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PUBLIC PAY ALF ASSESSMENT MANUAL

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PUBLIC PAY ALF ASSESSMENT MANUAL

14.1 Purpose

This manual provides guidance on the assessment of public pay individuals who are residing in or planning to reside in an assisted living facility (ALF) including individuals who may receive Medicaid-funded targeted ALF case management. For additional information on case management, see Appendix H. Individuals who are designated as public pay are either eligible for or receiving an Auxiliary Grant (AG).

For information on assessing individuals who are paying privately to reside in an ALF, refer to the Private Pay Assessment Manual, which is available on the Virginia Department of Social Services (VDSS) and the Department for Aging and Rehabilitative Services (DARS) public websites.

This manual should be used in conjunction with the User's Manual: Virginia Uniform Assessment Instrument. The User's Manual describes how to complete the Uniform Assessment Instrument (UAI) during the assessment process. The manual is located on the VDSS and DARS public sites.

This manual does not address reimbursement rates for ALF assessments and reassessments. Reimbursement procedures for non-LDSS assessors are addressed in Appendix J. LDSS assessors are reimbursed for assessments and reassessments via the VDSS Random Moment Sampling (RMS) system and do not follow the guidance in Appendix J.

14.2 Legal basis

Effective February 1, 1996, § 63.2-1804 of the Code of Virginia, and regulations, 22 VAC30-110-20, required that all individuals, prior to admission to an ALF, and individuals residing in an ALF must be assessed, at least annually, using the UAI to determine the need for residential or assisted living care, regardless of payment source or length of stay. Additionally individuals residing in an ALF must be assessed using the UAI whenever there is a significant change in the individual's condition that may warrant a change in level of care.

14.3 Definitions

The following words and terms are defined in the Code of Virginia and state regulations. Most of the definitions in this section appear in 22 VAC 30-110-10 unless otherwise noted. When used in this chapter, they shall have the following meaning, unless the context clearly indicates otherwise:

<u>Term</u>	<u>Definition</u>
Activities of Daily Living (ADLs)	Bathing, dressing, toileting, transferring, bowel control, bladder control, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.
Administrator	The licensee or a person designated by the licensee who is responsible for the general administration and management of an assisted living facility and who oversees the day-to-day operation of the facility, including compliance with all regulations for licensed assisted living facilities (22 VAC 40-73-10).
Assessment	A standardized approach using common definitions to gather sufficient information about individuals applying to or residing in an assisted living facility to determine the need for appropriate level of care and services.
Assisted Living Care	A level of service provided by an assisted living facility for individuals who may have physical or mental impairments and require at least moderate assistance with the activities of daily living. Moderate assistance means dependency in two or more of the activities of daily living. Included in this level of service are individuals who are dependent in behavior pattern (i.e., abusive, aggressive, disruptive) as documented on the uniform assessment instrument.

**Assisted
Living Facility
(ALF)**

Any public or private ALF that is required to be licensed as an ALF by the Department of Social Services under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia, specifically, any congregate residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance (scheduled and unscheduled) for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Behavioral Health and Developmental Services, but including any portion of such facility not so licensed; (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage; (iii) a facility or portion of a facility serving infirm or disabled persons between the ages of 18 and 21, or 22 if enrolled in an educational program for the handicapped pursuant to § 22.1-214 of the Code of Virginia, when such facility is licensed by the Department of Social Services as a children's residential facility under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia, but including any portion of the facility not so licensed; and (iv) any housing project for persons 62 years of age or older or the disabled that provides no more than basic coordination of care services and is funded by the U.S. Department of Housing and Urban Development, by the U.S. Department of Agriculture, or by the Virginia Housing Development Authority. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm or disabled adults. Maintenance or care means the protection, general supervision and oversight of the physical and mental well-being of an aged, infirm or disabled individual. Assuming responsibility for the well-being of individuals, either directly or through contracted agents, is considered general supervision and oversight.

Note: The term “Adult Care Residence” when used in the UAI, means Assisted Living Facility.

**Auxiliary
Grants
Program**

Cash payments made to certain aged, blind or disabled individuals who receive benefits under Title XVI of the Social Security Act, as amended, or would be eligible to receive these benefits except for excess income. (§ 63.2-100 of the Code of Virginia).

Case Management	Multiple functions designed to link individuals to appropriate services. Case management may include a variety of common components such as initial screening of need, comprehensive assessment of needs, development and implementation of a plan of care, service monitoring, and follow-up.
Case Management Agency	A public human service agency, which employs a case manager or contracts for case management.
Case manager	An employee of a public human services agency who is qualified to perform assessments and designated to develop and coordinate plans of care.
Department or DARS	The Virginia Department for Aging and Rehabilitative Services.
Dependent	For ADLs and instrumental activities of daily living (IADLs), the individual needs the assistance of another person or needs the assistance of another person and equipment or a device to safely complete the activity. For medication administration, dependent means the individual needs to have medications administered or monitored by another person or professional staff. For behavior pattern, dependent means the individual's behavior is aggressive, abusive, or disruptive.
Discharge	The process that ends an individual's stay in the ALF.
Emergency Placement	The temporary status of an individual in an ALF when the individual's health and safety would be jeopardized by not permitting entry into the facility until requirements for admission have been met.
Facility	An ALF.
Independent Physician	A physician who is chosen by an individual residing in the ALF and who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the facility.

Instrumental activities of daily living (IADLs)	Meal preparation, housekeeping, laundry, and money management. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.
Maximum Physical Assistance	An individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument.
Medication Administration	For purposes of this chapter, assessing the degree of assistance an individual requires to take medications in order to determine the individual's appropriate level of care.
Private Pay	An individual residing in an assisted living facility is not eligible for benefits under the Auxiliary Grants Program.
Public Human Services Agency	An agency established or authorized by the General Assembly under Chapters 2 and 3 (§§ 63.2-200 et seq. and 63.2-300 et seq.) of Title 63.2, Chapter 14 (§ 51.5-116 et seq.) of Title 51.5, Chapters 1 and 5 (§§ 37.2-100 et seq. and 37.2-500 et seq.) of Title 37.2, or Article 5 (§§ 32.1-30 et seq.) of Chapter 1 of Title 32.1, or hospitals operated by the state under Chapters 6.1 and 9 (§§ 23-50.4 et seq. and 23-62 et seq.) of Title 23 of the Code of Virginia and supported wholly or principally by public funds, including but not limited to funds provided expressly for the purposes of case management.
Public Pay	An individual in an ALF is eligible for benefits under the Auxiliary Grants Program.
Qualified Assessor	A person who is authorized to perform an assessment, reassessment, or change in level of care for an individual who is seeking admission to an ALF or who resides in an ALF. For public pay individuals, a qualified assessor is an employee of a public human services agency who is trained in the completion of the uniform assessment instrument and is authorized to approve placement for an individual who is seeking admission to or residing in an ALF. For private pay individuals, a qualified assessor is staff of the ALF trained in the completion of the uniform assessment instrument or an independent physician or a qualified assessor for public pay individuals.

Reassessment	An update of information on the uniform assessment instrument at any time after the initial assessment. In addition to an annual reassessment, a reassessment shall be completed whenever there is a significant change in the individual's condition.
Residential Living Care	A level of service provided by an ALF for individuals who may have physical or mental impairments and require only minimal assistance with the activities of daily living. Minimal assistance means dependency in only one ADL or dependency in one or more of the selected IADLs as documented on the uniform assessment instrument. Included in this level of service are individuals who are dependent in medication administration as documented on the uniform assessment instrument. This definition includes the services provided by the facility to individuals who are assessed as capable of maintaining themselves in an independent living status.
Significant Change	A change in an individual's condition that is expected to last longer than 30 days. It does not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.
Supportive Housing (SH)	A residential setting with access to supportive services for an AG recipient in which tenancy as described in § 37.2-421.1 of the Code of Virginia is provided or facilitated by a provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services that has entered into an agreement with the Department of Behavioral Health and Developmental Services pursuant to § 37.2-421.1 of the Code of Virginia (§ 51.5-160 of the Code of Virginia).
Targeted Case Management	The provision of ongoing case management services by an employee of a public human services agency contracting with the Department of Medical Assistance Services to an individual who is receiving an auxiliary grant in an ALF who meets the criteria set forth in 12 VAC 30-50-470.

Total Dependence	The individual is entirely unable to participate in the performance of an ADL.
Uniform Assessment Instrument or UAI	The department-designated assessment form. There is an alternate version of the uniform assessment instrument that may be used for individuals paying privately. Social and financial information that is not relevant because of the individual's payment status is not included on private pay version.
Virginia Department of Medical Assistance Services or DMAS	The single state agency designated to administer the Medical Assistance Services Program in Virginia.
User's Manual: Virginia Uniform Assessment Instrument	The department-designated handbook containing common definitions and procedures for completing the department-designated assessment form.

14.4 Background

Since July 1, 1994, publicly funded human service agencies in Virginia, including the LDSS, area agencies on aging (AAA) and screening (formerly known as preadmission screening (PAS)) teams used the UAI to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring an individual's needs across agencies and services. The UAI is comprised of a short assessment and a full assessment. The completion of the short UAI (Part A plus questions on behavior pattern and medication administration or full UAI (Part A and Part B) is based on the initial review of the individual's needs and which long-term care service has been requested.

14.5 Assisted living facilities (ALFs)

ALFs are licensed by VDSS, Division of Licensing Programs (DOLP), to provide maintenance and care to four or more adults. ALF placement is appropriate when the adult is assessed to need assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), administration of medication and/or supervision due to

behavioral problems, but does not require the level of care provided in a nursing facility. ALFs are licensed to provide:

- Residential living only.
- Residential living and assisted living level of care.

A searchable listing of licensed ALFs is available on the VDSS and DARS public website. However not all ALFs accept individuals who receive AG.

14.6 Individuals to be assessed

(22 VAC 30-110-20). All individuals applying to or residing in an ALF shall be assessed face-to-face using the UAI prior to admission, at least annually, and whenever there is a significant change in the individual's condition.

Except in the event of a documented emergency, all individuals must be assessed to determine the necessity for ALF placement **prior to** the ALF placement. See Section 14.41.1 for additional information about emergency admissions.

14.7 Assessors for public pay individuals

(22 VAC 30-110-20). For public pay individuals, the UAI shall be completed by a case manager or a qualified assessor to determine the need for residential care or assisted living care services. The assessor is qualified to complete the assessment if the assessor has completed a state-approved training course on the UAI. Assessors who prior to January 1, 2004, routinely completed UAIs as part of their job descriptions may be deemed to be qualified assessors without the completion of the training course.

Assessors for public pay individuals include the following:

- **Local departments of social services (LDSS):** There are 120 LDSS across the state.
- **Area agencies on aging (AAA).** There are 25 AAAs serving all jurisdictions in the state. AAAs develop or enhance comprehensive and coordinated community-based systems of services for the elderly in their designated planning and service areas.

- **Centers for independent living (CILs).** CILs are non-profit organizations which provide peer counseling, information and referral, independent living skills training, and advocacy to people with all types of disabilities.
- **Community services board (CSB)/Behavioral health authority (BHA).** CSBs and BHAs deliver mental health, intellectual disability (ID), and substance abuse services to individuals throughout Virginia.
- **Local departments of health.** Local health departments are responsible for local health initiatives that vary according to the needs of the community.
- **An independent physician.** An independent physician is a physician chosen by an individual residing in an ALF and who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the facility.
- **State facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS).** State facilities in the Commonwealth provide inpatient services for persons with mental illness or intellectual disability.
- **Acute care hospitals.** Many hospitals in the Commonwealth have contracted with DMAS to perform screenings or to complete the UAI for a home- and community-based waiver program. Acute care hospitals are limited to initial ALF assessments. Qualified emergency room staff may complete the assessment and authorization for ALF services if their hospital has a contract with DMAS to perform screenings.
- **Department of Corrections (DOC) or the DOC designee.** Staff trained to complete the UAI may complete the initial assessment only for inmates who may be appropriate for ALF services and have reached their appropriate release status. The authority to conduct an initial assessment for ALF services does not extend to those inmates who might be appropriate for nursing facility placement.

All of the above assessors may conduct initial assessments as well as annual reassessments except:

- State facilities operated by the DBHDS.
- Acute care hospitals.
- DOC.

These three entities may complete the initial assessment **only** and **must** send a copy of the UAI, DMAS-96, and individual's reassessment date to the Adult Services Supervisor of the LDSS in the jurisdiction where the ALF is located.

Note: Public pay assessors are not required to assess private pay individuals, but may do so when requested. If they choose to assess private pay individuals, the assessor may not charge more than public pay reimbursement rates for conducting the assessment.

(22 VAC 30-110-20). When a public human services agency assessor completes the UAI for a private pay individual, the agency may determine and charge a fee for private pay assessments that may not exceed the amount DMAS reimburses for public pay assessments.

14.8 Assessments in DBHDS facilities, Veterans Administration Medical Centers, and correctional facilities

Individuals in state DBHDS facilities who seek ALF admission directly from these facilities must be assessed as part of the required discharge plan (§ 37.2-505 of the Code of Virginia). Qualified staff of the state facility will complete these assessments. Some state facilities discharge individuals to ALFs for "trial visits" (§37.2-837 of the Code of Virginia) to ensure that the placement is appropriate.

Individuals in Veterans Administration Medical Centers (VAMC) who will be eligible for AG and who are applying to enter an ALF can be assessed by a qualified assessor from a public human services agency in the locality in which the facility is situated or by a physician of the hospital if the physician is enrolled as a DMAS provider to assess individuals who are residing in or wish to reside in an ALF. The physician may designate qualified staff to complete the assessment; however, he or she must sign and approve the assessment.

The Department of Corrections is responsible for assessments of individuals leaving the facility to enter an ALF. The correctional staff must have completed the UAI course. If a non-correctional facility assessor is requested to perform the assessment, the assessor is advised to contact the correctional facility prior to the assessment to determine whether the individual meets nursing facility or ALF criteria. If the individual is determined to require nursing facility care or Medicaid waiver, then the assessor must contact the local screening team for a screening.

14.9 ALFs operated by CSBs or a BHA

A CSB/BHA employee can complete the UAI for individuals who are residing in a CSB/BHA operated ALF. In order to be reimbursed for a public pay assessment, the assessor may be an employee of the CSB/BHA, but not of the ALF. The distinction is whether the staff is considered direct service staff. Direct service staff or employees of the ALF cannot perform either assessment or targeted ALF case management services for individuals residing in the ALF. If the ALF staff is also the individual's case manager, case management will be a part of the staff's usual responsibilities and will not be reimbursed separately by DMAS. If an agency staff person is placed in a facility to facilitate case management activities, such staff could complete the assessment and perform targeted case management services and be reimbursed by DMAS for these activities.

14.10 Uniform assessment instrument (UAI)

The UAI provides the framework for determining an individual's care needs. It contains measurable and common definitions to determine how individuals function in daily life activities. For public pay individuals, the short assessment (first four pages) of the UAI and an assessment of behavior/orientation and medication administration are required. The "Attachment to a Public Pay Short Form Assessment" can be used to document the required assessment areas not covered on the first four pages of the UAI. The assessor may also choose to complete Part A and the questions on medication administration and behavior pattern in Part B, rather than use the short form attachment.

If after completing the first four pages and the attachment, the assessor determines that the individual is dependent in two or more activities of daily living (ADLs) or dependent in behavior, then the full assessment (12-page UAI) must be completed.

The UAI and the "Attachment" are available on the DARS public site.

14.11 The ePAS system and ALF assessments

ePAS is the DMAS-developed system for electronic submission of the UAI for purposes of screenings **only**. ALF assessments and reassessments are not submitted in ePAS. LDSS assessors for public pay individuals will complete the assessment in the PeerPlace database. Non-LDSS assessor will complete the assessment using a paper UAI. LDSS assessors do NOT submit assessments for reimbursement. Non-LDSS assessors for public pay individuals should follow the submission guidelines described in Appendix J in order to be reimbursed for the assessment.

14.12 UAI training

The primary source of training on the completion of the UAI is the course **ADS 5011 Uniform Assessment Instrument (UAI)** which is offered by VDSS. The free, two-day, classroom training is offered periodically statewide. A certificate is made available after successful completion of the course and the certificate should be placed in the assessor's personnel file. Unless grandfathered prior to 2004, all public human services agency assessors are required to complete this or another authorized course on completion of the UAI.

Individuals, other than LDSS employees, who are interested in taking **ADS 5011** need to register with the VA Learning Center if they have not already completed the registration process. To register as a VA Learning Center user, visit the VA Learning Center webpage.

14.13 Request for the assessment

The individual seeking placement, a family member, the physician, a community health services or social services professional, or any other concerned individual in the community can initiate a request for ALF assessment.

When the request is made, it is important to determine whether the individual may require nursing facility placement or Medicaid-funded community-based care. If an individual requires either of these services, the individual must be referred to the local screening team for assessment.

It is also important to determine if the individual has applied for AG at the LDSS in the jurisdiction where the individual lives or lived prior to entering an institution. If the individual has not filed an application for AG, the assessor should instruct the individual to do so promptly.

14.14 Response to assessment request

Once the request is made, the assessor must make contact as soon as possible. The assessment process is complete only after the UAI is finished, a decision letter is sent to the individual who was assessed, and any referrals for services have been made. The assessment process should be completed as soon as possible but no later than 30 days from the date of the request.

14.15 Independent assessment

(22 VAC 30-110-30). At the request of the ALF, the individual residing in the ALF, the individual's legal representative, the individual's physician, the Department of Social Services, or the local department of social services, an independent assessment using the UAI shall be completed to determine whether the individual's care needs are being met in the current ALF. An independent assessment is an assessment that is completed by an entity other than the original assessor. The ALF shall assist the individual in obtaining the independent assessment as requested. If the request is for a private pay individual, the entity requesting the independent assessment shall be responsible for paying for the assessment.

14.16 Individuals who live out-of-state

For individuals who live out-of-state and wish to relocate to a Virginia ALF, the assessment shall be conducted prior to admission or on the day of admission.

14.17 Consent to exchange information

Prior to obtaining any information as a part of the assessment process, the assessor must advise individuals of the purpose for seeking this information and the consequences of failure to provide information and must complete the Consent to Exchange Information Form available on the VDSS or DARS public sites. Any legally capable individual who refuses to sign the consent form must be advised that the assessor may not proceed with the assessment process without a signed consent form. Any individual who is not legally capable to sign the form must have a legally authorized representative sign it prior to completion of the assessment process. The consent form allows the assessor to share information obtained through the assessment with ALFs or public human service agencies. These entities are required by law to maintain the individual's confidentiality.

Responsible persons who may sign the consent form are those authorized under § 54.1-2986 of the Code of Virginia. For those authorized, the order is:

1. The individual's guardian; or
2. The individual's spouse except where a divorce action has been filed and the divorce is not final; or
3. An adult child of the individual; or
4. A parent of the individual; or
5. An adult brother or sister of the individual; or
6. Any other relative of the individual in the descending order of blood relationship.

14.18 Completing the UAI

The UAI provides the framework for determining an individual's care needs. It contains measurable and common definitions for determining how individuals function in daily life and other activities. (22 VAC 30-110-30).

It is very important that an accurate assessment of the individual's functional status and other needs be recorded on the UAI, since this information is the basis for determining whether the individual meets the assisted living facility level of care criteria. The assessor must note the individual's degree of independence or dependence in various areas of functioning. See the UAI User's Manual for additional information on assessing an individual.

The process used to assess dependency considers how the individual is currently functioning (e.g. the individual actually receiving assistance to perform an ADL) and whether the individual's functioning demonstrates a need for assistance to perform the activity (e.g. the individual does not receive assistance to bathe but is unable to adequately complete his or her bath, and, as a consequence, has recurrent body rashes). If the individual currently receives the assistance of another person to perform the activity safely, or if the individual demonstrates a need for the assistance of another person to complete the activity (and not for a matter of convenience), the individual is deemed dependent in that activity. The individual's need for prompting or supervision in order to complete an activity qualifies as a dependency in that activity.

In determining whether an individual is dependent in medication administration (e.g., "administered by professional staff"), this choice should be made when a professional staff person is necessary to **assess** the individual and **evaluate** the efficacy of the medications and treatment. Individuals who receive medication from medication aides who have completed the medication management course would not be described as receiving medication "administered by professional staff" but rather as receiving medication "administered/monitored by lay person."

The optional Assisted Living Facility Level of Care Worksheet form helps the assessor quickly determine the level of care an individual may need.

Pursuant to 22 VAC-110-30 the ALF shall provide an area for the assessment to be conducted that ensures the individual's privacy and protects confidentiality.

14.19 Completing the short form

The short form includes the first four pages of the UAI plus an assessment of the individual's medication management ("How do you take your medicine?" question on

page 5 of the UAI) and behavior (“Behavior Pattern” section on page 8 of the UAI) must be completed. **Note:** The assessor will only be reimbursed at the short-form rate if that is all that is needed, even if the full assessment is completed.

Assessors will complete only the short assessment when the individual is:

- Rated dependent in only one of seven activities of daily living (ADLs); or
- Rated dependent in one or more of four selected instrumental activities of daily living (IADLs); or
- Rated dependent in medication administration.

14.20 Completing the full assessment

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

14.21 Prohibited conditions

Assessors must also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions are present, the assessor must document that they are present on the UAI. If appropriate, contact a health care or mental health care professional for assistance in the assessment of these prohibited conditions.

Additional information about pressure ulcers is located at on the National Pressure Ulcer Advisory Panel website. Descriptions of pressure ulcer stages and categories are also available.

State law prohibits admission or retention of individuals in an ALF when they have any of the following conditions or care needs (Bold text indicates language from 22 VAC 40-73-310).

- **Ventilator dependency** describes the situation where a ventilator is used to expand and contract the lungs when an individual is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require it in the event that they are unable to breathe on their own.

- **Dermal ulcers III and IV except those stage III ulcers that are determined by an independent physician to be healing** and care is provided by a licensed health care professional under a physician's or other prescriber's treatment plan: Dermal ulcers include pressure ulcers (e.g., bed sores, decubitus ulcers, pressure sores) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The prohibition is based on the size, depth, and condition of the wound regardless of the cause.
- **Intravenous therapy or injections directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia.** Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein. Examples may include the infusion of fluids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parenteral nutrition (TPN).

Intermittent intravenous therapy may be provided for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician's or other prescriber's treatment plan. When a course of treatment is expected to be ongoing and extends beyond a two-week period, evaluation is required at two-week intervals by a licensed health care professional.

- **Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.**
- **Psychotropic medications without appropriate diagnosis and treatment plans.** Psychopharmacologic or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotic, antidepressants, and the anti-anxiety/hypnotic class. A treatment plan means a set of individually planned interventions, training, habilitation, or supports prescribed by a qualified health or mental health professional that helps an individual obtain or maintain an optimal level of functioning, reduce the effects of disability or discomfort, or improve symptoms, undesirable changes or conditions specific to physical, mental, behavioral, social, or cognitive functioning.
- **Nasogastric tubes.** A nasogastric (NG) tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.

- **Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.** Gastric tube feeding is the use of any tube that delivers food, nutritional substances, fluids and/or medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).
- **Individuals presenting an imminent physical threat or danger to self or others.** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the individual.
- **Individuals requiring continuous licensed nursing care** (seven days a week, twenty-four hours a day). Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Individuals requiring continuous licensed nursing care may include:
 - Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or
 - Individuals with a health care condition with a high potential for medical instability.
- **Individuals whose physician certifies that placement is no longer appropriate.**
- **Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance.** Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.
- **Individuals whose physical or mental health care needs cannot be met in the specific assisted living facility as determined by the facility.**

14.22 Private pay individuals only-exception of certain prohibited conditions

At the request of the private pay individual, when the individual's independent physician determines that such care is appropriate for the individual, care for the following conditions or care needs may be provided to the individual in an ALF by a physician licensed in Virginia, a nurse licensed in Virginia or a nurse holding a multistate licensure privilege under a physician's treatment plan, or by a home care organization licensed in Virginia:

- Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia; and
- Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.

These exceptions do not apply to individuals who receive AG.

14.23 Care of special medical needs

When care of an individual's special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency.

14.24 Hospice care in the ALF

Notwithstanding the prohibited conditions described above at the request of the individual residing in an ALF, hospice care may be provided in an ALF, if the hospice program determines that such program is appropriate for the individual.

14.25 Residential level of care

(22 VAC 30-110-60). Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

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

2. Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management).
3. Rated dependent in medication administration.

14.26 Assisted living level of care

(22 VAC 30-110-70). Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in two or more of seven ADLs.
2. Rated dependent in behavior pattern (i.e., abusive, aggressive, and disruptive).

14.27 Independent living status

Individuals who are assessed as independent can be admitted into an ALF. However, individuals who are assessed as independent are **NOT** eligible for AG payments unless they were public pay residents prior to February 1, 1996.

14.28 Psychosocial assessments

An individual's psychological, behavioral, cognitive or substance abuse issues can impact an individual's ability to live in an ALF and the ability of the ALF staff to provide proper care.

Cognitive impairments can affect an individual's memory, judgment, conceptual thinking and orientation. In turn, these can limit the individual's ability to perform ADLs and IADLs. When assessing an individual for possible cognitive impairment, it is important to distinguish between normal, minor losses in intellectual functioning and more severe impairments caused by disorders such as Alzheimer's Disease or other related dementias. Some cognitive impairments may be caused by a physical disorder such as a stroke or traumatic brain injury or by side effects or interactions of medications.

When determining the appropriateness of ALF admission for individuals with mental illness, intellectual disability, or a history of substance abuse, a current psychiatric or psychological evaluation may be needed. The need for an evaluation will be indicated if there are dependencies in the Psychosocial Status section of the UAI and if the individual

demonstrates any of the behaviors or symptoms identified on the guidance tool Appendix K located on the VDSS and DARS public website. **Note:** Appendix K is a reference guide for referring individuals to providers to address mental health, intellectual disability or substance abuse issues and to determine ongoing eligibility for individuals who want to reside in a SH setting. Appendix K is not a form that needs to be completed. A referral to an Auxiliary Grant Supportive Housing (AGSH) provider should be made if the individual meets criteria #5, 6, or 7 on Appendix K.

A recommendation for further assessment may also be suggested by the individual's case manager, another assessor or by the admission staff at the time of the admission interview. The mental health evaluation must be completed by a person having no financial interest in the ALF, directly or indirectly as an owner, officer, employee, or as an independent contractor with the facility.

The assessor is not diagnosing the individual, but rather using his professional judgment to look for indicators of the possible need for a referral to the local CSB or BHA or other mental health professional for a more thorough mental health and/or substance abuse assessment and possible diagnosis.

Appendix K should be included with the UAI when it is forwarded to the ALF provider.

14.29 Referral for mental health (MH), intellectual disability (ID), or substance abuse (SA) evaluation

If the UAI and the guidance in Appendix K reveal mental health indicators, an evaluation must be completed prior to the individual's admission date.

It is the responsibility of the individual seeking admission to an ALF, his legal representative and the ALF admission staff to ensure that the evaluation is completed. The assessor or case manager may assist with arranging the evaluation.

Referrals for MH, ID, or SA evaluations should be made using the following guidelines.

14.29.1 Referral for MH evaluation

A referral for a MH evaluation should be made when the individual is believed to have a mental illness. A mental illness is disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care treatment for health, safety, or recovery of the individual or for the safety of others.

14.29.2 Referral for ID evaluation

A referral for an ID evaluation should be made if the individual has a disability that originated before the age of 18 years and is characterized concurrently by:

- Significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and
- Significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

14.29.3 Referral for substance abuse evaluation

A referral for substance abuse evaluation should be made if the individual uses drugs enumerated in the Virginia Drug Control Act without a compelling medical reason or alcohol that:

- Results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use; or
- Results in mental, emotional, or physical impairment that causes socially dysfunctional or social disordering behavior; and because of such substance abuse, requires care and treatment for the health of the individual.

14.30 Licensing requirements for screening of psychosocial, behavioral and emotional functioning prior to admission

14.30.1 Mental health screening

(22 VAC 40-73-330). A mental health screening shall be conducted prior to admission if behaviors or patterns of behavior occurred within the previous six months that were indicative of mental illness, intellectual disability, substance abuse, or behavioral disorders and that caused, or continue to cause, concern for the health, safety, or welfare either of that individual or others who could be placed at risk of harm by that individual.

Exceptions:

1. If it is not possible for the screening to be conducted prior to admission, the individual may be admitted if all other admission requirements are met. The reason for the delay

shall be documented and the screening shall be conducted as soon as possible, but no later than 30 days after admission.

2. The screening shall not be required for individuals under the care of a qualified mental health professional immediately prior to admission, as long as there is documentation of the person's psychosocial and behavioral functioning as specified in 22 VAC40-73-340 A1.

14.30.2 Psychosocial and behavioral history

(22 VAC 40-73-340). A. When determining appropriateness of admission for an individual with mental illness, intellectual disability, substance abuse, or behavioral disorders, the following information shall be obtained by the facility:

1. If the prospective resident is referred by a state or private hospital, community services board, behavioral health authority, or long-term care facility, documentation of the individual's psychosocial and behavioral functioning shall be acquired prior to admission.
2. If the prospective resident is coming from a private residence, information about the individual's psychosocial and behavioral functioning shall be gathered from primary sources, such as family members, friends, or physician. Although there is no requirement for written information from primary sources, the facility must document the source and content of the information that was obtained.

14.30.3 Mental health screening determination form

The Mental Health Screening Determination model form posted on the VDSS public site can be used to document the completion of the individual's mental health screening by the accepting ALF.

14.31 Admission of individuals with serious cognitive impairments

When determining the appropriateness of ALF admission, serious cognitive deficits should be noted on the UAI or other screening tool. The ALF must determine if it can meet the needs of the individual.

All facilities that care for individuals with serious cognitive impairments due to a primary diagnosis of dementia who cannot recognize danger or protect their own safety and

welfare are subject to additional licensing requirements. The assessor may consult VDSS DOLP regulations and guidance or speak with VDSS DOLP staff for further information regarding ALF services for individuals with serious cognitive impairments.

14.32 Physical examination

VDSS, DOLP regulations require that all individuals admitted to an ALF have a physical examination completed prior to the admission. DOLP has prepared a model form, Report of Resident Physical Examination, which may be used for the physical examination.

The use of this form is not required; any physical examination form that addresses all of the requirements is acceptable (i.e., includes tuberculosis status, etc.). A physician or his designee must sign the physical examination report.

It is the responsibility of the ALF to ensure that the physical examination is completed.

14.33 Outcome of assessments

After the assessor has completed an assessment, the assessor is responsible for authorizing the appropriate services. During the authorization process, the assessor, with input from the individual being assessed, will decide what services, if any are needed; who will provide the services; and the setting where services will be provided. The assessor will identify the available community services and make referrals as appropriate.

Regardless of the outcome of assessment, the assessor must offer the individual the choice of services providers, including ALF providers. The individual's choice of providers is a federal as well as a professional and ethical requirement.

The possible outcomes of an ALF assessment may include:

- A recommendation for ALF care (either residential or assisted living);
- Referral to the screening team to review if the individual is appropriate for Medicaid long-term services and supports;
- Referrals to other community resources (non-Medicaid-funded) such as home health services, adult day care centers, home-delivered meals, etc.; or
- A determination that services are not required.

14.34 Referral to ALF

When a recommendation is made that an individual meets ALF level of care (either residential or assisted living), the assessor will document this decision on the UAI and the Medicaid-Funded Long-Term Care Services Authorization (DMAS-96).

Key Points regarding the assessment package:

- The assessor indicates #11 for residential care or #12 for assisted living on the DMAS-96. If #12 is authorized, the assessor must also enter the ALF provider number and date the ALF starts. If the individual requires Medicaid-funded targeted case management, this would also be indicated. Also note the effective date of authorization. The assessor enters his or her agency's provider number in the first line of the space for "Level I Screening Identification" on the DMAS-96. The second line is used for screenings only.
- The assessor must send a copy of the DMAS-96 which verifies the individual's level of care to the LDSS eligibility worker. The eligibility worker does not need a copy of the UAI.
- The assessor must send the UAI, DMAS-96, and the decision letter to the ALF.
- The assessor must send the decision letter to the individual who was assessed. See sample decision letters in Appendix E-G.

The assessor should follow guidance in Appendix J of this manual regarding reimbursement procedures. The assessor keeps copies of the UAI, the DMAS-96, the consent form and decision letter.

14.35 Referrals to Medicaid Long-term services and supports

Medicaid-funded long-term services and supports (LTSS) may be considered when the assessor completes an assessment and determines that an individual may meet the criteria for nursing facility care and is at risk of nursing facility placement unless additional help is received.

Home and community-based services include waiver services, such as the CCC Plus waiver, which offers services such as personal care, adult day health care, and respite care. For additional information about Medicaid-funded LTSS visit the DMAS website.

If the assessor believes the individual may be appropriate for Medicaid-funded LTSS, the assessor should contact the local screening team and send the original UAI to the local

department of health or the LDSS to initiate a preadmission screening. The individual should be referred to the LDSS to complete a Medicaid application. The original assessor will complete the DMAS-96, indicating “None” for services recommended

14.36 Referrals to Non-Medicaid community resources

When the assessor determines that an individual requires assistance in the home and is appropriate for a referral to community service or combination of services, the assessor will initiate the referral. Depending upon the type of service required, the assessor will make the referral to the appropriate agency and assure that the individual and family understand how to receive services.

It is essential for assessors to maintain current information on available community resources, such as health services, adult day care centers, home-delivered meals, to assist in developing alternatives to long-term institutionalization.

When referrals are made to non-Medicaid-funded community services, the assessor enters #8, “Other Services Recommended,” on the DMAS-96.

The assessor must distribute the following information:

- A copy of the UAI and the consent form to the community service agency.
- A copy of the DMAS-96 to the LDSS Eligibility Worker:
- The decision letter to the individual being assessed. See sample decision letters in Appendix E-G.

The assessor keeps copies of the UAI, the DMAS-96 and consent form, and decision letter.

14.37 Determination that services are not required

When the assessor determines that an individual can safely and adequately reside in the home with assistance from relatives, friends, or neighbors and requires no additional monitoring or supervision, the assessor makes no referrals.

When no referrals for services are required, the assessor enters #0, “No other services recommended” on the DMAS-96.

In addition to the initial assessment package, the assessor must distribute the following information:

- A copy of the DMAS-96 to the LDSS Eligibility Worker.
- The decision letter to the individual being assessed. See sample decision letters in Appendix E-G.

The assessor keeps copies of the UAI, the DMAS-96 and consent form, and decision letter.

14.38 Requests for ALF assessment in a nursing facility

Assessors are permitted to conduct an ALF assessment on individuals who reside in nursing facility settings, but maybe appropriate for discharge to an ALF. Assessors are frequently contacted by nursing facility staff requesting an assessment on an individual who, according to the nursing facility, no longer meets nursing facility level of care criteria. However, in some instances after the assessment is conducted, the assessor determines that that individual still meets nursing facility criteria and is not appropriate for ALF admission. DMAS will not reimburse for the assessment when the individual who is residing in a nursing facility is assessed but does not meet assisted living or residential level of care. DMAS will only reimburse for an ALF assessment in a nursing facility, if the individual meets assisted living or residential level of care and is appropriate for discharge from the nursing facility to an ALF.

To decrease the number of ALF assessments in nursing facilities in which the assessment outcome is that the individual still meets nursing facility criteria and is not appropriate for residential or assisted living level of care, assessors are encouraged to obtain as much information about the individual's situation prior to the assessment visit.

14.39 Authority to authorize public payment

(22 VAC 30-110-50). The assessor is responsible for authorizing public payment to the individual for the appropriate level of care upon admission to and for continued stay in an ALF.

In those instances when the assessment documentation does not clearly indicate that the individual meets ALF criteria, public funding for these services cannot be authorized. Any information that is needed to support the assessor's level of care decision must be documented on the UAI.

Any authorization made by the assessor is subject to change based on any change that occurs in the individual's condition or circumstances between the time the authorization occurs and the admission of the individual to an ALF. All individuals applying to reside in or residing in an ALF and for whom assessment and/or targeted case management

services are provided, have the right to appeal the outcome of any assessment. See Section 14.50 for appeal information.

14.40 Time limitation of assessments

An authorized assessor's approval decision and the completed UAI regarding an individual's appropriateness for ALF placement are valid for 12 months or until an individual's functional or medical status changes, and the change indicates the individual may no longer meet the authorized level of care criteria.

See Section 14.41.2 concerning time limitations on assessments from individuals who are awaiting admission to an ALF.

14.41 Admission to the ALF

Prior to an individual's admission to an ALF, the assessor should contact the ALF to discuss the level of care needed and to ensure that the ALF has the appropriate license. The assessor must also discuss with the ALF the types of services needed by the individual and determine whether the ALF is capable of providing the required services or that they are available in the community.

Once the placement is finalized, the assessor must notify the LDSS eligibility worker responsible for determining AG eligibility of the date of admission as listed on the DMAS-96.

14.41.1 Emergency admission

(22 VAC3-110-30). An emergency placement shall occur only when the emergency is documented and approved by a Virginia adult protective services worker for public pay individuals or by a Virginia adult protective services worker or independent physician for private pay individuals.

See Section 14.3 for the definition of emergency placement. Prior to the emergency admission, the APS worker must discuss with the ALF the individual's service and care needs based on the APS investigation to ensure that the ALF is capable of providing the needed services. The individual cannot be admitted to an ALF on an emergency basis if the individual has any of the prohibited conditions.

This is the **only** instance in which an individual may be admitted to an ALF without first having been assessed to determine if he or she meets ALF level of care.

The UAI and the DMAS-96 must be completed within **seven working days** from the date of the emergency placement. There must be documentation in the individual's ALF record that a Virginia APS worker or physician approved the emergency placement. A statement by the APS worker or physician that is included in a comment section of the UAI will meet this requirement.

14.41.2 Awaiting ALF admission

At times, an individual who has been assessed as appropriate for ALF admission has to remain in the community while awaiting admission. When the admission can proceed, and if no more than 90 days have elapsed, a new assessment does not have to be completed unless there has been a significant change in the individual's condition. If more than 90 days have elapsed since the assessment was conducted, then a new assessment must be completed.

14.42 Respite services

Respite is a temporary stay in the facility, usually to relieve caregivers from their duties for a brief period of time. Individuals admitted to an ALF for respite services must be assessed prior to admission. The initial assessment is valid for 12 months if the level of care of the individual remains the same. A reassessment would be required annually provided that the respite services continue to be provided, even if it provided intermittently.

Individuals who receive AG are typically not admitted to an ALF for respite care. However, if respite services are requested, the assessor shall assess the individual to determine if he or she meets ALF level of care.

14.43 Annual reassessment

(22 VAC 30-110-30). The UAI shall be completed annually on all individuals residing in ALFs. UAIs shall be completed whenever there is a significant change in the resident's condition. All UAIs shall be completed as required by 22 VAC 30-110-20. The ALF shall provide an area for assessments and reassessments to be conducted that ensures the individual's privacy and protects confidentiality.

The purpose of the annual reassessment is the reevaluation of service need and utilization review. The assessor shall review each individual's need for services annually, or more frequently as required, to ensure proper utilization of services. Each individual residing in an ALF must be reassessed at least annually.

It is the original assessor's responsibility to ensure that the required annual reassessments are completed. An assessor is responsible for securing another assessor if he or she cannot continue the assessment of the individual. The assessor may refer the responsibility for conducting the annual reassessment to another assessor no later than one month prior to the due date of the annual reassessment. Future reassessments then become the responsibility of the new assessor. Both the original assessor and the assessor to whom assessment responsibility is transferred should keep written documentation acknowledging the transfer of reassessment responsibilities. Individuals who are receiving AG may have AG payments terminated if the individual is not reassessed or the reassessment information is not communicated to the LDSS eligibility worker in a timely manner.

The annual reassessment is based upon the date of the last completed assessment. The reassessment does not need to be performed in the same month as the initial assessment. A current assessment is one that is not older than 12 months. The ALF shall keep the individual's UAI and other relevant data in the individual's ALF record.

If, during the reassessment, it is determined that a change in level of care has occurred, the assessor must treat the reassessment as change in level of care. The UAI and the DMAS-96 must be completed.

14.44 Who can conduct an annual reassessment

(22 VAC 30-110-90). The annual reassessment shall be completed by the qualified assessor conducting the initial assessment. If the original assessor is neither willing nor able to complete the assessment and another assessor is not available, the local department of social services where the individual resides in the ALF shall be the assessor, except that individuals who receive services from a community service board or behavioral health authority shall be assessed and reassessed by qualified assessors employed by the community services board or behavioral health authority.

The annual reassessment is completed by:

- The assessor conducting the initial assessment;
- The qualified assessor of the CSB or BHA for CSB/BHA clients;
- The agency chosen by the individual for ongoing case management services; or

- The agency accepting the referral from the agency that completed the initial assessment. If no agency accepts the referral for reassessment, then the LDSS where the ALF in which the individual resides is located is the assessor.

If an individual is receiving targeted case management services for mental illness or ID, the agency case manager for this service must complete the reassessment as part of case management responsibilities for that individual. This case management will be noted on the individual's UAI at the time of the initial assessment and the mental health case manager will be advised of the individual's authorization for ALF residence and the date when the reassessment is needed. The mental health case manager must complete the reassessment and follow the process of the annual reassessment.

14.45 Who cannot conduct annual reassessments?

ALF staff may only conduct annual reassessments on individuals who are paying privately to reside in the ALF.

Acute care hospitals, DBHDS facilities, and correctional facilities may not complete the 12-month reassessment. These groups may perform the initial assessments only.

When original assessments are completed by any of these agencies, reassessment responsibilities must be referred to another assessor as soon as possible, but no later than one month prior to the due date of the annual reassessment. The original assessor must send the UAI, the DMAS-96, and the reassessment date to the new assessor and notify the eligibility worker in the LDSS that is responsible for determining the individual's AG eligibility. The ALF must also be aware of reassessment dates and ensure that timely reassessments are completed.

14.46 The annual reassessment package

The annual reassessment package includes the following:

- **ALF Eligibility Communication Document.** This form notifies the LDSS eligibility worker who determined the individual's AG eligibility, whether the individual continues to meet criteria to reside in the ALF.
- **UAI (short or long form as appropriate).** For LDSS assessors only: PeerPlace allow the UAI to be copied. The worker can then updated the copied version.

The DMAS-96 is NOT used for an annual reassessment.

In addition to the reassessment package, the assessor must distribute the following:

- The Eligibility Communication Document to the LDSS eligibility worker.
- A copy of the Eligibility Communication Document and the UAI to the ALF.
- The decision letter to the individual being assessed. See sample decision letter in Appendix E-G.

The assessor keeps a copy of the UAI and the Eligibility Communication Document.

14.47 Changes in level of care

The UAI must be completed or updated as needed whenever the individual has a significant change or it appears the individual's approved level of care has changed. See the definitions section of this manual for the definition of significant change. A change in level of care assessment should be conducted within two weeks of receipt of the request for assessment.

14.47.1 Who can complete an assessment for a change in level of care?

Only the following entities can perform an assessment for a change in level of care:

- LDSS.
- AAAs.
- CILs.
- CSBs.
- Local departments of health.
- State facilities operated by DBHDS.
- Acute care hospitals.
- An independent physician for residents of ALFs.

Note: Individuals who are residing in an ALF and are receiving case management services for mental illness or ID must receive change in level of care assessments from the CSB/BHA providing case management services.

14.47.2 Temporary changes in condition

Temporary changes in an individual's condition are those that can be reasonably expected to last less than 30 days. Such changes do not require a new assessment or update. Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

14.48 Outcomes of annual reassessments or change in level of care

The possible outcomes from a reassessment may include:

- Continue at the current level of care.
- Change in the level of care.
- Transfer to another ALF at the appropriate level of care with the addition of other services (e.g. home health).
- Referral to the screening team if the individual is appropriate for Medicaid LTSS.
- Referrals to other community resources (non-Medicaid-funded) such as home health services, adult day care centers, home-delivered meals, etc.

14.49 Change in level of care assessment package

The change in level of care package includes the following:

- **DMAS-96.** On the DMAS-96, indicate the change in level of care determination as follows: #11 for residential living, #12 for assisted living. See the DMAS-96 for other options.
- **UAI (short or long form as appropriate).** Any updated UAI.

In addition to the reassessment package, the assessor must distribute the following:

- A copy of the DMAS-96 to the LDSS Eligibility Worker.
- The original UAI and the DMAS-96 to the ALF.

- A decision letter to the individual being assessed. See sample decision letter in Appendix E-G.

The assessor keeps copies of the UAI, DMAS-96, and the decision letter.

14.50 Appeals

(22 VAC 30-110-110). Assessors shall advise orally and in writing all public pay individuals of the outcome of the assessment or the annual reassessment, including a statement indicating that the local department of social services will notify the individual whether he is eligible to receive the auxiliary grant. An individual who is denied an auxiliary grant because the assessor determines that the individual does not meet the care needs for residential level of care has the right to file an appeal with the Department of Social Services under § 63.2-517 of the Code of Virginia. Notification of the right to appeal will be included in the notice of action provided by the local department of social services. A determination that the individual does not meet the criteria to receive targeted case management is an action that is appealable to DMAS in accordance with the provisions of 12 VAC30-110.

The assessor, by letter, must inform the individual and the referral source of the assessment decision to authorize or deny Medicaid payment for long-term care services and indicate the reason(s) for the decision. See Appendix E-G for sample decision letters.

An individual who is denied AG because he does not meet residential level of care has the right to appeal to:

VDSS, Division of Fair Hearings and Appeals

801 East Main Street, Richmond VA, 23219

The VDSS Request for Appeal form is located on the public site.

An individual who does not meet criteria for targeted case management may appeal to DMAS. Any individual wishing to appeal should notify the Appeals Division, DMAS, in writing, of his or her desire to appeal within 30 days of the receipt of the assessor's decision letter. The DMAS appeal request form is available on the DMAS website.

14.51 Transfers to another setting

14.51.1 ALF-to-ALF transfer

22 VAC 40-73-440). G. When a resident moves to an assisted living facility from another assisted living facility or other long-term care setting that uses the UAI, if there is a completed UAI on record, another UAI does not have to be completed except that a new UAI shall be completed whenever:

1. There is a significant change in the resident's condition; or
2. The previous assessment is more than 12 months old.

The ALF from which the individual is moving must send a copy of all current assessment material to the facility to which the individual is moving. If the ALF to which the individual is relocating is outside of the jurisdiction of the discharging ALF, the discharging ALF must arrange for an assessor in the new jurisdiction as part of the discharge plan. The requirements for discharge notifications must be followed. The receiving ALF is then responsible to initiate the appropriate documentation for admission purposes.

14.51.2 ALF-to-hospital transfer

Hospital screening teams do not complete an assessment for individuals who are admitted to a hospital from an ALF, when the individual is to be discharged back to either the same or a different ALF and the individual continues to meet the same ALF level of care or is expected to meet the same criteria for level of care within 30 days of discharge. In the event that the individual's bed has not been held at the ALF where the individual lived prior to being hospitalized, the individual would still not need to be evaluated by the hospital staff provided that he or she is admitted to another ALF at the same level of care.

If an individual is admitted to a hospital from an ALF and the individual's condition has not changed, but placement in a different ALF is sought, a new assessment is NOT required. The second ALF would be required to complete necessary documentation for admission. The first ALF must provide the required discharge notifications.

If there has been a change in level of care since the individual's admission to the hospital, the hospital assessors shall perform a change in level of care assessment, unless the change is anticipated to be temporary (e.g., expected to last less than 30 days).

If an individual is admitted to the hospital from an ALF and the individual needs to transfer to Medicaid-funded LTSS, a screening must be completed by appropriate hospital staff. It is not the responsibility of the community-based screening team to complete a screening for a person in a hospital.

14.52 Discharge from an ALF

When there is a determination made that an individual is no longer appropriate for ALF level of care and must be discharged, the ALF must follow certain discharge procedures.

(22 VAC 40-73-430). A. When actions, circumstances, conditions, or care needs occur that will result in the discharge of a resident, discharge planning shall begin immediately, and there shall be documentation of such, including the beginning date of discharge planning. The resident shall be moved within 30 days, except that if persistent efforts have been made and the time frame is not met, the facility shall document the reason and the efforts that have been made.

B. As soon as discharge planning begins, the assisted living facility shall notify the resident, the resident's legal representative and designated contact person if any, of the planned discharge, the reason for the discharge, and that the resident will be moved within 30 days unless there are extenuating circumstances relating to inability to place the resident in another setting within the time frame referenced in subsection A of this section. Written notification of the actual discharge date and place of discharge shall be given to the resident, the resident's legal representative and contact person, if any, and additionally for public pay residents, the eligibility worker and assessor, at least 14 days prior to the date that the resident will be discharged.

C. The assisted living facility shall adopt and conform to a written policy regarding the number of days notice that is required when a resident wishes to move from the facility. Any required notice of intent to move shall not exceed 30 days.

D. The facility shall assist the resident and his legal representative, if any, in the discharge or transfer process. The facility shall help the resident prepare for relocation, including discussing the resident's destination. Primary responsibility for transporting the resident and his possessions rests with the resident or his legal representative.

An individual must be discharged from the ALF if a prohibited condition is revealed during the reassessment or a screening team determines that the individual needs nursing

facility level of care. The individual must also be discharged if the ALF is not licensed for the level of care needed.

Pursuant to 22 VAC 30-110-40, for public pay individuals, ALF staff shall provide written notification of the individual's date and place of discharge or of the individual's death to the LDSS eligibility worker in the jurisdiction responsible for authorizing the individual's AG and the qualified assessor who conducted the most recent assessment. The ALF shall make these notifications at least 14 calendar days prior to the individual's planned discharge or within five calendar days after the individual's death.

14.52.1 Emergency discharge

(22 VAC 40-73-430). E. When a resident's condition presents an immediate and serious risk to the health, safety, or welfare of the resident or others and emergency discharge is necessary, the 14-day advance notification of planned discharge does not apply, although the reason for the relocation shall be discussed with the resident and, when possible, his legal representative prior to the move.

F. Under emergency conditions, the resident's legal representative, designated contact person, family, caseworker, social worker, or any other persons, as appropriate, shall be informed as rapidly as possible, but no later than the close of the day following discharge, of the reasons for the move. For public pay residents, the eligibility worker and assessor shall also be so informed of the emergency discharge within the same time frame. No later than five days after discharge, the information shall be provided in writing to all those notified.

14.52.2 Discharge to Medicaid-funded LTSS

The screening team in the jurisdiction where the ALF is located is responsible for screening individuals who are residing in an ALF but will need Medicaid funded LTSS. The ALF staff, the individual, or the individual's family may contact the screening team to complete the individual's screening. The screening team handles this referral like any other community-based referral.

The individual must apply for Medicaid in order for services to begin, however a Medicaid application does not need to be completed prior to the screening.

14.52.3 Discharge to the Community without Medicaid Funded LTSS

When an individual residing in an ALF moves back to the community without Medicaid funded home and community-based services, an updated copy of the UAI may be forwarded to a local service provider if requested by the individual or his representative. The ALF must follow all required discharge procedures.

14.52.4 Readmission to ALF after discharge

Some individuals may request discharge from the ALF, only to request readmission to the ALF shortly thereafter. If an individual was discharged from an ALF but requests readmission, if the current UAI is less than 90 days old and the individual has had no significant changes, the current UAI may be used for purposes of readmission. If the individual's UAI is older than 90 days or the individual has had a significant change, the assessor shall complete a new UAI.

14.53 Record retention

All assessment forms and Medicaid authorization forms (DMAS-96) must be retained the assessor for five years from the date of the assessment.

14.54 Suspension of license or closure of an ALF

(22 VAC 30-110-40). Upon issuing a notice of summary order of suspension to an ALF, the Commissioner of the Virginia Department of Social Services or his designee shall contact the appropriate local department of social services to develop a relocation plan. Individuals residing in an ALF whose license has been summarily suspended pursuant to § 63.2-1709 of the Code of Virginia shall be relocated as soon as possible to reduce the risk to their health, safety, and welfare. New assessments of the individuals who are relocating are not required, pursuant to 22 VAC 30-110-30 D.

In the event that the local department receives advance notification of the suspension of an ALF's licensure or of an ALF's plans for closure, the LDSS should immediately contact the appropriate Adult Protective Services Regional Consultant to begin planning for the event. The ALF Relocation Plan may be helpful to LDSS staff assisting in the relocation of individuals residing in an ALF that plans to close.

14.55 Appendix A: AG Program

The Auxiliary Grant (AG) Program is a state and locally funded assistance program to supplement the income of an individual who is Supplemental Security Income (SSI) and other aged, blind, or disabled individuals residing in a licensed ALF. This assistance is available from local departments of social services (LDSS) to ensure that individuals are able to maintain a standard of living that meets a basic level of need. Before an individual can receive assistance from the AG program, the LDSS the individual resides must determine eligibility for the program. If the individual is not currently receiving AG, the assessor must advise the individual and/or the individual's family to contact the LDSS to initiate the AG eligibility determination. The LDSS eligibility worker in the locality in which the individual resided prior to admission to the ALF must be informed that ALF placement is being sought. Residence for AG eligibility is determined by the city or county within the state where the person last lived outside of an institution or adult foster care home. If the individual is entering the ALF from an institution, the application is to be filed in the locality where the individual resided before he or she entered the institution.

Virginia residency requirements for the AG Program became effective in December 2012. Information about requirements is available in the DARS public website.

14.55.1 Determining eligibility for AG

The assessor should instruct the individual and/or family to prepare for the eligibility process by obtaining proof of income, copies of bank statements, life insurance policies, savings certificates, stocks, bonds, etc., as this information may be needed by the eligibility worker.

At the time the request for an assessment is made, the assessor must inform the individual and/or family that:

- The authorization for public payment for ALF services does not mean that the individual will definitely be eligible for AG or Medicaid;
- AG eligibility must be determined by an LDSS eligibility worker;
- AG cannot reimburse for services unless the individual has been determined to be financially eligible; and

The assessor shall conduct a preliminary screening of an individual's financial status and estimate whether the individual would likely be eligible for an AG.

Entitlement to AG begins the month that the individual meets all eligibility criteria. If an individual does not meet all eligibility criteria at the time of application, but meets all criteria when the application is processed, entitlement begins the month all criteria are met.

To be eligible for an AG in Virginia, an individual must meet all of the following:

- Be 65 or over or be blind or be disabled.
- Reside in a licensed ALF or an approved adult foster care home or supportive housing setting.
- Be a citizen of the United States or an alien who meets specified criteria.
- Meet Virginia residency requirements.
- Have a non-exempted (countable) income less than the total of the AG rate approved for the ALF plus the personal needs allowance.
- Have non-exempted resources less than \$2,000 for one person or \$3,000 for a couple.
- Have been assessed and determined to be in need of care in an ALF, adult foster care home or supportive housing.

AG covers the following:

Room and Board

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

Maintenance and Care

- Medication administration, including insulin injections.
- Provision of generic personal toiletries including soap and toilet paper.

- Minimal assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.
- Minimal assistance with care of personal possessions; care of personal funds if requested by the recipient and residence policy allows it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; correspondence; securing health care and transportation when needed for medical treatment; providing social and recreational activities as required by licensing regulations; and general supervision for safety.

All individuals applying for AG must have an assessment completed before AG payment can be issued.

Individuals desiring to participate in the supportive housing program must follow eligibility criteria set forth in the AGSH Operations Manual.

The LDSS family services specialist will make a referral to the AGSH provider for further evaluation. The family services worker will submit the eligibility communication document to the LDSS eligibility worker for continued AG eligibility while waiting for notification from AGSH provider. Once the individual has been accepted into the AGSH program and the family services worker has received notification of move in date, then the family services worker can close the case record for annual ALF reassessments. SH reassessments are conducted by other non-LDSS assessors.

14.55.2 When a private pay individual needs to apply for AG

When a private pay individual needs to apply for an AG, the individual must submit an application for AG to the local department of social services where the individual last lived prior to entering an institution. ALFs are considered institutions for purposes of determining AG eligibility.

The individual must be assessed by a public pay assessor and the public pay assessor must provide the LDSS eligibility worker with a copy of the Medicaid Funded Long-Term Care Services Authorization (DMAS-96) as verification of the assessment.

14.55.3 When an Individual with AG Becomes a Private Pay Resident

If an individual becomes ineligible for an AG due to income or countable resources, the LDSS eligibility worker will issue a notice of action to the individual eleven days in advance of terminating AG. The ALF and the individual must determine whether the individual will continue to reside in the ALF. If the individual had a case manager, the case manager would participate in the discharge planning process if appropriate, and then terminate case management services. If the individual plans to reside in the ALF as a private pay resident, assessment requirements for private pay individuals must be followed.

14.56 Appendix B: Assessment process chart

Step 1: Contact	Request for assessment is made. Assessor makes contact with the individual/requester. Verify AG eligibility or that application for AG has been made. If possible, conduct a preliminary screening to determine if there are any prohibited conditions or other medical issues that may require more care than is available in an ALF. Refer to the screening team, if appropriate.
Step 2: UAI	Conduct a face-to-face visit. Get consent to release information. Assessor completes the appropriate UAI. If UAI has been completed in last 90 days, and there are no changes, do not complete a new UAI. If individual meets NF criteria, stop assessment process and refer to screening team.
Step 3: Prohibited Conditions	Assessor determines if individual has a prohibited condition. The individual is NOT eligible for ALF placement if he has a prohibited condition. Stop assessment process and refer to the screening team or to other services.
Step 4: Determine Level of Care	Determine individual's level of care. DMAS-96 and prepare individual's authorization letter approving or denying ALF services.
Step 5: ALF Availability/ Case Management	Discuss with the individual his choice of ALF. Ensure that ALF is licensed for the person's level of care. Verify that ALF can provide requested services or if they are available in the community. Determine if the individual requires only the 12-month reassessment or ongoing Medicaid-funded targeted ALF case management services. If only 12-month reassessment, continue. If case management services needed, arrange for a case manager.
Step 6: Notifications for Initial Assessments & Level of Care Changes	Submit the DMAS-96 and UAI according to Appendix J instructions. (LDSS assessors do not do this) . Send copy of DMAS-96 to LDSS eligibility worker. Send the DMAS-96 and UAI to ALF. Send original decision letter to individual being assessed. Assessor keeps copies of the UAI, DMAS-96, consent form, and decision letter.
Step 7: Plan Reassessment	At least every 12 months, perform reassessment. Original assessor is responsible for reassessment; if unwilling or unable to do so; original assessor is responsible for arranging for another assessor to do the reassessment. If original assessor is hospital staff, state facility staff, or a community release unit of a correctional facility, assessor he must refer reassessment responsibility to another assessor. In this case, the new assessor must be identified at time the individual is admitted to ALF.
Step 8: Reassessment Notification	Follow guidance in Appendix J regarding payment. (LDSS assessors do not do this) . Send copy of Eligibility Communication Document to LDSS eligibility worker. Send the UAI and Eligibility Communication Document to ALF. Send decision letter to individual. Assessor keeps UAI and ALF Eligibility Communication Document.

14.57 Appendix C: Assessment responsibilities

14.57.1 Assessor's Responsibilities

- Determining if the individual to be assessed is already receiving AG or has made an application for AG.
- Completing the assessment process within 30 days of the request.
- Determining appropriate level of care and authorizing services.
- Contacting the ALF of choice and determining if the ALF is licensed for the individual's level of care authorization and if the ALF can meet the individual's needs.
- Directly assisting the individual through the admission process if requested.
- Submitting UAI and associated forms to all entities as directed.
- Referring the individual for a psychiatric or psychological evaluation if needed. (See Appendix K for more information on when these evaluations are recommended).
- Planning for the annual reassessment or making a referral to an alternate assessor if needed.

14.57.2 ALF Staff Responsibilities

- Ensuring the assessment is completed prior to admission, except in a documented emergency admission.
- Coordinating with the assessor to ensure that assessments are completed as required.
- Providing an area for assessments and reassessments to be conducted that ensures the individual's privacy and protects confidentiality.
- Knowing levels of care criteria.
- Knowing prohibited conditions.
- Keeping the UAI in the individual's ALF file.

- Arranging for discharge when an individual's needs do not meet level of care.
- Sending the UAI with an individual when the individual transfers to another ALF.

14.57.3 VDSS DOLP Responsibilities

- Licensing ALFs.
- Ensuring that individuals are assessed as required.
- Monitoring compliance with licensing standards.

14.57.4 DMAS Responsibilities

- Payment for assessments, reassessment and targeted case management.

14.58 Appendix D: Guidelines for assessment

Authorization of services to be provided

The assessor is responsible for authorizing the appropriate level of care for admission to and continued stay in an assisted living facility (ALF). The ALF must also be knowledgeable of level of care criteria and is responsible for discharge of the individual whenever an individual does not meet the criteria for level of care in an ALF upon admission or at any later time. The appropriate level of care must be documented based on the completion of the Uniform Assessment Instrument (UAI) and definitions of activities of daily living and directions provided in the User's Manual: Virginia Uniform Assessment Instrument.

Rating of Levels of Care on the Uniform Assessment Instrument

The rating of functional dependencies on the UAI must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. Please see the User's Manual: Virginia Uniform Assessment Instrument for more detailed definitions.

The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

Bathing

- (a) Does not need help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Performed by others **(D)**

Dressing

- (a) Does not need help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Performed by others **(D)**
- (f) Is not performed **(D)**

Toileting

- (a) Does not need help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Performed by others **(D)**
- (e) Is not performed **(D)**

Bowel Function

- (a) Does not need help **(I)**
- (b) Incontinent less than weekly **(d)**
- (c) Ostomy self-care **(d)**
- (d) Incontinent weekly or more **(D)**
- (e) Ostomy not self-care **(D)**

Transferring

- (a) Does not need help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Performed by others **(D)**
- (f) Is not performed **(D)**

Bladder Function

- (a) Does not need help **(I)**
- (b) Incontinent less than weekly **(d)**
- (c) External device, indwelling catheter, or ostomy self-care **(d)**
- (d) Incontinent weekly or more **(D)**
- (e) External device, not self-care **(D)**
- (f) Indwelling catheter, not self-care **(D)**
- (g) Ostomy not self-care **(D)**

Eating/Feeding

- (a) Does not need help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Performed by others: Spoon fed **(D)**
- (f) Performed by others: Syringe or tube fed **(D)**
- (g) Performed by others: Fed by IV **(D)**

Instrumental Activities of Daily Living (ALF)

- (a) Meal Preparation
 - (1) No help needed
 - (2) Needs help **(D)**
- (b) Housekeeping
 - (1) No help needed
 - (2) Needs help **(D)**
- (c) Laundry
 - (1) No help needed
 - (2) Needs help **(D)**
- (d) Money Management
 - (1) No help needed
 - (2) Needs help **(D)**

Medication Administration (ALF)

- (a) Without assistance **(I)**
- (b) Administered, monitored by lay person **(D)**
- (c) Administered, monitored by professional staff **(D)**

Behavior Pattern

- (a) Appropriate **(I)**
- (b) Wandering/passive less than weekly **(I)**
- (c) Wandering/passive weekly or more **(d)**
- (d) Abusive/aggressive/ disruptive less than weekly **(D)**
- (e) Abusive/aggressive/ disruptive weekly or more **(D)**

14.59 Appendix E: Sample approval letter

Date

Individual's Name/Address

Dear _____:

Virginia regulations require that any individual seeking admission to an assisted living facility (ALF) be assessed to determine if he or she meets the level of care for an ALF prior to admission. You were assessed on _____ (date) and it was determined that you meet criteria for:

___ Residential living

___ Assisted living

___ Ongoing Medicaid-funded targeted case management

The assessor, in accordance with policy and procedures of the Department of Medical Assistance Services, has determined that you meet the level of care criteria necessary for ALF placement. The assessor discussed with you the choice of facility services, and it was determined that ALF placement would best meet your needs at the present time. The assessor is responsible for assessing your needs upon admission and, you will be assessed periodically thereafter in order to demonstrate that you continue to meet the criteria.

Sincerely,

Assessor

14.60 Appendix F: Sample denial letter-Medicaid funded Targeted ALF Case Management

Date

Individual's Name/Address

Dear _____:

In order to receive an Auxiliary Grant, you must be determined to need the level of care offered by an assisted living facility (ALF). You were assessed on _____ (date) and it was determined that you do not meet criteria for:

Ongoing Medicaid-funded targeted case management

The reason you were determined not to meet the criteria for the above-checked item is (note: **specify** reason why the individual does not meet the criteria).

If you do not agree with this decision, you may request a hearing.

You must request a hearing within 30 days of the date this notice is postmarked. The hearing is a private, informal meeting with you, anyone you wish to bring, a Hearing Officer, and me. You will have the opportunity to tell the impartial Hearing Officer, who is a representative of the Virginia Department of Medical Assistance Services, why you disagree with the above decision. Your request must be mailed to: Recipient Appeals Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

Sincerely,

Assessor

c: Individual's Legal Guardian (if applicable)

14.61 Appendix G: Sample denial letter-does not meet minimum residential level of care

Date

Individual's Name/Address

Dear _____:

In order to be eligible for an Auxiliary Grant, you must be determined to need the level of care offered by an assisted living facility (ALF). You were assessed on _____ (date) and it was determined that you do not meet the minimum residential level of care guidelines because (note: **specify** reason why the individual does not meet the level of care).

If you do not agree with this decision, you may request a hearing.

You must request a hearing within 30 days of the date this notice is postmarked. The hearing is a private, informal meeting with you, anyone you wish to bring, a Hearing Officer, and me. You will have the opportunity to tell the impartial Hearing Officer, who is a representative of the Virginia Department of Social Services, why you disagree with the above decision. Your request must be mailed to:

Manager, Appeals and Fair Hearings, Virginia Department of Social Services

801 East Main Street, Richmond, Virginia 23219

If you need help to request a hearing, please contact your service worker.

Sincerely,

Assessor

C: Individual's Legal Guardian, if applicable

14.62 Appendix H: Case management services

Case management services include assessment, service location, coordination and monitoring for individuals, residing in an ALF, who are applying for or receiving AG.

There are two types of Medicaid-funded case management services for individuals in an ALF:

- Annual reassessment only; or
- Ongoing targeted ALF case management.

Most individuals with AG who reside in an ALF will only need the annual reassessment and not ongoing targeted case management services.

Annual Reassessment

The purpose of the annual reassessment is the reevaluation of service need and utilization review. The assessor or case manager shall review the individual's need for services annually, or more frequently as required, to ensure proper utilization of services.

If an individual is receiving targeted case management services for mental illness or intellectual disability, the agency case manager for this service must complete the reassessment and change in level of care assessment as part of case management responsibilities for that individual. Note: DMAS will not reimburse the case management agency for the completion of these assessments since they are a function of the case management procedures. DMAS will not reimburse for the duplicate provision of case management services.

Ongoing Medicaid-Funded Targeted ALF Case Management Services

Ongoing Medicaid-funded targeted ALF case management is a service provided to individuals with AG who are receiving residential or assisted living services and are not receiving targeted case management for mental health or intellectual disability. Individuals appropriate for ongoing Medicaid-funded targeted ALF case management:

- Require coordination of multiple services and/or have some problem which must be addressed to ensure the individual's health and welfare; and
- Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and

- Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor should select “yes” on the DMAS-96 for ALF targeted case management ONLY when the individual is determined to need Medicaid-funded ongoing targeted case management services that have been specifically developed for individuals residing in an ALF. “No” should be selected if the individual will receive only the annual reassessment or may be receiving other types of Medicaid-funded case management services.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not the facility is capable of providing the required coordination of services. Prior to the individual’s admission to the ALF, the assessor must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The assessor must communicate with the ALF to identify service needs and to ensure that service needs can be met. Based upon information obtained, the assessor should authorize case management services if the ALF cannot provide or arrange all the services needed by the individual. The individual selects a case management agency of his choice in the area where he will reside. The assessor must be aware of available Medicaid-funded ALF targeted case management agencies and assist the individual in his selection.

In order to provide services to an individual with AG, a case management agency must have signed an agreement with DMAS to be reimbursed for the provision of targeted case management services.

The case manager identifies care needs and assists in locating and arranging for services that are beyond the scope of the ALF services. The individual chooses from the options made available by the case manager, and the case manager facilitates accessing the service provider.

Ongoing targeted ALF case management must be terminated when the resident no longer requires these services.

Who can provide Medicaid-funded ALF Case Management?

Medicaid-funded case management services (either the annual reassessment or targeted ongoing case management) can be provided by following agency staff, provided that the staff person has the knowledge, skills, and abilities (KSAs) of a case manager:

- Local departments of social services;

- Area agencies on aging;
- Centers for independent living;
- Community services boards;
- Local departments of health; and
- Private physicians who have a contract with DMAS to conduct assessments and who wish to follow clients on a continuing basis. Physicians who conduct assessments or reassessments or perform Medicaid-funded targeted case management may not have financial ties with the ALF.

(22 VAC30-110-100). The local department of social services where the individual resides, following admission to an ALF, shall be the case management agency when there is no other qualified case management provider willing or able to provide case management.

Who cannot provide Medicaid-funded ALF Case Management?

Acute care hospitals, state mental health or ID facilities, and correctional facilities may not provide Medicaid-funded targeted ALF case management.

14.63 Appendix I: Forms

The following forms may be used during the assessment process. Unless otherwise indicated all forms are located at on the DARS or VDSS public site.

Virginia Uniform Assessment Instrument (UAI)

This form is used to assess public pay (Auxiliary Grant) individuals who are residing in or planning to reside an ALF.

Virginia UAI Attachment

This form is to be used with the short form of the UAI to answer questions on medication administration and behavior pattern.

Medicaid Funded Long-Term Care Services Authorization (DMAS-96)

This form is used during initial assessment and for a change in level of care.

Worksheet to Determine ALF Level of Care (Use of this form is optional.)

This form is used to determine an individual's level of care.

Eligibility Communication Document

This form is used to notify LDSS eligibility worker of an annual reassessment or other changes to an individual who is residing in an ALF.

UAI Plan of Care

This form is used by a case manager to develop plan of care based on the completed UAI for individuals in an ALF who are receiving ongoing Medicaid-funded targeted case management.

Interagency Consent to Release Confidential Information about Alcohol and Drug Patients

This form can be used to request information from or send information to a substance abuse program.

Consent to Release Information

This form permits an assessor to share an individual's information with ALFs or other service agencies.

AGSH fact sheet

This document is to be used to educate the individual regarding the AGSH program and should be given to the individual at the time of his or her annual reassessment.

Supportive Housing referral form

This form indicates whether the individual meets the minimum requirements for referral to the AGSH program.

14.64 Appendix J: Submitting an assessment for reimbursement

Non-LDSS assessors shall follow the process below in order to submit an assessment and receive reimbursement:

Initial ALF Assessment Claims Submission:

- Continue to complete the “traditional” paper UAI and associated documents for AG individuals;
- Retain the completed paper forms in the individual’s record for future audit purposes;
- Submit the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96) to the LDSS eligibility worker who is processing the AG application.
- For claims submission, send **only** the completed DMAS-96 by mail or fax to:

DMAS, Division for Aging and Disability Services

Attention: Sharon Terry/Off Line Payments

600 East Broad Street, 10th Floor, Richmond, VA 23219

FAX: 804-452-5468

ALF Reassessment Claims Submission:

- Continue to complete the “traditional” paper UAI and associated documents for AG individuals;
- Retain the completed paper forms in the individual’s record for future audit purposes; do not submit any ALF assessment forms to DMAS;
- Submit the ECD to the LDSS eligibility worker who is reviewing the AG application.
- Upon completion of the reassessment, submit an electronic claim using the DMAS Medicaid web portal.
 - Select “Provider Resources”, then select “Claims Direct Data Entry (DDE)”

- **Note:** Registration information is available at this site if the provider is not yet registered to submit claims. If you have any questions regarding the Virginia Medicaid Portal, please contact the Web Support Health Desk; toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays.

Paper ALF assessments and reassessments received by DMAS or the DMAS designee (Conduant) are being returned to the originating agency with these instructions for claims submission on the cover sheet.

14.65 Appendix K: Indicators for referral

You will obtain important direct and indirect information from other sections of the instrument which can be used to complete the mental health assessment. Pay particular attention to the following aspects of the individual's appearance and behavior during the total interview with the client and/or caregiver for pertinent information about a person's cognitive and emotional behavior.

Demographic: Can the client accurately give information about address, telephone number, date of birth, etc.?

Physical Environment: Is the living area cluttered, unclean, with spoiled food around, or numerous animals not well cared for? Is there evidence of pests?

Appearance: Does the client have soiled clothing and poor hygiene?

Functional Status: Does the client have difficulty with physical/maintenance of activities of daily living (ADLs)? Does a once routine activity now seem too complex to the client? (This may indicate dementia.) Does the client start an activity and then stop in the middle of it? Does the client walk with unsteady gait, have trouble with balance, and appear awkward? Does the client have slowed movements; everything seems an effort, tired, weak? Any of these may indicate depression or the need for further evaluation.

IADLs: Does the client have diminished or absent ability to do instrumental ADLs?

Health Assessment: Does the client have somatic concerns: complain of headaches, dizziness, shortness of breath, heart racing, faintness, and stomach or bowel disturbances (May indicate depression)? Does the client have trouble falling asleep awakening early or awakens for periods in the middle of the night? This may also indicate depression or the need for further evaluation.

Medication: Is there inappropriate use or misuse of prescribed and/or over-the-counter medications?

Speech: Are there speech difficulties, slurring, word-finding problems, can't get ideas across? (May indicate dementia).

Fractures/Dislocations: Does the client have fractures/bruises and is hesitant to give the cause?

Nutrition: Does the client have problems with appetite--eating too much or too little? Does the client have an unhealthy diet?

Hospitalization/Alcohol Use: Does the client have problematic alcohol use?

Cognitive: Does the client appear confused, bewildered, confabulates answers, speaks irrelevantly or bizarrely to the topic? Is the client easily distracted, has poor concentration, responds inconsistently when questioned? Is the client aware of surroundings, time, place, and situation? Does the client misplace/lose personal possessions? (May or may not complain of this) Does the client have angry outbursts and agitation? Does the client have decreased recognition of family and familiar places?

Emotional/Social: Does the client appear sad, blue, or despondent? Have crying spells, complains of feeling sad or blue, speaks and moves slowly, suffers significant appetite and sleep habit changes, has vague/somatic complaints and complains of memory impairments without objective impairment? (May indicate depression) Does the client appear unusually excited or emotionally high? Show pressured, incessant and rapid speech? Brag, talk of unrealistic plans, and show a decreased need for food or sleep? (May indicate grandiosity, euphoria, mania) Does the client appear to be hallucinatory? Hear or see things that aren't there? Talk, mutter, or mumble to himself/herself? Giggle or smile for no apparent reason? (May indicate hallucinations) Does the client appear to be suspicious, feel that others are against him/her? Out to get him/her? Feel others are stealing from him/her? Feel he/she is being persecuted or discriminated against? Believe has special qualities/power? (May indicate delusions) Does client feel life is not worth living? Has she/he given up on self/ Does individual feel those who care about him/her have given up on him/her? Has the client ever considered ending his/her life? (May indicate suicidal thoughts, ideation, or gestures) Has the client ever considered harming someone? (May indicate homicidal ideation) Is the client fidgety, nervous, sweating, fearful, pacing, agitated, frightened, and panicky? (May indicate fearfulness, anxiety, or agitation) Inappropriate and disturbing (disruptive) behavior, particularly when it is more problematic for caretakers than the client (take note of how often the behavior occurs, when it began, and how much it currently upsets people in the immediate environment):

- Being suspicious and accusatory
- Verbally threatening to harm self or others
- Yelling out, screaming, cursing
- Taking others' things, hiding/hoarding possessions
- Being agitated, uncooperative and resistive with necessary daily routines
- Being a danger to self or others

- Exhibiting inappropriate sexual behavior
- Inappropriately voiding of urine or feces (voiding in non-bathroom locations)
- Being unaware of need to use bathroom or problems locating a bathroom
- Exhibiting intrusive or dangerous wandering (danger of getting lost, entering/damaging others' property, wandering into traffic)
- Exhibiting poor impulse control
- Exhibiting impaired judgment

Based on your assessment, if the client is currently exhibiting any of the following, a referral to the local CSB/BHA or other mental health professional should be considered:

Behavior	Thinking	Affective/Feelings
Aggressive/combative	Hallucinations	Helplessness
Destructive to self, others, or property	Delusions	Hopelessness
Withdrawn/social isolation	Disoriented	Feeling worthless
Belligerence/hostility	Seriously impaired judgment	Sadness
Anti-social behavior	Suicidal/homicidal thoughts, ideas, or gestures	Crying spells
Appetite disturbance	Cannot communicate basic needs	Depressed
Sleep disturbance	Unable to understand simple commands	Agitation
Problematic substance abuse	Suspicion/persecution	Anxiety
Sets fires	Memory loss	
	Grandiosity/euphoria	

If an individual is dangerous to self or others or is suicidal, an immediate call must be made to the local CSB/BHA or other mental health professional.

Substance Abuse: A referral to the CSB/BHA should be considered when:

- A client reports current drinking of more than 2 drinks of alcohol per day. Further exploration of the usage is suggested; or
- Any current use of non-prescription mood-altering substances (e.g., marijuana, amphetamines).

Intellectual Disability/Developmental Disability

Intellectual Disability:

Diagnosis if:

- The person's intellectual functioning is approximately 70 to 75 or below;
- There are related limitations in two or more applicable adaptive skills areas; and
- The age of onset is 18 or below.
- Use these questions or observations to assess undiagnosed but suspected ID:
 - Did you go to school?
 - What grade did you complete in school?
 - Did you have special education?
 - Does the individual have substantial functioning limitations in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work?

If a person meets the above definition of intellectual disability, a referral should be made to the local CSB/BHA.

Developmental Disability

Definition: A severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental or physical impairments;
- Is manifest before age 22;
- Is likely to continue indefinitely; and
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language; mobility; self-direction and capacity for independent living or economic self-sufficiency; or reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated.

Developmental disability includes, but is not limited to, severe disabilities attributable to autism, cerebral palsy, epilepsy, spinal bifida, and other neurological impairment where the above criteria are met. People who have mental health, intellectual disability, or substance abuse problems should be assisted to achieve the highest level of recovery, empowerment, and self-determination that is possible for them. In order to achieve this, applications to and residents of facilities such as assisted living facilities may need mental health, intellectual disability, or substance abuse services.

If a need for these services is identified, the client should be referred to the CSB/BHA, or other appropriate licensed provider that serves the locality in which the person resides. It is not necessary to make a diagnosis or to complete a clinical assessment to make a referral to a CSB/BHA/licensed provider, but it is important to describe the behavior and/or symptoms that are observed on the screening matrix.

SCREENING FOR MENTAL HEALTH/INTELLECTUAL DISABILITY/SUBSTANCE ABUSE NEEDS

Concerns/Symptoms/Behaviors	Refer to CSB/BHA or appropriate Licensed Provider for MH services	Refer to CSB/BHA or appropriate Licensed Provider for ID services	Refer to CSB/BHA or appropriate Licensed Provider for SA services	Refer 1 st to PCP for Medical Screening/ Services	Please record info. on most appropriate UAI sections noted below
1. Received a diagnosis of intellectual disability, originating before the age of 18 years, characterized by significant sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning (IW test) that is at least two standard deviations below the mean and significant limitations in adaptive behavior as expressed in conceptual, social, and practical skills.		X			#1- Demographic Info/Education #1-Current Formal Services #2-Functional Status-Comments #3-Diagnoses #5- Client Case Summary
2. Currently engaging in I.V. drug abuse and is willing to seek treatment.			X		#4-Drug Use #5-Client Case Summary
3. Currently pregnant and engaging in substance abuse to the degree that the health/welfare of the baby is seriously compromised, and is willing to seek treatment.			X		#4-Drug Use #5-Client Case Summary
4. Currently expressing thoughts about wanting to die or to harm self or others.	X Call immediately				#4-Emotional Status #5-Client Case Summary
5. Currently under the care of a psychiatrist and taking medications prescribed for serious mental health disorders (e.g. schizophrenia, bi-polarity, or major affective disorders.)	X				#1-Current Formal Services #3-Physical Health #4-Emotional Status #4-Hospitalization #5-Client
6. Past history of psychiatric treatment (outpatient and/or hospitalizations) for serious mental health disorders (e.g. schizophrenia, bipolarity, or major affective disorders.)	X				#4-Hospitalization #5-Client Case Summary
• Currently exhibiting the following behaviors that are not due to medical or organic causes:	X				#3-Sensory Functions

• Reports hearing voices, and/or talks to self, giggles/smiles at inappropriate times).					#4-Emotional Status #5-Client Case Summary
• Reports seeing thing that are not present.	X				#3-Sensory Functions #4-Emotional Status #5-Client Case Summary
• Inflicting harm on self by cutting, burning, etc.	X Call immediately				#4-Emotional Status #5-Client Case Summary
• Has difficulty staying physically immobile, insists on constantly moving physically within the environment, paces rapidly, and/or talks in a very rapid fashion, and may express grandiose and obsessive thoughts.	X				#3-Sensory Functions #4- Behavior Pattern #4-Emotional Status #5-Client Case Summary
• Confused, not oriented/aware of person, place, and time; may wander in or outside of facility/ home.				X	#4-Cognitive Functions #4-Behavior Pattern #5-Client Case Summary
• Significant mood changes occur rapidly within one day and are not related to the environment.	X				#4-Emotional Status #5-Client Case Summary
• Becomes easily upset and agitated, exhibits behaviors others find intimidating, threatening, or provocative, may destroy property, and may feel others will “hurt” them.	X				#4-Emotional Status #5-Client Case Summary
• Cries often, appears consistently sad, and exhibits very few other emotions.				X	#4-Emotional Status #5-Client Case Summary
• Has little appetite or energy, consistently sleeps more than 9-10 hours /day, or has problems sleeping, and has little interest in social activities.				X	#3-Nutrition #4-Emotional Status #4-Social Status #5-Client Case Summary

• Level of personal hygiene and grooming has significantly declined.				X	#3-Functional Status #5-Client Case Summary
7. Displaying behaviors that are considered very unusual in the general population and a medical exam has found no physical basis (i.e. Alzheimer’s Disease, brain injury, MR, etc.) Behaviors may include:	X				#5-Client Case Summary
• Eating non-food items	X				#5-Client Case Summary
• Voiding (urine and/or feces) in inappropriate places and/or inappropriately handling/disposing of these items.	X				#5-Client Case Summary
• Inappropriate sexual aggression or exploitation.	X				#5-Client Case Summary
• Combatively engaging in odd, ritualistic behaviors.	X				#5-Client Case Summary