AFC Service Plan) to the DAIL regional office (LTCCC).
10. If the change includes the enrollment into Hospice the AFC Coordinator will obtain a copy of the Hospice plan and submit it with the CFC documentation.
11. DAIL shall complete Utilization Review (UR).
12. DAIL shall authorize the Service Plan, including any adjustments as determined in UR process.
13. DAIL shall mail, fax or secure email the approved Service Plan to the individual and the AFC Coordinator.

D. Enhanced Residential Care (ERC) Service Changes

1. The ERC provider will complete a new Resident Assessment (RA) if the individual has had a significant change in physical or cognitive function.
2. The ERC provider shall assess the individual's circumstances, resources, strengths and needs.

3. The ERC provider shall ensure that a registered nurse completes or signs-off on the reassessment.
4. If the ERC provider believes the new assessment will result in an ERC Tier change, the ERC provider shall update the RA and complete the ERC Tier worksheet.
5. If the ERC Tier has changed, the ERC Provider shall complete a CFC ERC Service Plan.
6. The ERC Provider shall obtain the signature of the applicant or legal representative and ERC Provider on the Service Plan.
7. The ERC Provider shall sign the Service Plan.
8. The ERC Provider shall compile and submit a complete change package to DAIL regional office (LTCCC). The case manager shall ensure that the package is complete, containing the following documents:
 - a. ERC Service Plan
 - b. ERC Tier Worksheet
 - c. Resident Assessment (RA)
 - d. Permission for Release of Information (if applicable)
 - e. Hospice Plan for Dual Participation in Hospice (if applicable)
9. DAIL shall return incomplete packets to the ERC Provider.
10. DAIL shall complete Utilization Review (UR).
11. DAIL shall authorize the Service Plan, including any adjustments as determined in UR process.
12. DAIL shall mail, fax or secure email the approved Service Plan to the individual and ERC provider.

E. Nursing Facility (NF) Service Changes

1. The NF provider shall complete the Minimum Data Set (MDS) according to existing NF regulation.
2. The NF provider shall assess the individual's circumstances, resources, strengths and needs.
3. The NF provider shall complete a "Change Report Form" for active Choices for Care participants when:
 - a. The individual is requesting a change of setting (to home-based or ERC) within Choices for Care,
 - b. The individual has been admitted to the hospital,
 - c. The individual been readmitted to the NF after a hospital stay,
 - d. The individual has had a change in payer source, or
 - e. The individual terminates from Choices for Care. (*See Denials and Terminations*)

II. Transfer of Setting Procedures

Individuals may transfer between CFC settings at any time using the following procedures.

A. Home-Based → Nursing Facility (NF)

1. The **individual, family and/or case manager or consultant** must ensure that a NF is available and willing to accept the individual as a resident.
2. The **individual and/or family** must complete all applicable NF admission forms with help from the case manager and nursing home provider when necessary.
3. **Case manager or consultant** shall complete a “Change Report” form (CFC 804) and send to DAIL, DCF and the NF provider.
4. The **NF provider** shall complete an MDS according to existing regulations.
5. **DCF** shall recalculate the patient share and send notice to the individual, DAIL, and NF provider.

B. Home-Based → ERC or AFC

1. The **individual, family and/or case manager** must ensure that an AFC or ERC provider is available and willing to accept the individual for home provider matching (AFC) or as a resident (ERC).
2. The **individual and/or family** must complete all applicable AFC or ERC admission forms with help from the case manager and AFC or ERC provider when necessary.
3. **The case manager, AFC or ERC provider** shall follow the Initial Assessment Procedures for the AFC or ERC setting.

C. Flexible Choices → any other CFC option

1. For Home-based, the **participant** shall choose a case management agency (HHA or AAA).
2. The **consultant** shall complete a “Change Report” form (CFC 804) and send to DAIL, DCF, the case management agency and applicable CFC provider.
3. The **case manager** will complete a new assessment if needed. The amount of services the participant receives in the new option will be determined by their assessed need at the time of the transfer from Flexible Choices.
4. The **consultant** shall work with the participant and the receiving option to assure a smooth

transition to the new option.

5. Whenever possible, the **participant or surrogate** employer shall give their employees reasonable notice that their services will no longer be required.

D. ERC → Home-Based

1. The ERC Provider must ensure that a home is available in the community for the individual to reside.
2. The **ERC Provider** shall make a referral to the case management agency of the participant's choice (HHA or AAA).
3. The ERC Provider will complete a "Change Report" (CFC 804) form and send to DAIL and DCF.
4. The **Case Manager** shall follow the Initial Assessment Procedures for Home-Based setting.

E. ERC → AFC

1. The **ERC Provider** must ensure that an Authorized Agency (AA) is able to work with the participant to identify an AFC home provider match in the community.
2. The ERC Provider will complete a "Change Report" (CFC 804) form and send to DAIL and DCF.
3. The AA shall follow Initial Assessment Procedures for completing the AFC ILA, Tier Worksheet and Service Plan.

F. AFC or ERC → Nursing Facility (NF)

1. The **individual, family and/or AFC or ERC** provider must ensure that a NF is available and willing to accept the individual as a resident.
2. The **individual and/or family** must complete all applicable NF admission forms with help from the AFC or ERC provider and nursing home provider when necessary.
3. **The AFC or ERC provider** shall complete a "Change Report" form (CFC 804) and send to DAIL and DCF.
4. The **NF provider** shall complete an MDS according to existing regulations.
5. **DCF** shall recalculate the patient share and send notice to the individual, DAIL, and NF provider.

G. AFC → ERC

1. The **AFC Provider** must ensure that an ERC provider is able accept the individual as a resident.
2. The **individual and/or family** must complete all applicable ERC admission forms with help from the AFC or ERC provider when necessary.
3. The AFC Provider will complete a “Change Report” (CFC 804) form and send to DAIL and DCF- ESD.
4. The ERC provider shall follow Initial Assessment Procedures for the ERC setting.
5. The **ERC provider** follows the level of care variance procedure, completes the RA within 14 calendar days of admission and follows the Initial Assessment Procedures for ERC setting.

H. AFC → Home Based

1. The AFC Provider must ensure that a home is available in the community for the individual to reside.
2. The **AFC Provider** shall make a referral to the case management agency of the participant’s choice (HHA or AAA).
3. The AFC Provider will complete an “Change Report” (CFC 804) form and send to DAIL and DCF- ESD.
4. The **Case Manager** shall follow the Initial Assessment Procedures for Home-Based setting.

I. Nursing Facility (NF) → Home-Based

1. The **NF provider** shall make a Section Q referral to the local AAA (if the individual is over 60 years old) or VCIL (if the individual is under 60 years old) for options counseling.
2. The Options Counselor will have the participant choose a case management agency to work with (AAA or HHA) and will make the referral to the chosen agency.
3. The NF will complete a “Change Report” form and send to DAIL and DCF.
4. **Case manager** shall follow the Initial Assessment Procedures for Home-Based setting or ERC setting.

J. Nursing Facility (NF) → ERC or AFC

1. The NF provider shall make a Section Q referral to the local AAA (if the individual is over 60 years old) or VCIL (if the individual is under 60 years old) for options counseling.
2. The Options Counselor will make a referral to the chosen ERC provider or Authorized

Agency for AFC.

4. The NF will complete a “Change Report” form and send to DAIL and DCF.
5. **If DAIL staff** receive a 804A form from a NF for a transfer to another setting from a NF prior to receiving an AFC Service plan or ERC Service Plan and Resident Assessment they will make a referral to the Authorized Agency or ERC provider indicated on the form.
6. The **ERC provider** follows the level of care variance procedure, completes the RA within 14 calendar days of admission and follows the Initial Assessment Procedures for ERC setting.
7. The Authorized Agency will complete an AFC ILA, Tier Score Worksheet and Service plan within 14 days of receipt of the referral and follows the Initial Assessment Procedures for AFC.

III. Other Changes

- A. Financial Changes: The **individual or legal representative** is responsible for reporting all changes in the income or resources to the local Department for Children and Families (DCF) Economic Services Division (ESD) according to their policies.
- B. Address Changes: An 804 “Change Report” form must be completed any time an individual has a change in address. For the home-based setting, the **case manager** completes the form. For NF setting, the **NF provider** completes the form. For ERC setting, the ERC provider completes the form. For AFC setting, the AFC provider completes the form. The form must be sent to DAIL and DCF.
- C. Legal Representative Change: An 804 “Change Report” form must be completed any time an individual has a change in legal representative. For the home-based setting, the **case manager** completes the form. For NF setting, the **NF provider** completes the form. For ERC setting, the **ERC provider** completes the form. For AFC home based setting, the **AFC provider** completes the form. The form must be sent to DAIL and DCF.
- D. Hospital Admissions: **NF providers** must complete a “Change Report” CFC 804B form when an individual is admitted to a hospital and plans on returning to the nursing facility. The Change Report form must be mailed to DCF, and DVHA.
- E. Terminations: An 804 “Change Report” form must be completed when individuals terminate from “Choices for Care”. For the home-based setting, the **case manager** completes the CFC 804 Change form. For the ERC setting, the **ERC provider** completes the form. For the AFC setting, the **AFC provider** completes the form. For NF setting, the **NF provider** completes the CFC 804A Discharge form. The form must be sent to DAIL and DCF. Terminations include:
 - Death
 - Permanent move out of state
 - Temporary stay out of state exceeding 30 continuous days
 - The individual no longer requires Choices for Care services (condition has

improved or other services meeting their needs)

For more information, refer to manual Section V.7. Denials and Terminations.

- F. Readmission from Hospital: NF providers must complete a “Change Report” CFC 804B form when an individual is readmitted to the NF from a hospital stay. The Change Report form must be mailed to DCF, and DVHA.

IV. Effective Start Dates

A. Initial Service Authorization

The effective start date that the Department of Disabilities, Aging and Independent Living (DAIL) will use when authorizing services will be the latest of the following:

1. Date of Application date, or
2. Date off of wait list (if applicable), or
3. Date of Long-Term Care Medicaid eligibility (per the Department for Children and Families notice), or
4. Home-Based (fee for service and flexible choices options): Date Assessment/Service Plan completed if completed more than 14 days after receipt of the Clinical Certification.
5. ERC: Date Level of Care Variance issued by Department of Licensing and Protection for Residential Care Home
6. NF: Date of admission
7. AFC: Date moved into AFC Home

B. Annual Service Plan (Reassessment)

The effective start date that DAIL will use when authorizing Home-Based and ERC Service Plans upon reassessment will be the day after the previous Service Plan expired.

C. Service Plan Changes

The effective start date for all Home-Based and ERC service changes (except Participant or surrogate directed services), will be no earlier than the date the Service Plan is received at the DAIL regional office.

The effective start date for Participant or surrogate-directed service changes (Home-Based Fee for Service and Flexible Choices) will be no earlier than the start of the next payroll period after the Service Plan is received at the DAIL regional office.

D. Retroactive Change Requests

1. Retroactive requests for an increase in Home-Based or ERC services will be considered for approval only under certain circumstances when a precipitating event necessitates an immediate increase of services exceeding the currently approved volume of services.
2. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility (NF) placement. For example: The home-based primary caregiver is hospitalized or the individual has a medical event that requires immediate increase in services.
3. Retroactive Service Plan changes will not be approved to cover administrative errors or non-emergent requests for increases.
4. All requests for retroactive coverage must accompany a Service Plan change, a written request for a specific start date and a description of the precipitating event.