Table of Contents

FORMS AND INSTRUCTIONS

110 - INTRODUCTION

This Appendix contains forms used in care coordination.

The forms are organized alphabetically by name. The form number follows the name of the form, as indicated on the Appendix 100 Table of Contents. Instructions for each form are placed immediately after the form.

When completing forms manually, use the following guidelines:

- Use ink.
- Correct entries by placing one line through the error and initialing. Do not use "white out", felt tip markers, or other materials to obliterate the error.
- Write legibly.
- Use standard medical abbreviations and symbols.

120 - FORMS REPRODUCTION

Area Agencies on Agency (AAAs) reproduce and use DHR CCSP forms as indicated in the Care Coordination Manual. AAAs reproduce forms from the original locally. AAAs request approval from the Division of Aging Services before changing the existing forms.

Division of Medical Assistance (DMA) forms are obtained from DMA, or the pharmacist.

NOTE: Providers are responsible for reproducing the CCNF found in the Provider Manual Index.

Georgia Department of Human Resources

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

- ☐ ninety (90) days unless I specify an earlier expiration date here: (Date)
- ☐ one (1) year.
- ☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or relationship to Individual)

(Signature of Parent or other legally Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

Form 5459 (Rev. 4-11-03) Previous versions are obsolete and should not be used.

Instructions
Community Care Services Program

AUTHORIZATION FOR RELEASE OF INFORMATION, FORM 5459

Purpose: This form is used to obtain permission from a CCSP applicant or client to share or secure information about the client.

Who Completes/When Completed: The care coordinator completes Form 5459 for information needed but not included on the Authorization For Release of Information and Informed Consent.

Instructions:
Explain the purpose of the form to the client, complete Form 5459 and ask the client to sign or indicate a witnessed mark **(X)**

1. Enter the name of the client/patient/applicant.

2. Enter the birth date of the client/patient/applicant.

3. Enter the ID number used by the requesting agency (if available)

4. Enter the ID number used by the releasing agency (if available)

5. Enter the name of the agency requesting information.

6. Enter the address of the agency requesting information.

7. Specify the information requested.

8. Specify the purpose of information requested.

9. Specify the duration of the authorization release (not to exceed one year)

10. Enter the date the client/patient/applicant signed the release.

11. Signature of the client/patient/applicant

12. Signature of witness, if client signs by mark (**X**)

13. Signature of parent or authorized representative if client/patient/applicant is incompetent/under age 18 or has a physical disability that prevents his signing.

Distribution: At each completion, place the original in the case record and send copies to each agency/person(s) holding information about the client.

Georgia Department of Human Resources
COMMUNITY CARE SERVICES PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION
&
INFORMED CONSENT

_____ 1. This is to certify that the Community Care Services Program is hereby authorized to release necessary information including medical data to the agencies which will provide services to me as outlined in the CCSP Comprehensive Care Plan.

_____ 2. This is to certify that I choose to participate in the Community Care Services Program.

_____ 3. This is to certify that I choose Nursing Home Placement.

_____ 4. Discharge plan discussed with client/representative.

_____ 5. This is to certify that I participated in determining which services will be provided to me through the Community Care Services Program as ordered in the Comprehensive Care Plan.

_____ 6. ALL OF THE MEDICAL, SOCIAL AND FINANCIAL INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

7. _____
SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE DATE

8. _____
SIGNATURE OF CCSP CARE COORDINATOR DATE

Instructions

Community Care Services Program

AUTHORIZATION FOR RELEASE OF INFORMATION & INFORMED CONSENT

Purpose: This form allows care coordinators to release necessary information including medical data to the agencies that will provide services to the client. It also serves as the client's acknowledgment of information received regarding the CCSP, and indicates whether the client chooses CCSP or Nursing Home Placement.

Who Completes/When Completed:

- At initial assessment, the RN completes the form.
- At reassessment, the care coordinator completes items 1, 4, and 5 and other applicable items.
- At CCP Review, the care coordinator completes item 5 and other applicable items.

Instructions:

1. Client initials in the space provided allowing the care coordinator to release necessary information to the agencies which will provide his/her services.

2. Client initials if he/she chooses to participate in the CCSP.

3. Client initials if he/she chooses Nursing Home Placement.

4. Client initials confirming that discharge plan(s) have been discussed with client/representative and care coordinator.

5. Client initials that he/she has received an opportunity to provide input in determining services which will be provided by CCSP as ordered in the CCP.

6. Client initials that all medical, social and financial information provided is true and complete to the best of their knowledge.

7. Client or representative signs and dates form.

8. Care coordinator signs and dates form.

Distribution: At initial assessment and reassessment, send a copy to providers. Place the original in the case record.

CARE COORDINATION COMPLAINT LOG

Date	Provider Name	Provider contact/#	Nature of Complaint: Health, safety, welfare issues, Abuse, neglect, exploitation, Missed visits, Staff not performing duties., Insufficent staff, Lack of RN Supervision , etc	Client	Caller	Care Coordinator	CC Intervention requests Plan of Correction	CC Comments	CC Accepts Plan of Correction

Instructions
Community Care Services Program

CARE COORDINATION COMPLAINT LOG

Purpose: Care coordinators are responsible for follow up on provider complaints. The log has been developed as a quality improvement tool to assess timely follow up and resolution of complaints. It also provides an opportunity for care coordinating agencies and AAAs to analyze the number and nature of complaints to determine possible trends.

Who completes/When completed:

Care coordinators enter information into the log in Microsoft Excel. The care coordination manager reviews logs monthly to assess for trends in complaints or providers.

Instructions:

1. Date: Enter the date the complaint was received.

2. Provider Name: Enter the name of the provider the complaint is being made against.

3. Provider Contact/#: Enter the name/phone number of the person contacted regarding the complaint.

4. Nature of Complaint: State briefly the details concerning the complaint..

5. Client Name: Enter client's name.

6. Caller: Enter name of person making complaint and relationship to client.

7. Care Coord: Enter the name of the assigned Care Coordinator.

8. CC Interventions: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Removed from Rotation Log per AAA Instructions, or you may specify another intervention in the space.

9. CC Comments: Enter information about follow up activities.

10. Referral: Enter referral(s) such as AAA, ORS, APS, OMB, DAS or you may specify another intervention in the space.

11. AAA Interventions: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Letter to DAS for clarification/issues, Removed Provider from Rotation Log, Address(ed) at Network Meeting or you may specify another intervention in the space.

12. AAA Comments: Enter information received from AAA.

13. Outcome/Date: Enter resolution and date.

Note: Record detailed information about follow up and interventions in case notes.

Distribution: Send a copy of the Care Coordination Complaint Log to the AAA monthly. Attach copy to monthly Programmatic report sent to DAS.

Rev. 8/02

Community Care Services Program

CARE COORDINATOR S PRIOR AUTHORIZATION REQUEST TRANSMITTAL (CCT)

The care coordinator completes this form and submits it with each prior authorization and prepayment request (DMA-80).

1. Name of client _____

2. Client Medicaid number _____

3. Date client entered service _____

4. Total cost to CCSP, in current calendar year to date _____

5. Projected cost to CCSP for balance of current calendar year _____

6. Total estimated cost to CCSP for current calendar year _____

7. Client cost share (if applicable) _____

8. Provider requesting PA ( ) PPR ( ) _____

9. Provider Number _____

10. Will client require additional PARs? Yes _____ No _____

    If "Yes", for how many months _____

11. Number of prior approvals _____ Number of prepayment reviews _____
    approved by the Division of Aging Services in current calendar year

12. Comments _____

_____

_____

Date _____ PSA _____

Care Coordinator _____ Telephone (_____) _____

rev. 12/99

Instructions
Community Care Services Program

CARE COORDINATOR S PRIOR AUTHORIZATION REQUEST TRANSMITTAL (CCT)

Purpose: This form calculates the actual cost of services rendered for the client's care through the date of the DMA-80 request and estimates cost of care for the remainder of the calendar year.

Who Completes/When Completed: The care coordinator completes this form to accompany each DMA-80 request and copy of pended SAF to the Division of Aging Services for approval.

Instructions:

1. Enter client's name (last name, first, middle initial).

2. Enter client's Medicaid number. (Be sure Medicaid number on DMA-80 is correct.)

3. Enter month, day and year client entered service.

4. Enter cost to CCSP program for client for the current calendar year, including amount of the DMA-80 request submitted with this transmittal.

5. Enter estimated cost to CCSP program for client for remainder of calendar year.

6. Enter total cost to date plus projected cost.

7. Enter amount of MAO client's cost share, even if amount is "O."

8. Indicate by (✓) if this PAR is a prior authorization or prepayment review request and indicate by name provider who is making request.

9. Enter provider ID number from DMA-80 form in Section 11.

10. Indicate (✓) A yes or A no.
If yes, enter number of months client is anticipated to exceed monthly cost cap.

11. Enter number of PARs, excluding DMA-80 being submitted with this transmittal, approved by the Division of Aging Services in this calendar year.

12. Comments: clarify information about client not stated or explained on DMA-80.

Care coordinator: Signature of care coordinator completing transmittal.

PSA/Care coordinator (CC): Enter planning and service area code and code assigned to care coordinator completing transmittal.

Date: Enter date transmittal was completed, signed by care coordinator and mailed.

Telephone number: Enter care coordinator's area code and telephone number.

Distribution: Send original with DMA-80 and pended SAF to Division of Aging Services for approval. File copy in client's case record

Case Notes

Date Range Selected
From: 7/21/2004 **To:** 7/21/2004

Jane Doe 001-00-0001

7/21/2004 Note By: Type Contact Telephone Time in Minutes: 5
TC

Ms. Doe called to inquire about her services start date.

Instructions

Community Care Services Program

CASE NOTES

Purpose: Case notes are used to record comprehensive notations about the client's entire process from beginning to end.

Who Completes/ When Completed: The care coordinator uses CHAT to record client activities on case notes in order of occurrence.

Instructions:

Description:	Enter a brief description of the notation. For example: Home Visit (HV), Office Visit (OV), Telephone (T), Written Correspondence (W), Community Care Notification Form (CCNF), Initial Assessment (IA), Reassessment (R), or Comprehensive Care Plan Review (Review).
Date:	Enter the date in the space directly below the description, clicking in that space will automatically enter today's date.
Care coordinator:	Enter the initials of the care coordinator who is entering the notation in the space to the right of the date.
Notation:	Enter as much detail as needed about the current event/action.

Information on this form is NOT shared with other agencies and can only be obtained with a subpoena.

CCSP Care Coordination ADH checklist

Client _____ **Date** _____ **CC Coordinator**_____

Name of ADH _____ ☐ **Level 1** ☐ **Level 2**

1. <u>Physical Environment</u> (1103.1)

a. ☐Yes☐No Environment clean, odor free?
b. ☐Yes☐No Lighting is adequate for client?
c. ☐Yes☐No Temperature is comfortable for client?
d. ☐Yes☐No Environment accessible to client?
e. ☐Yes☐No System in place to monitor client's whereabouts?

f. Comments_____

2. <u>Supervision of client care</u> (1103.5)

a. ☐Yes ☐No RN supervisory visit completed <u>monthly</u>?
b. ☐Yes ☐No ☐N/A Client changes/problems documented with appropriate follow up?
c. ☐Yes ☐No ☐N/A Documentation of other services being rendered?
d. ☐Yes ☐No Documentation of client participation in therapeutic activities?
e. ☐Yes ☐No Client satisfied with services/activities provided?

f.Comments_____

3. Documentation of <u>medications</u> (1103.4)

a. ☐Yes ☐No Prescription label matches medication sheet?
b. ☐Yes ☐No Med sheets signed by RN supervising medication administration?
c. ☐Yes ☐No ☐N/A Documentation of missed medications, reason and corrective action?
d. ☐Yes ☐No Client medications under lock and key?

e.Comments_____

4. <u>Staffing</u> (1104.2)

a. ☐Yes ☐No RN or LPN on site when CC visit made?
b. ☐Yes ☐No RN available if not present during visit?
c. ____ # staff present during visit d. ____ # participants present during visit

e. Comments_____

5. <u>Other Service Providers</u> (1103.6)

a. ☐Yes ☐No Documentation of evaluation, re-evaluations and progress notes in client record?

b. Comments_____

6. <u>Client condition</u>

a. ☐Yes ☐No Client and clothing clean?
b. ☐Yes ☐No Client condition matched documentation in RN supervisory note?

c. Comments_____

Instructions
Community Care Services Program

CARE COORDINATOR CHECKLIST FOR ADH

Purpose: This form is used as a checklist to assess the facility and client care in ADH.

Who Completes/When Completed: The care coordinator completes annually at the time of CCP review or reassessment.

Instructions:

1. Physical Environment
    a. Indicate if environment is clean and well-maintained.

    b. Indicate if lighting is adequate for reading and client activities.

    c. Indicate if temperature is appropriate for client (70-75 degrees F. during winter months and 80-85 degrees F during summer months)

    d. Indicate if environment accommodates client's mobility, transfer, and handicapped access if required.

    e. Specify if a system is in place to monitor client's whereabouts when outdoors or away from site with family or friends.

    NOTE: Monitoring may include sign out book, door alarm, observation by staff, or other.

    f. Use this section to clarify any of the above.

2. Supervision
    a. Specify if supervisory visits are within the standard.

    b. Indicate whether medical, mental, emotional or behavioral changes have been identified and follow up in the clinical record.

    c. Indicate if documentation of other services client may be receiving.

    NOTE: This may include skilled nursing, therapy services such as PT, OT, ST, hospice, or other.

    d. Indicate if client participates in the therapeutic activities as identified on provider care plan.

    e. Enter client's response regarding satisfaction with services.

    f. Use this section to clarify any of the above.

3. Medications
    a. Specify client name, medication, dosage and frequency on medication package/bottle label matches client medication sheet.

    b. Note if client medication sheets are signed by RN.

    c. Indicate if medication sheets show documentation of any missed medications and action taken by staff.

    d. Indicate if client's medications are under lock and key.

    e. Use this section to clarify any of the above.

4. Staffing
    a. Specify if the RN or LPN was present during visit.

    b. Determine if RN is available off site if not present during visit.

    c. Enter number of staff present.

    d. Enter total number of participants present.

    e. Use this section to clarify any of the above.

5. Other Service Providers
    a. Determine if other provider(s) documentation is in the client record regarding evaluation, progress notes, re-evaluation, discharge plan, or other.

    b. Use this section to clarify above.

6. Client Condition
    a. Indicate if client and clothing are clean.

    b. Indicate if documentation in clinical record accurately reflects client's current status.

    c. Use this section to clarify any of above

NOTE: Discuss concerns about client care and/or physical environment with Lead Care Coordinator and/or report to DAS/CCSP Care Coordination Specialist and Provider Specialist assigned to your area. If you have answered **no** to any of the checklist question, document action taken in case notes.

Reference: CCSP General Manual
ADH Provider Manual
Distribution: File original in care coordination agency's client record and copy to binder under specific provider.

CCSP Care Coordination ALS checklist

Client _____ Date _____ Care Coordinator_____

Name of ALS _____ Type ___Family ___Group

Name of Provider Agency if Family Model_____

1. <u>General Information</u>

a. ☐Yes ☐No Provider license is posted and current for _____# clients
b. Total # clients living at ALS _____
c. _____#CCSP clients
_____ # staff present at time of CC visit _____
e. Staff job title_____
f.Comments_____

2. The <u>facility</u> provides a safe, clean homelike environment for its residents (1203.2)

a. ☐Yes ☐No Building/client room temperature comfortable? *(no lower than 70º or higher than 75º in winter; 80º or below in summer)*
b. ☐Yes ☐No Lighting in facility/client room adequate
c. ☐Yes ☐No Client's room is neat, clean, odor-free and in good repair?
d. ☐Yes ☐No Environment accessible for client?
e. ☐Yes ☐No Furnishings are in good repair?
f. ☐Yes ☐No ☐N/A Client's assistive device(s) available and in good repair?
g. ☐Yes ☐No Facility has system to monitor client's whereabouts?

h.Comments_____

3. <u>Supervision of client care</u> (1203.4 group ALS/1253.6 family model ALS) Documentation of face-to- face RN supervisory visit 2 times per month with a minimum of 14 days between visits (can alternate RN with every other LPN supervisory visit).

a. ☐Yes ☐No ☐N/A Supervisory visits completed 2 times each month with 14 days between?
b. ☐Yes ☐No ☐N/A Client changes/problems documented with appropriate follow up?
c. ☐Yes ☐No ☐N/A Documentation of any additional services being rendered?
d. ☐Yes ☐No Client satisfied with assistance provided by ALS staff?

e. Comment_____

4. Documentation of <u>medications</u> (1203.7 C Group ALS/1253.9 C Family Model ALS)

Client record shows:
a. ☐Yes ☐No Client name and medication on prescription label matches medication sheet?
b. ☐Yes ☐No Med sheets signed by RN supervising medication administration?

c. ☐Yes ☐No ☐N/A Documentation of missed medications, reason and corrective action?

d. ☐Yes ☐No Medications are under lock and key?

e. Comments_____

5. <u>Client condition</u>

a. ☐Yes ☐No Client and clothing clean?

b. ☐Yes ☐No Client condition matches documentation in progress notes?

c.Comments_____

6. <u>Client Incident reports</u>

a. ☐Yes ☐No ☐N/A Any incident reports since last CC visit? #/date of incident reports?

_____

b.☐Yes ☐No Documentation for each incident and action taken in client record?

c. CC identification of patterns or trends in review of all incident reports?

☐ Time of day ☐ Place ☐ Caregiver ☐ Cause _____

Comments:_____

d. CC action plan to reduce/prevent client injury:

☐ See Service Evaluation ☐ See Case Notes

☐ Other_____

Instructions

Community Care Services Program

CARE COORDINATOR CHECKLIST FOR ALS

Purpose: This form is used as a checklist to assess the facility and client care in ALS.

Who Completes/When Completed: The care coordinator completes at each CCP review and reassessment.

Instructions:

1. General Information

   Check appropriate box after reviewing provider license.

   Enter number of clients living in home.

   Enter how many of the clients are CCSP clients.

   Enter number of staff present.

   Enter job title of staff present. Trained direct care staff must be present.

   Use comment section to clarify any of the above.

2. Facility
   a. Indicate if appropriate temperature in common areas and client room.

      NOTE: PCH rules and regulations require residential areas to be no lower than 70 degrees F. or higher than 75 degrees F. in winter months during waking hours and no higher than 80 degrees F. in summer months. Mechanical heating or cooling devices are required to maintain these temperatures.

   b. Indicate if lighting is sufficient for reading and other activities (60 watt minimum).

   c. Indicate if client room is appropriately maintained and furnished.

   d. Specify if environment accommodates client's mobility, transfer and handicapped access if required.

   e. Indicate if furnishings throughout the common areas and client's room are in good repair.

   f. Indicate if client's assistive device is readily available and in safe condition.

g. Indicate if appropriate system(s) in place to monitor client's whereabouts 24/7 including supervision of clients who are cognitively impaired.

NOTE: This may include a sign out book, door alarms, personal monitoring systems such as Wandergard or Watchmate used to monitor client when outside building or away from facility with family or friends. If the client has cognitive impairment, document the monitoring system in place to prevent elopement or entry into unsafe areas.

h. Use comment section to clarify any of the above.

3. Supervision
   a. Specify if supervisory visits are within the standard (twice monthly with a minimum of 14 days between visits).

      NOTE: The provider is not required to provide RN supervisory visits for a CCSP client enrolled in a Medicare/Medicaid hospice program.

   b. Indicate whether medical, mental, emotional or behavioral changes have been identified and follow up in the clinical record.

   c. Indicate provider documentation of other services client may be receiving. This may include skilled nursing, therapy services such as PT, OT, ST, hospice or other services.

   d. Enter client's response regarding satisfaction with services.

   e. Use comment section to clarify any of the above.

4. Medications
   a. Specify if client name, medication, dosage and frequency on medication package/bottle label matches client medication sheet.

   b. Note if client medication sheets are signed by RN.

   c. Indicate if medication sheets note any missed medications and action taken by staff.

   d. Indicate if client's medications were under lock and key.

   e. Use comment section to clarify any of the above.

5. Client Condition
   a. Indicate client and clothing are clean.

   b. Indicate documentation in clinical record accurately reflects client's current status.

c. Use comment section to clarify any of above.

6. Incident reports

a. Review clinical record for documentation of any incidents (falls, injuries, elopement, other).

b. Review clinical record for staff follow up for each incident.

c. Identify any pattern or trend that may lead to corrective action by staff.

EXAMPLE: Incident reports indicate client has fallen three times in bathroom during night. Corrective actions might include: leave light on in bathroom at night, leave bathroom door open at night, use of alarm system at night to advise staff that client is out of bed, or every 4 hour toileting schedule at night.

d. Indicate location of care coordinator documentation of plan to reduce or prevent client incidents/injury.

NOTE: Discuss concerns about client care and/or physical environment with Lead Care Coordinator and/or report to DAS/CCSP Care Coordination Specialist and Provider Specialist assigned to your area. If you have answered **no** to any of the checklist questions, document action taken in case notes.

Reference: Rules and Regulations for Personal Care Homes, Chapter 290-5-35
CCSP General Manual
ALS Provider Manual

Distribution: File original in care coordination agency's client record and copy to binder under specific provider.

Community Care Services Program

CLIENT REFERRAL FORM

1. Date of referral _____

2. Referral source_____ Telephone (____)_____

3. Is client aware of CCSP referral? Yes _____ No _____

4. Has client indicated an interest in receiving CCSP services? Yes_____ No_____

5. Is client interested in other resources if CCSP is not appropriate or available?
   Yes_____ No _____

6. Client's name_____Telephone (____)_____
   Address _____
   Street, Route, Apt. # _____ City _____ Zip _____ County _____
   Date of birth _____ Age _____Marital Status _____
   Lives alone Yes _____ No _____Monthly income _____
   Social Security # _____Medicaid # _____
   Medicare # _____

7. Contact person_____Relationship _____
   Address _____ Telephone (____)_____

8. Physician _____ Telephone (____)_____
   Address _____

9. Major health problems _____
   _____

10. What is needed from CCSP?_____
    _____

11. Is client now receiving services from other sources? Yes _____ No _____

    If Yes, what are the services? _____
    _____

    From what agencies?_____
    _____

12. Directions to client's house_____
    _____
    _____

Instructions
Community Care Services Program

CLIENT REFERRAL FORM

Purpose: To provide information to the AAA/Care Coordination Intake and Referral Unit to assure that an eligible applicant for CCSP receives CCSP and/or other appropriate services as quickly as possible. This form is a sample form for use by agencies or individuals to use when making referrals to the CCSP.

Who Completes/When Completed: An individual or agency outside CCSP, such as the client/client representative or a provider when referring an individual to the CCSP.

Instructions:

1. Enter the date the form is completed and mailed or faxed by an outside person to the AAA/care coordination unit.

2. Enter the name of the agency and person making the referral. That agency contact person's telephone number is listed in case further information is needed.

3. Check (✓) the appropriate space if individual is not aware of being referred.

4. Check (✓) the appropriate space to indicate whether or not individual is interested in receiving CCSP services.

5. Check (✓) the appropriate space if individual is/is not interested in being referred to other services if CCSP is not appropriate or available.

6. Enter individual information, providing data which assists the AAA/care coordination staff in their efforts to contact and get the individual into service.

7. Identify the contact person for the individual being referred. The AAA/care coordination staff may need the name, address, telephone number, and relationship in order to get or verify information or to set up an appointment for a visit.

8. Enter the name, address, telephone number, including area code, of the individual's physician.

9. Document the individual's major health problems.

10. Record what the individual says is wanted or needed from CCSP or other appropriate services.

11. To prevent duplication of effort and to make sure the appropriate individuals get into CCSP, or receive other appropriate services, identify current services and who is providing services.

12. The care coordination unit will need accurate directions to the individual's home in order to complete the assessment.

Distribution: The Client Referral Form is sent to the AAA/care coordination Intake and Referral Unit.

Community Care Services Program

CLIENT REFERRAL FORM - HOME DELIVERED MEALS

Date _____

SSN:_____

Client Name_____
Client Address_____
_____
_____

Meal Delivery Instructions

Number per day M__T__W__T__F__S__S__
Days per week M T W T F S S
(Please circle specific days for meals)

Type of Meal: __Regular ___Modified ___ Special ___Alternative(explain)

__ADA (how many calories)_____

Nutrition Education and Counseling Needs:
_____
_____
_____
_____
_____

Special Instructions/Notations:
_____
_____
_____
_____
_____

Comments:
_____
_____
_____

Care Coordinator: _____

Telephone: (_____)_____

Instructions
Community Care Service Program

CLIENT REFERRAL FORM- HOME DELIVERED MEALS

Purpose: The Client Referral Form is used to initiate Home Delivered Meals (HDMs) from the home delivered meals provider on behalf of the CCSP client. The form contains information needed by the HDMs provider regarding the client's condition, dietary needs and specific instructions.

Who Completes/When Completed: The care coordinator completes this form when:

- ordering HDM service and
- reporting changes.

Instructions:

Enter the clients name, social security number and the date of the referral.

Indicate the number of meals ordered per day.

Circle the specific days of the week that the meals are to be delivered.

Indicate the type of meal required by the client. Therapeutic meals must have physician's orders on the LOC page.

Indicate any nutrition education and counseling needs of the client.

Indicate any special instructions/notations such as limitations which might impact the delivery of the meal. For example the client has arthritis and is slow to answer the door, or client is very hard of hearing- KNOCK LOUDLY.

Indicate any other additional comments that may be helpful to the provider, such as instructions to the home etc.

Enter name and phone number of the care coordinator.

Distribution: The care coordinator completes this form and sends it to the home delivered meals provider. A copy of the form is kept in the client's case record.

Program: _____

CCSP Client Registration Report for AIMS

☐ New Assessment ☐ Reassessment

Basic Information:

1.SSN 1-00-0001

2a.Last Name: Doe 2b.Suffix: _____ 2c. First Name: Jane 2d.Middle Name: _____

3a. Residential Address: _____ 3b. Additional Address Information: _____

3c. City: _____ 3d. State: GA 3e. Zipcode: _____

4. Mailing Address: ☐ Uncheck if Mailing Address is Different

4a.Mailing Address: _____ 4b. Additional Address Information: _____

4c.City: _____ 4d. State: GA 4e. Zipcode: _____

5.Medicaid #: _____ 6.Medicare #: _____ 7.County: _____

8.Gender: ☐ Male ☐ Female 9.Phone #: _____ 10.DOB: _____

11.Marital Status
- ☐ Divorced
- ☐ Married
- ☐ Never Married
- ☐ Other: _____
- ☐ Separated
- ☑ Unknown
- ☐ Widow/Widower

12.Race/Ethnicity
- ☐ Asian/Pacific Islander
- ☐ Black (not Hispanic)
- ☐ Hispanic
- ☐ Other: _____
- ☐ Native American
- ☑ Unknown
- ☐ White (not Hispanic)

13.Living Arrangement
- ☐ Alone
- ☐ Group Setting with Non-Relatives
- ☐ Transient/Homeless
- ☐ With Child
- ☐ With Domestic Partner
- ☐ With Others Not Spouse/Child
- ☐ With Spouse Only
- ☐ With Spouse and Others
- ☐ Unknown

14.Language Spoken:
- ☐ African Generic
- ☐ Chinese
- ☐ English
- ☐ Farsi
- ☐ French
- ☐ German
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Laotian
- ☐ Other: _____
- ☐ Norwegian
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese

15.Education Level:
- ☐ 1 - Completed 8th grade or less
- ☐ 2 - Completed 9th-11th grade
- ☐ 3 - Completed 12th grade
- ☐ 4 - 1 - 3 years college
- ☐ 5 - 4 years college
- ☐ 6 - over 4 years college
- ☐ Unknown

16.Number in household: 0 17.Gross Annual Income $: _____ 18. Economic Need Category _____

19. ☐ Veteran

20. ☐ Disability

21.Referred by:
- ☐ Area Agency on Aging
- ☐ DFCS
- ☐ Family Member
- ☐ Friend
- ☐ Home Health Agency
- ☐ Hospital/Health Care Facility
- ☐ Other Client
- ☐ Other Health Professional
- ☐ Other Service Professional
- ☐ Primary Caregiver
- ☐ Primary Care Physician
- ☐ Self
- ☐ Social Security Office

23.How did you hear about us?:
- ☐ Brochure
- ☐ Educational Session
- ☐ Health Fair
- ☐ Internet
- ☐ Medicare Publication
- ☐ Newspaper/Magazine
- ☐ Other
- ☐ Radio/T.V.
- ☐ Social Security

22.Referral Date: _____

24. Care Coordinator _____

Version 3.04 = Minimum Required Data Entr

Additional Information:

1. Data Entry Initials: _____
2. Date: _____
3. Provider: _____
4. Provider Site: _____

Program: _____

CCSP Client Registration Report for AIMS

☐ New Assessment ☐ Reassessment

Client Assessment Information:

1. Assessment Date: 1/23/2004

2. Program:
- ☐ AoA Demo Grant
- ☑ CCSP
- ☐ Caregiver
- ☐ HCBS

3. Type of Assessment:
- ☐ 6 Month Followup Assessment
- ☐ Initial Assessment
- ☐ Reassessment
- ☐ Other
- ☐ Prior to discharge
- ☐ Return from Hosital

4. Assessed By: _____

5. Diagnosis:

Congestive Heart Failure 428 Dementia other than Alzheimer's disease 294.8 Arthritis 716.9

Thyroid disease (hyper or hypo) 246.9

6.Number of Prescribed Medications _____

7. Over the Counter Medications _____

Nutritional Status

8. NSI Checklist Score (0-21): _____

9. ☐ Nutrition Level 1 Screening Done:

10.Medical Foods:
- ☐ Do Not Know
- ☐ Not Needed
- ☐ Theraputic Diet
- ☐ Modified Diet
- ☐ Supplement

DON-R/Functional Assessment

NAPIS Report

11.Total A: _____ 12.Total B: _____ 13.Total C: _____ 14.Total D: _____ 15.Total No. ADLs: _____ 16.Total No. IADLs: _____

Scores

17. MMSE: _____

18. LOC Date: _____

19.Eligibility Type:
- ☐ MAO
- ☐ PMAO
- ☐ Other
- ☐ SSI

20. Advanced Assessment:
- ☐ Caregiver Assessment
- ☐ Depression Assessment

Version 3.04 = Minimum Required Data Entr

Jane Doe

Additional Information:

1. Data Entry Initials: _____
2. Date: _____
3. Provider: _____
4. Provider Site: _____

Instructions
Community Care Services Program

CLIENT REGISTRATION REPORT FOR AIMS

Purpose: The Client Registration Report for AIMS provides the mandatory information for entering client data in AIMS.

Who Completes/When Completed: The care coordinator/CHAT completes the fields listed below for client registration in AIMS. Only highlighted fields are needed for AIMS registration. The care coordinator registers the client after brokering services. Care coordinators register clients in AIMS within 3 business days of brokering services to CCSP.

Instructions:

Complete only the numbered items below to enter AIMS data.

1. SSN: CHAT automatically enters the data in this field based on data entered in other fields.

2. Name: CHAT automatically enters the data in this field.

3. Residential address: CHAT automatically enters the data in this field.

4. Mailing address: The care coordinator writes the mailing address. If the address is the same as the residential address, write the word "same as residential" on the line.

5. Medicaid #: CHAT automatically enters the data in this field.

7. County: CHAT automatically enters the data in this field.

8. Gender: CHAT automatically enters the data in this field.

9. Phone: CHAT automatically enters the data in this field.

10. DOB: CHAT automatically enters the data in this field.

11. Marital Status: CHAT automatically enters this data into field.

12. Race/Ethnicity: CHAT automatically enters the data in this field.

13. Care Coordinator: CHAT automatically enters the data in this field.

14. Assessment/LOC date: The care coordinator writes the initial LOC date in this field. The care coordinator updates the LOC date at every reassessment.

15. The care coordinator writes the primary diagnoses as indicated on the LOC page.

16. The care coordinator writes the secondary diagnoses as indicated on the LOC page.

17. The care coordinator writes the tertiary diagnoses as indicated on the LOC page.

18. NSI checklist score (pre-services): The care coordinator writes the NSI score from the screening completed at initial assessment.

    NOTE: If the care coordinator completes the NSI for an active client, enter the reassessment score as the initial score.

19. Eligibility type: CHAT automatically enters the data in this field.

20. The care coordinator writes the number obtained from DON-R completed at assessment.

21. The care coordinator writes the number obtained from DON-R completed at assessment.

22. Begin date: The care coordinator completes this field. Enter date from CCNF that client received first CCSP waivered service reimbursed by Medicaid.

23. Initial Services Begin Date: Same as #80.

24. End Date: The care coordinator completes this field. The last date on which the service was provided.

25. Eligibility Disposition Code: The care coordinator completes this field. The reason the case was closed.

26. Data entry initials and date: The person entering the data into AIMS initials and dates the form and returns it to the care coordinator.

Distribution: The form is returned to the care coordinator to be filed in the client's record when data entry is completed.

Community Care Services Program

CLIENT RIGHTS AND RESPONSIBILITIES

As a client, you have the following *rights*:

To be treated with respect and maintain one's dignity and individuality.

To be free of any discrimination because of race, creed, color, religion, national origin, or handicap.

To voice grievances and complaints regarding treatment or care that is furnished or fails to be furnished, without fear of retaliation, discrimination, coercion, or reprisal.

To a choice of approved service provider(s).

To accept or refuse services.

To be informed of your service plan and the right to participate in the planning.

To be advised in advance of the provider(s) that will furnish care and the frequency of visits ordered.

To be promptly and fully informed of any changes in the services plan.

To be informed of any charges and/or cost of services rendered.

To confidential treatment of all information, including information in your record.

To receive services in accordance with the current care plan.

To expect to be notified by the provider agency(s) of any temporary changes in the service plan.

To have your property and residence treated with respect.

As a client, you have the following *responsibilities:*

To notify service provider(s) of temporary changes in your care needs.

To treat provider staff in a courteous and respectful manner, including not discriminating because of race, creed, color, religion, national origin, or handicap.

To be as accurate as possible when providing information on your health history and personal care needs.

To actively participant in decisions regarding your health care.

To follow your physician's advice and instructions.

To notify your physician, service provider(s), or care giver if you notice a change in your condition.

To cooperate with and respect the rights of the care givers providing services.

To maintain a safe home environment.

To inform provider(s) of safety hazard(s) in the home.

I acknowledge that I have reviewed this information and I understand my rights and responsibilities as a client.

_____	_____
Client/Client Representative Signature	Date

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Instructions
Community Care Services Program

CLIENT RIGHTS AND RESPONSIBILITIES

Purpose: This form is used to inform clients of their rights and responsibilities as participants in the CCSP.

Who Completes/When Completed: During the initial assessment, the care coordinators gives this form to new participants in the CCSP.

1. Client reads or has someone read the contents of this form.
2. A signature or witnessed mark (X) indicates that client and/or representatives understands the rights and responsibilities of CCSP participation.

Distribution: The original is given to the client at initial assessment and a copy is filed in the client's case record.

Community Care Services Program

CLIENT TRANSFER FORM

1. Client name _____
   (Last, First, M.I.)
2. Social Security number _____
3. Medicaid number _____
4. Client transfer from:
   PSA _____

   County _____

   Care coordinator / Contact person _____

   Telephone (___) _____

   Last service day _____

   Client's previous address _____

   City _____ State _____ Zip _____
5. Client transfer to:

   PSA _____

   County _____

   Care coordinator/Contact person _____

   Telephone _____

   Client's new address _____

   City _____ State _____ Zip _____

   Telephone (_____) _____

Instructions
Community Care Services Program

CLIENT TRANSFER OUT OF PSA

Purpose: The client transfer form is used to transfer case records from one PSA to another.

Who Completes/When Completed: The care coordinator completes the client transfer form. It accompanies the original case record to the receiving PSA.

Instructions:

1. Enter client's name (last name, first, and middle initial).

2. Enter client's social security number.

3. Enter client's Medicaid number.

4. Enter PSA and county client is transferring from.

   - Enter the name, area code, and telephone number of the care coordinator/contact person transferring the case record.

   - Enter client's last date of service.

   - Enter client's prior address.

5. Enter PSA and county client is transferring to.

   - Enter the name, area code, and telephone number of the care coordinator/contact person receiving the case record. If the new care coordinator's name is not known default to care coordinator unassigned.

   - Enter client's new address.

Distribution: The original Client Transfer Out of PSA accompanies the original client case record to the receiving PSA. A copy is filed in the duplicate case record maintained at the transferring PSA.

NOTE: This form or a copy of this form is used by the care coordinator or data entry to update AIMS.

Georgia Department of Human Services Resources
COMMUNITY CARE COMMUNICATOR

CLIENT NAME	COUNTY	PSA NUMBER
ADDRESS (STREET AND NUMBER)	SOCIAL SECURITY NUMBER	MEDICAID NUMBER
CITY STATE ZIP CODE	DATE OF BIRTH	TELEPHONE NUMBER

SECTION I COMPLETED BY CARE COORDINATOR:

I. The client has elected to accept Community Care Services Program: Case Management began effective _____ and the client was placed in service effective _____.

- ☐ **The client is currently receiving MAO. Please calculate cost share.**
- ☐ **The client has been referred for eligibility determination and cost share.**
- ☐ **The client will require a home visit for application (Reason in Remarks).**

Signature_____ Telephone No._____ Date_____

SECTION II COMPLETED BY DFCS MEDICAID WORKER:

II. ☐ **The date client applied for MAO _____**

- ☐ **The client has been determined Medicaid eligible effective _____.**
- ☐ **The client is receiving Community Care Program Services and is responsible for contributing toward the cost.**
- ☐ **The client has a change in cost share.**

$ _____ EFFECTIVE _____ $ _____EFFECTIVE _____ $ _____EFFECTIVE _____

☐ **The client has been determined ineligible, effective _____ (Reason in Remarks).**

Signature _____ Telephone No. _____ Date _____

SECTION III COMPLETED BY CARE COORDINATOR:

III. The above named client is being released from the Community Care Services Program effective _____. for the following reason:

- ☐ **Client deceased; Date of Death _____**
- ☐ **Condition has improved; services no longer needed.**
- ☐ **Condition has worsened; entering a nursing home. Name, if known_____**
- ☐ **Other _____**

Signature _____ Telephone No. _____ Date _____

SECTION IV COMPLETED BY CARE COORDINATOR or DFCS MEDICAID WORKER:

REMARKS: _____

Instructions
Community Care Services Program

COMMUNITY CARE COMMUNICATOR (CCC)

Purpose: The Community Care Communicator (CCC) provides information about clients entering the CCSP. The CCC is the primary line of communication between the DFCS MAO caseworker, care coordinator, and nursing home.

Who Completes/When Completed: DFCS and care coordinators use the CCC to share eligibility information and other changes in a client's situation, such as ineligibility, death, nursing home placement.

Instructions:

Enter the client's full name, complete address, county, social security number, date of birth, PSA number, Medicaid number, if known, telephone number (including area code), and the name, address and telephone number of any client representative.

Section I: Care coordinator completes all required information for MAO clients requesting cost share determination and potential MAO clients applying for Medicaid benefits and determination of cost share. Care coordinator forwards information to DFCS with a copy of the Level of Care (LOC) page and PMAO worksheet. Care coordinator indicates date care coordination began/case management, date client was placed in service, checks appropriate box identifying reason for referral to DFCS, signs and dates form. Care coordination/case management begins the day the care coordinator admits the client to CCSP/brokers service. The service date is the day the client receives the first waivered service. Care coordinator's telephone number, including area code, is written after signature.

Section II: DFCS Medicaid caseworker, upon receipt of CCC, begins the Medicaid eligibility process. Medicaid caseworker lists Medicaid number, completes Section III, and returns one copy of CCC or sends a computer-generated notice to the care coordinator. Medicaid caseworker notifies care coordinator of any changes affecting the recipient's eligibility or cost share liability. Medicaid caseworker signs and dates form.

Section III: Care coordinator notifies DFCS caseworker of changes in client's situation, including: change of address, change in financial circumstances, if client no longer receives a waivered service, or if client is terminated from CCSP.

Section IV: Care coordinator and DFCS caseworker use this section for additional comments such as directions to client home; name, address and telephone number, including area code, of client representative; client physical condition; reason client requires home visit by Medicaid caseworker and reason for eligibility termination.

Distribution: Care coordinator sends original of CCC to Medicaid caseworker and retains a copy. Medicaid caseworker returns original with appropriate information or sends a computer-generated notice to care coordinator.

COMMUNITY CARE LEAD AGENCY
PROGRAMMATIC REPORT

PSA # _____ **DATE** _____ **MONTH** _____ **YEAR** _____

CONTRACTOR'S NAME (Lead Agency) _____

I. SCREENING INFORMATION

A. NUMBER OF UNSCREENED REFERRALS (Enter Manually)

1. Number of unscreened referrals carried over from previous months _____

2. Number of unscreened referrals received this month _____

3. Subtotal (I.A.1 + I.A.2) _____

B. NUMBER OF PENDED TELEPHONE SCREENS NEEDING ADDITIONAL INFORMATION _____

C. REFERRAL SOURCES FOR COMPLETED TELEPHONE SCREENS (INCLUDING SCREENED OUT REFERRALS):

1. Self _____
2. Family/Friend _____
3. Hospital _____
4. M.D. _____
5. DFCS _____
6. Nursing Facility (NF) _____
7. CCSP Provider (Exclude CCSP HDS) _____
8. Home Health Agencies (Include CCSP HDS) _____
9. Other _____
10. **TOTAL** (Add I.C.1 thru I.C.9) = _____

Form M-CCSP, Rev.3/00

PSA #_____ DATE _____ MONTH _____ YEAR _____

D. TELEPHONE SCREENINGS AND WAITING LIST

1. Screens on Waiting List Carried Over from Previous Month _____

2. New Telephone Screenings Completed this Month

a. Appropriate for CCSP- Add to Waiting List for Full Assessment + _____
b. Inappropriate for CCSP:
1. Needs, Services, Medical Problems Inappropriate + _____
2. Needs, Medical Problems too Great + _____
3. Financially Ineligible + _____
4. Refused Cost Share + _____
5. Refused Services + _____
6. Other Placement or Services + _____
7. Insufficient Information + _____
8. Other + _____
9. Total Inappropriate = _____

3. Total New Telephone Screenings Completed During Month
(I. D2a)+(I. D2b.9) = _____

4. Sub Total: Waiting for Full Assessment (I. D1) + (I. D2a) = _____

5. Waiting List Disposition:

a. Referred for CCSP Assessment _____
b. No longer appropriate for Waiting List:
1. Entered NF _____
2. Deceased _____
3. Needs, Services, Medical Problems Inappropriate _____
4. Needs, Medical Problems too Great _____
5. Financially Ineligible _____
6. Refused Cost Share _____
7. Refused Services _____
8. Other Placement or Services _____
9. Unable to Contact _____
10. Other _____
11. Total of b (5b1 through 5 b 10) = _____
c. Total Removed from Waiting List (5a +5b 11) _____

6. Telephone Screenings on Waiting List carried Over (I.D.4.-I.D5c.) = _____

PSA #_____ DATE _____ MONTH _____ YEAR _____

II. ASSESSMENT/REASSESSMENT INFORMATION

A. NUMBER OF REFERRED SCREENS NOT ASSESSED

1. Deceased	
2. Hospitalized	
3. Entered Nursing Facility	
4. Refused Services	
5. Refused Cost Share	
6. Unable to Contact	
7. Other	
8. Total Not Assessed	

B. ASSESSMENTS

1. Initial Assessments Performed	
2. Number of Completed Initial Assessments:	
a. 48 hours emergency assessments only	
b. 1-7 Days	
c. 8-14 Days	
d. 15-21 Days	
e. 22+ Days	
f. **TOTAL** (Add II.B.2a thru II.B.2e)	
3. Initial Assessments Pending	
4. Disposition of Completed Initial Assessments (same as II.B.2f):	
a. Recommended for CCSP	
b. Not Recommended for CCSP:	
1. Financially Ineligible	
2. Requires Immediate Institutional Care Without Further Assessment	
3. Failure to Meet Level of Care Requirements	
4. Needs, Medical Problems too Great	
5. Chooses NF Placement Due to Unavailable Alternatives	
6. Refuses Cost Share	
7. Refuses Services	
8. Other Placement or Services	
9. Other	=
10.Total not recommended (Add II B.4 b1 thru II B.4b9)	

c. **TOTAL COMPLETED ASSESSMENTS** (II.B.4a.) + (II.B.4b.10.) (same as II.B.2f)

5. Medicaid Status of Initial Assessments Performed:

a. SSI Eligible		
b. MAO Eligible		
c. Referral to DFCS for Determination of PMAO Eligible		
d. Other		
e. **TOTAL** (Add II.B.5a through II.B.5d)	=	

C. REASSESSMENTS

1. Purpose of Reassessments:

a. Reassessments Performed		
b. Reason for Reassessments Performed:		
1. Scheduled/Annual		
2. Requested (No equivalent in CHAT)		0
3. Other		
4. **TOTAL**	=	

2. Disposition of Reassessments Performed:

a. Recommend Continuation of CCSP		
b. Recommend Termination from CCSP		
c. Recommend NF Placement/Client Selected NF		
d. Client Selected Other Placement		
e. **TOTAL (**Same as II. C.1b4**)**	=	

PSA #_____ DATE _____ MONTH _____ YEAR_____

III. CLIENT INFORMATION

A. CLIENTS SERVED:

1. Clients Carried Over From Previous Month		
2. New Clients	+	
3. Reinstated From Previous SFY	+	
4. Reinstated From This SFY	+	
5. Transferred In From Another PSA	+	
6. Subtotal (Add III.A.1 thru III.A.5)	=	
7. Transferred Out To Another PSA	=	
8. Terminated From Service	=	
9. **TOTAL ACTIVE - END OF PERIOD**	=	

B. MEDICAID STATUS OF CLIENTS:

1. SSI Eligible		
2. MAO Eligible		
3. Potential Medical Assistance Only		
4. Other		
5. **TOTAL** (Add III.B.1 through III.B.4)	=	

C. NUMBER OF CLIENTS TERMINATED BY CATEGORY:

1. Determined No Longer Eligible/Appropriate at Reassessment	
2. UR Recommended Termination	
3. No Service In 60 Days	
4. Expired	

PSA #_____ **DATE** _____ **MONTH** _____ **YEAR**_____

5. Client Requested Termination _____

6. Client Moved Out of State _____

7. Client Entered NF _____

8. Other _____

9. No Longer Meets Level of Care Criteria _____

10. **TOTAL** _____

***For the following items with * enter information manually*:**

		MONTH	**SFYTD**
D.	NUMBER OF COMPLETED CCP REVIEWS		N/A
E.	UNDUPLICATED NUMBER OF CLIENTS SERVED*	N/A	
F.	NUMBER OF INDIVIDUALS IN PROCESS*		N/A
G.	NUMBER OF CLIENTS PROJECTED TO DRAW DOWN MEDICAID $ *		N/A
H.	EXPENDITURES AUTHORIZED FOR CCSP*		
I.	PERCENT OF ALLOCATION AUTHORIZED YTD (SFYTD) divided by Annual Allocation)*	N/A	
J.	MONTHLY/YTD SAF PER INDIVIDUAL CCSP CLIENT*		
M.	AVERAGE YTD DEAUTHORIZATION RATE *	N/A	
N.	NUMBER OF CLIENTS TO ADD OR SUBTRACT *		N/A

I certify that these figures are accurate to the best of my knowledge. _____
Date

_____ _____ _____
Name Signature Title

_____ ( )_____
Name of Person Completing Report Telephone Number

Instructions
Community Care Services Program

COMMUNITY CARE LEAD AGENCY PROGRAMMATIC REPORT (M-CCSP)

Purpose: The Division of Aging Services and the AAAs use information from the Programmatic Report to:

1. Meet federal and state reporting requirements
2. Determine if program objectives are being met
3. Track and calculate whether programmatic budget limitations are being observed
4. Provide information to the General Assembly and others regarding CCSP.
5. Provide information to determine how many clients Care Coordination may add or subtract each month on local and statewide levels.

Who Completes/When Completed:

1. Care coordination or a designee using information provided by CHAT and AIMS completes all of the report except for items K. (The Average SFYTD Deauthorization Rate) and L. (The Number of Clients to Add or Subtract) and forwards the report to the Area Agency on Aging on or before the 5th business day of the month following the report month.

2. The AAA or a designee completes items K. and L. of the report upon receipt. It is the AAAs responsibility to assure determination of the Average Deauthorization Rate and to assure programmatic report information is entered into the CCSP tracking document to complete items K. and L. This information is used by AAA to inform Care Coordination of the number of clients that may be added or subtracted at the local level. Upon completion of items K. and L. the AAA Director approves, signs and has the report faxed to the Division of Aging Services.

Instructions:

Enter data in every blank. Blanks with no data are interpreted by the Division as missing or unreported data, therefore enter a "0" for items having no activity. **Do not modify this form.**

PSA NUMBER: Enter PSA number in the space provided on each page of this report.

DATE: Enter date the report was completed in the space provided on each page of this report.

MONTH/YEAR: Enter calendar month and year in the space provided on each page of this report.

CONTRACTOR'S NAME: Enter the name of the AAA /Lead Agency.

NOTE: Most of the time CHAT uses status codes to calculate data; therefore, it is essential

that status codes be completed correctly on each client.

SECTION I: SCREENING INFORMATION

A. NUMBER OF UNSCREENED REFERRALS

1. Enter manually the number of unscreened referrals from *previous* months. This includes referrals where there has been *no contact* as of the end of the report month. It also includes referrals *not entered into the computer* as of the end of the report month.
2. Enter manually the number of unscreened referrals received *this reporting month*. This includes referrals where there has been *no contact* as of the end of the report month. It also includes referrals *not entered into the computer* as of the end of the report month.
3. Subtotal (I.A1+I.A2)

B. NUMBER OF PENDED TELEPHONE SCREENS NEEDING ADDITIONAL INFORMATION

CHAT enters the number of telephone screens at the end of the report month where some contact was made but more information is needed before the screen can be completed. This includes screens from previous months and from the report month.

C. REFERRAL SOURCES FOR COMPLETED TELEPHONE SCREENS (INCLUDING SCREENED OUT REFERRALS)

The information in this section is taken from completed telephone screenings. **Include referrals that were screened out.** CHAT calculates and enters the following:

1. Number of self referrals (applicant).
2. Number of referrals made by family or friends of applicant.
3. Number of referrals made by hospitals.
4. Number of referrals made by applicant's physician.
5. Number of referrals made by DFCS.
6. Number of referrals made by a nursing facility.
7. Number of referrals made by CCSP providers (exclude CCSP HDS Providers).
8. Number of referrals made by Home Health Providers (including CCSP HDS Providers.).
9. Number of referrals made by other sources.
10. Total referral sources of completed telephone screens in this reporting month (add I.C1 through I.C9).

D. TELEPHONE SCREENINGS AND WAITING LIST:

1. CHAT enters number of telephone screened clients on the waiting list carried forward from last reporting month.

2. CHAT enters the number of telephone screened clients (including those screened out) for this month in the following categories.

a. Number of applicants screened who were appropriate for the CCSP and were added to the waiting list for full assessment.

b. Number of applicants screened out as inappropriate for the CCSP:

1. Number of applicants screened out because needs, services, and medical problems made them inappropriate for the CCSP, includes MH/MR diagnosis.
2. Number of applicants screened out because medical problems too great.
3. Number of applicants screened out for financial ineligibility.
4. Number of applicants screened out for refusal to pay cost share.
5. Number of applicants screened out because services refused.
6. Number of applicants screened out for other placement services (e.g. Hospice, Medicare Home Health, or Family meeting needs).
7. Number of applicants screened out for insufficient information.
8. Number of applicants screened out for any other reason.
9. Total number of applicants inappropriate for the CCSP this reporting month (add b 1 through b 8).

3. CHAT enters the total number of new telephone screenings completed during the report month (I.D2a + I.D2b9).

4. CHAT enters the total number of applicants waiting for full assessment (I.D1 + I.D2a).

5. Waiting List Disposition:

This section reports the reasons applicants were removed from the waiting list during the report month.

CHAT calculates and enters the following:

a. Number of applicants referred for CCSP assessment.
b. Number of applicants removed from the Waiting List for the following:

1. Entered a nursing facility.
2. Deceased.
3. Needs, services, medical problems were inappropriate.
4. Needs, medical problems were too great.
5. Financially ineligible.
6. Refused to pay cost share.
7. Refused services.
8. Other placement or services.
9. Unable to contact
10. Other
11. Subtotal of persons removed from the waiting list 5 b1-5 b10.

c. Total number of applicants removed from the waiting list (add I.D5a + I.D 5b11).

6. CHAT enters total number of telephone screenings on the waiting list carried forward to next reporting month (I.D4 - I.D-5c).

SECTION II: ASSESSMENT/REASSESSMENT INFORMATION

This section contains data from care coordinators relating to care coordinator activities during the reporting month. CHAT enters the following:

A. THE NUMBER OF REFERRED SCREENS NOT ASSESSED

1. Applicant deceased
2. Applicant hospitalized
2. Applicant enters a nursing facility
4. Applicant refused services
5. Applicant refused to cost share
6. Unable to contact client
7. Other
8. Total not assessed.

B. ASSESSMENTS: CHAT enters the following assessment information.

1. Initial Assessments Performed: This is the number of face-to-face initial assessments performed this month.

2. Number of Completed Initial Assessments: The number of completed initial assessments includes those assessments where the signed level of care page has been returned from the doctor and the LOC/Recommendation for CCSP has been assigned this month. This number also includes initial assessments that were not recommended for CCSP this month.
   a. Number of emergency assessments ONLY.
   b. Number of assessments completed within 1 - 7 days.
   c. Number of assessments completed within 8 - 14 days.
   d. Number of assessments completed within 15 - 21 days.
   e. Number of assessments completed within 22 days or more.
   f. Total initial assessments completed within report month (add II.B2a through II.B2e).

   NOTE: CHAT uses status codes to calculate and enter the number of calendar days to complete an assessment; therefore it is essential that status codes be completed correctly on each client.

3. Initial Pending Assessments: This includes any initial assessment where the home visit has been completed but the level of care has not been assigned during the report month. The initial assessment could have been performed in another report month.

4. Disposition of Completed Initial Assessments:

Data from CHAT status codes is used to complete this portion of the report. Totals in this portion of the report are the same as totals provided in Item II. B(2)(f).

a. CHAT enters number of applicants recommended for the CCSP.

b. CHAT enters the number of assessed applicants who were not recommended for the CCSP for the following reasons.

1. Applicants found financially ineligible.
2. Applicants requiring immediate institutional care.
3. Applicants failing to meet Level of Care (LOC) requirements (Use Item 40 on the 5588).
4. Applicants whose needs, medical problems are too great.
5. Applicants choosing nursing homes due to unavailable alternatives (e.g., services needed are unavailable in PSA).
6. Applicants refusing to cost share.
7. Applicants refusing services.
8. Applicants choosing other placements or services.
9. Applicants not recommended to the CCSP for other reasons.
10. Total applicants NOT recommended for the CCSP in the reporting month(add II.B.4b1 through II.B.4b9).

c. Total number of assessments disposed of in report month (II.B.4a + II.B.4b10), Same as II. B.2f.

5. Medicaid status of persons assessed: CHAT enters the following:

a. Number of persons SSI Medicaid eligible.
b. Number of persons MAO eligible. This includes QMB, Public Law, Katie Becket and any other category of Medicaid other than SSI.
c. Number of persons referred to DFACS for determination for PMAO.
d. Number of MAO/PMAO persons assessed for other reasons. (Services paid entirely by Medicare or cost share.)
e. Totals for Medicaid status of persons assessed in report month. (II.B.5a through II.A.5d). This total is the same as II-B.4c.

C. REASSESSMENTS:

1. Purpose of Reassessments: CHAT enters the following reassessment data:

a. Reassessments Performed: The number of reassessments visits performed this report month.

b. Reasons for Reassessments Performed: The number of reassessments performed

this month that were:

1. Scheduled/annual reassessments (e.g., fixed intervals.)
2. Requested by care coordinator. (There is no equivalent in CHAT. This figure will always be "0".
3. For other reasons, (This includes any reassessment other than fixed interval.)
4. Total number of reassessments performed this month, total of II.C1b. 1-3. This number is the same as II.C1a.

2. Disposition of Reassessments Performed: CHAT enters the following for the report month:

a. Number of reassessments recommended for continuation in the CCSP.
b. Number of reassessments recommended for termination from the CCSP.
c. Number of reassessments recommended for NF placement/client selected NF.
d. Number of reassessments where client selected other placement.
e. Total number of reassessments performed this report month (Add II.C.b2a thru b2d). This total is the same as (II.C1b4) above.

III. CLIENT INFORMATION

CHAT enters the following:

A. 1. Number of clients carried over from last month. This is the number from line III. A9 if of last month's report.)
2. Number of new clients brought into the CCSP during this report month.
3. Number of clients reinstated from previous SFY during this report month.
4. Number of clients reinstated during current SFY in this report month.
5. Number of clients transferred in from another PSA during this report month.
6. Subtotal of clients served during report month (Add III.A1 thru III.A5).
7. Minus number of clients transferred out of PSA during report month.
8. Minus number of clients terminated from services during report month.
9. Total number of clients in active case load at the end of report month (III.A6-III.A7-III.A8).

B. MEDICAID STATUS OF CLIENTS:

1. Number of active clients who are SSI Medicaid eligible.
2. Number of active clients who are MAO eligible. (This includes QMB, Public Law, Katie Becket, and any other category of Medicaid other than SSI.)

3. Number of active clients who are PMAO eligible.
4. Number of MAO/PMAO active clients who are eligible but not using Medicaid dollars, (e.g., waivered services are totally paid by Medicare or client's cost share).

5. Total Medicaid status of all active clients at the end of report month (Add III.B1 thru III.4). This total is the same as III.A9.

C. NUMBER OF CLIENTS TERMINATED BY CATEGORY:

1. Number of clients no longer eligible/appropriate at reassessment.
2. Number of clients recommended for termination by UR.
3. Number of clients who received no service in past 60 days.
4. Number of clients who expired in report month.
5. Number of clients who requested termination of services.
6. Number of clients who moved out of state.
7. Number of clients who entered a nursing home.
8. Number of clients who were terminated for any other reason.
9. Number of clients who no longer meet level of care.
10. Total number of clients terminated in report month (Add III.C1 thru III.C9). This total is the same as III.A8.

D. NUMBER OF COMPLETED CCP REVIEWS:
CHAT enters the number of completed CCP reviews in the report month.

E. UNDUPLICATED NUMBER OF CLIENTS SERVED:
Manually enter the number of unduplicated clients served in SFYTD. This information will be provided by the AIMS unduplicated client count report.

F. NUMBER OF INDIVIDUALS IN PROCESS:
Manually enter number of individuals in process at the end of report month. This number includes persons whose initial assessment has not been returned from physician and initial clients whose data has not been entered in AIMS at the end of the report month.

G. NUMBER OF CLIENTS PROJECTED TO DRAW DOWN MEDICAID FUNDING:
Manually enter the number of CCSP clients who are projected to draw down Medicaid dollars at the end of report month. Add (III.B1 through III.B3) + (III-F)] to calculate the projection.

H. EXPENDITURES AUTHORIZED FOR CCSP BENEFITS:
Manually enter expenditures for all active clients at the end of report month and SFYTD. Use the figures from the AIMS Service Authorization Summary, for the reporting month. List the "Net Total Authorized" for reporting month and the "Cumulative Net Total" for SFYTD.

I. PERCENT OF ALLOCATION AUTHORIZED YTD:
Manually enter percent of CCSP allocation authorized SFYTD, including report month. Divide the total service benefit funds authorized SFYTD (in Item H above) by the annual PSA total allocation for the CCSP. This calculation helps the AAA determine if spending is on track for the year.

J. MONTHLY/YTD SAF COST PER INDIVIDUAL CLIENT:
Manually enter both the monthly and SFYTD SAF cost per CCSP client. This information

is obtained from the month/total column on the AIMS Service Authorization Summary Report.

K. AVERAGE SFYTD DEAUTHORIZATION RATE:
Manually enter the average SFYTD deauthorization rate. Use the average SFYTD de-authorization rate from the past SFY until the first deauthorization occurs in the current fiscal year. Thereafter, use the average SFYTD deauthorization rate for the current fiscal year. Calculate and manually enter both the reporting month and average SFYTD deauthorization rates.

L. NUMBER OF CLIENTS TO ADD OR SUBTRACT:
Manually enter the number for the report month from Column S of the Authorization and Allocation Tracking Worksheet. Enter a (+) sign if the clients are to be added to the slots currently in effect and enter a minus (-) sign if the number of clients are to be subtracted from those currently in effect.

1. Enter the name of the AAA contact person authorized to certify the programmatic report.
2. Enter the signature of the AAA contact person.
3. Enter the title of the AAA contact person.
4. Enter the date the AAA contact person signs the report.
5. Enter the name of the person completing the report.
6. Enter the telephone number and area code of the person completing the report.

Distribution:

1. The care coordination completes the report and sends the original to the AAA within the deadline set by the AAA.

2. The AAA Director signs and dates indicating that the report is accurate and faxes the report to the Division within 5 business days after the reporting month.

3. The AAA Director mails the hard copy original and 3 copies: Director, Division of Aging Services; Two Peachtree Street, N.W., Suite 36.385, Atlanta, GA 30303-3176 within 10 business days after the reporting month.

Supplemental Information to Programmatic Report

AAA _____ Date _____ Report Month/Year_____

I. Nursing Home Admissions Please indicate reasons below why terminated clients go into nursing homes	
Reason	**Number**
A. **CLIENT PLACED IN NH, *NO HOSPITALIZATION***	
1. Client suffered an *acute* medical episode that resulted in a rapid decline in health	
2. Caregiver support breakdown	
3. Client experienced a *steady* progressive decline in health	
4. Client experienced a fall or fracture	
5. Other: **Please define reasons other than those listed above**	
Subtotal	
B. **CLIENT WAS PLACED IN NH FROM HOSPITAL**	
1. Client suffered an *acute* medical episode that resulted in a rapid decline in health	
2. Caregiver support breakdown	
3. Client experienced a *steady* progressive decline in health	
4. Client experienced a fall or fracture	
5. Other: define reasons other than those listed above	
Subtotal	
TOTAL NUMBER of clients transitioned to Nursing Homes	

II. Disposition of Completed Initial Assessments	
Not Recommended for CCSP	
9. Other **Please define reason**	

III. Number of Clients Terminated by Category	
Other: define why clients were terminated under the category	**Number**
1.	
2.	
3.	

IV. Waitlist	
1. Number of clients on waitlist that are receiving non-CCSP services pending CCSP admission	
2. Average number of months those admitted to CCSP were on wait list before admission to CCSP	
Screenings	
1. Total re-screens completed this month	
2. Number of re-screens needed to be done that are 120 days or older	

V. Summary of Monthly Supervisory Review

Problem/Issue	Corrective Action Plan
Triggers	
Triage Levels	
Case load size	
Observations of weight, skin & meds	
Hospitalizations	
Minimal Services	
Review of LOC	
Clinical Records Read (ALS & ADH) Completion of Checklists	
Latest Policies and Procedures	
Celebrate Comprehensive Care Coordination Activities	
Other	

Instructions
Community Care Services Program

COMMUNITY CARE LEAD AGENCY SUPPLEMENTAL REPORT (S-CCSP)

Purpose: The Division of Aging Services and the AAAs use the drill down information from the Supplemental Report to determine:

1. The reasons clients were terminated and are placed in Nursing Homes with or with out hospitalization (III.C.7 on the Programmatic Report)
2. The reasons clients are not recommended for CCSP under Disposition of Completed Initial Assessments, "other" (II.B.4.9 on the Programmatic Report)
3. The reason clients were terminated under the Number of Clients Terminated by Category "other" (III.C.8. on the Programmatic Report)
4. The number of persons on the waiting list that are receiving non-CCSP services pending CCSP admission and the average time clients were on the waiting list prior to CCSP admission
5. Monthly supervisory activities at the care coordination level

Who Completes/When Completed:

Care coordination completes Section I, Section II, Section III, and Section IV and forwards the information to the AAA. The AAA completes Section IV. The report is completed and due at the same time as the Programmatic Report. The Supplemental Report is attached to the Programmatic Report and submitted to the Division of Aging Services.

Instructions:

Enter data in every blank if applicable. If there is no activity enter a "0" or "NA."

AAA:	Enter the AAA name.
DATE:	Enter the date the report was completed in the space provided.
REPORT MONTH/YEAR:	Enter the reporting month and the year in the space provided.

SECTION I: Nursing Home Admissions

A. CLIENT PLACED IN NH, NO HOSPITALIZATION

1. Enter the number of clients that suffered an *acute* medical episode that resulted in a rapid decline in health.
2. Enter the number of clients where there was caregiver support breakdown.
3. Enter the number of clients who experienced a *steady* progressive decline in health

4. Enter the number of clients who experienced a fall or fracture.
5. Enter the number of clients who do not fall into 1-4 and define **the reason(s)** in the space provided.

Add the numbers for 1-5 and enter the subtotal.

B. CLIENT WAS PLACED IN NH FROM HOSPITAL

1. Enter the number of clients that suffered an *acute* medical episode that resulted in a rapid decline in health.
2. Enter the number of clients where there was caregiver support breakdown.
3. Enter the number of clients who experienced a *steady* progressive decline in health
4. Enter the number of clients who experienced a fall or fracture.
5. Enter the number of clients who do not fall into 1-4 and define **the reason(s).**

Add the numbers for 1-5 and enter the subtotal.

Add the two subtotals together and enter the number in the **TOTAL NUMBER of client's transition to Nursing Homes.**
NOTE: The total figure should agree with III.C.7 on the Programmatic Report

SECTION II. **Disposition of Completed Initial Assessments**
Enter the number of clients not recommended for CCSP and define the reason(s).

NOTE: This number should be the same as the number on II.B4.b.9 of the Programmatic Report.

SECTION III. Number of Clients Terminated by Category

Enter the number of clients that were terminated under the category "other" and define the reason(s) they were terminated.

NOTE: This number should agree with III.C.8 of the Programmatic Report.

SECTION IV: Waitlist

1. Enter the number of clients on the waitlist that are receiving non-CCSP services pending admission to CCSP.
2. Enter the average number of months those admitted to CCSP were on the waitlist before admission to CCSP.

SECTION V. Summary of Monthly Supervisory Review
Write in the space provided by each problem and issue listed any activity that took place during the reporting month and if appropriate any corrective action that will be taken as result of the monthly supervisory reviews of 10% or the case records.

Community Care Services Program

COMMUNITY CARE NOTIFICATION FORM (CCNF), FORM 6500

1. Check (T) the appropriate box to indicate the reason for sending the CCNF:
   ( ) Initial ( ) Change ( ) Complaint / Concern ( ) Transfer ( ) Discharge

2. To _____ Date _____

3. From _____ Telephone (_____) _____
   (Agency name)

4. Client name _____ Telephone (_____) _____

5. Client address _____
   City _____ Zip _____ County _____
   ( ) Check if new address

6. Date provider completed initial evaluation of client _____

7. Services accepted: ( ) No - Reason _____
   _____
   ( ) Yes - Date service began _____
   - Frequency / Units _____

8. Client status change:
   ( ) Request for service increase ( ) Request for information
   ( ) Request for service decrease ( ) Client request for provider change
   ( ) Client in hospital ( ) Client termination
   ( ) Client out of home ( ) Other

9. Effective date of change _____

10. Discharge (briefly describe actions leading up to need for discharge process) _____
    _____
    _____

11. Date discharge (30-day) letter sent _____ Actual discharge date _____

12. Are services continuing through 30-day notice? ( ) Yes ( ) No

Explain _____

13. If complaint or concern, be specific _____
    _____
    _____

14. Comments _____
    _____

    _____

15. Sender's Signature _____ Title _____

16. Recipient's Signature _____ Date _____

17. Response _____

Instructions
Community Care Services Program

COMMUNITY CARE NOTIFICATION FORM (CCNF), FORM 6500

Purpose: Providers and care coordinators use the CCNF to share information about clients.
Who Completes/When Completed: Provider and care coordinators use CCNF to advise each other regarding client services and other information, such as hospitalization, death, etc.

Instructions:

1. Use a check (✓) mark to indicate the reason for completion of the CCNF.

2. Enter the individual's name to whom the CCNF is being sent and the date.

3. Enter the name and telephone number (including area code) of the agency completing the CCNF.

4. Enter the complete client name, area code and telephone number.

5. Enter the client's mailing address, including city, zip code and county of residence. Check (✓) if the address is new.

6. Indicate whether the client has accepted CCSP services. If no, give the reason. If yes, give the date service began. Secondly, indicate the frequency of service, and the units per month. Follow up and report back to sender within 3 business days.

7. Enter date provider completed initial evaluation of client.

8. Check (✓) the reason for the CCSP client status change.

9. Indicate the effective date for a CCSP provider service change.

10. Describe briefly the actions leading up to a discharge of the CCSP client.

11. Indicate the date that the provider mailed the 30-day discharge letter. Give the actual discharge date.Check (✓) "yes" or "no" to indicate whether services will continue through the 30-day notice of discharge. Provide necessary explanation.

12. If sending a CCNF because of a complaint or concern, give specific details.

13. Provide other comments, if necessary.

14. Sender types name or signs the form and indicates work title.

15. Recipient types name or signs the form and records the date.

16. Note any recipient response to the CCNF.

Distribution: If the Provider initiates the CCNF the original is sent to the care coordinator and the Care coordinator returns CCNF original within three business days and files copy in client case record. Likewise if the Care Coordinator initiates the CCNF the original is sent to the provider and the provider returns the original CCNF within three business days and the care coordinator files the original in the clients record.

If sent electronically, print a copy and file in client case record.

Community Care Services Program

COMMUNITY CARE SERVICES PROGRAM PARTICIPATION, FORM 5389

Date _____

Dear _____:

Welcome to the Community Care Services Program (CCSP). The CCSP Registered Nurse (RN) reviewed your situation and recommended community-based services through CCSP.

Services will begin after the providers listed below have visited you. Someone from the following service agency will be contacting you within a week from the date of this letter.

1. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

2. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

3. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

4. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

As a participant in the Community Care Services Program:

1. You will not lose any medical assistance benefits that you are currently receiving by participating in the Community Care Services Program.

2. You may withdraw from the CCSP at any time.

Please contact the care coordinator listed below by _____ to discuss your services. You may have someone call on your behalf.
(Date)

_____
Care Coordinator

(____) _____
Telephone Number

Instructions
Community Care Services Program

CCSP PARTICIPATION, FORM 5389

Purpose: This form is used to notify the client of acceptance into the CCSP and to advise that someone will be in contact to provide services. Furthermore, it serves as a tickler to the care coordinator to check to see if services have begun.

Who Completes/When Completed: The care coordinator completes Form 5389 when services have been brokered with providers.

Instructions:

Date:	Enter date services were brokered with provider.
Greeting:	Enter client's name.
Provider Agency:	Enter name(s) of provider agency chosen by client or by rotation system.
Contact Person:	Enter name(s) of person(s) within provider agency that client or family member may contact, if necessary.
Telephone Number:	Enter telephone number(s) of provider agency.
Care Coordinator:	Enter signature of care coordinator assigned to case.
Date:	Enter date client/representative will contact care coordinator to follow- up on services. If client fails to call, care coordinator contacts client.
Telephone Number:	Enter the care coordinator's telephone number, including area code.
Distribution:	Original - Client Copy - Client case record.

NOTE: It is suggested that the copy be placed in a tickler file until the client contacts care coordinator. If the client fails to contact the care coordinator, the tickler is a reminder for the care coordinator to contact the client. The copy may then be placed in the case record.

Georgia Department of Human Resources

COMMUNITY CARE SERVICES PROGRAM

Service Order

Client Name	SSN	Medicaid #	Care Plan Type	Recommendation	Date	Next Care Plan	Triage Code
Jane Doe	001-00-0001				2114/2005		

Medicaid Card Checked

Comments

Skin Integrity Change **Weight Change** **Medication Change**

 # MD Visits **# ER Visits** **# Hospitalizations**

Service	Provider	Phone	C Freq	Units Cost	Ordered	Begin	End
Personal Support Services			☐	0			

Name John Doe ☐ **Client Signature on File** **Signature Date**

Signature Date

☐ **Client Chose CCSP vs. Nursing Home Placement**

Signature Date

Care Coordinator _____

Collaborating Team Member _____

Instructions
Community Care Services Program

COMPREHENSIVE CARE PLAN (CCP) SERVICE ORDER

Purpose: The care coordinator uses the Service Order of the CCP to describe the client's service needs.

Who Completes/When completed: The care coordinator completes the Service Order at initial assessment, 60-day review, comprehensive care plan review, and reassessment.

Instructions:

NOTE: These numbered items correspond to CCP Service Order screen items in CHAT.

1. Enter name of client.

2. Enter Social Security number (SSN) of client.

3. Enter Medicaid number of client. Leave this item blank if the client is a PMAO client who does not have a Medicaid number at this point.

4. Enter care plan type, i.e., Initial, 30 day, CCP Review, Reassessment, or Interim.

5. Indicate care coordination team's recommendation for client.

   NOTE: Use Interim care plan type to make changes-adding/deleting provider, frequency of service-- between reviews or reassessment and no review or reassessment is required.

6. Enter date the Service Order is completed.

7. Indicate date of next care plan review or double click to enter a date four months from care plan date. If this is an initial assessment, the next CCP Review will be due 60 days from the date services were brokered.

8. Use the Comments section to explain why services were ordered, changed, discontinued, etc., or to add any specific information regarding any services being provided to client or to alert provider with specific instructions. Include discharge plan recommendations and informal support. If completing a care review and reassessment at the same time, document this information in the Comments section.

9. Service: Use the drop list to record all services including CCSP which the client currently receives. At initial assessment, use the comments section to document services received in the past three months that are now terminated. The care coordinator uses the client's input

to develop the care plan services. For informal support services, use InfS for the name of the service.

10. Enter name of provider, including non-CCSP providers. For informal support services, indicate caregiver's relationship to client.

11. Enter the telephone number including area code of provider agency.

12. Indicate whether the CCSP provider was the client's choice or was selected from the rotation list. If the client chooses a provider, but the care coordinator does not broker service with the selected provider, document an explanation in case notes.

13. Enter the frequency of service to be provided. For non-CCSP services, including informal support services, enter frequency of service if known.

14. Enter the units of service to be provided. For non-CCSP services enter units of service if known.

15. Enter the estimated Medicaid cost per month for the service to be provided. Calculate cost per month by multiplying rate per unit of service by number of units provided (for example: ALS $ x 30 units per month = $). Use current provider rates to determine cost per month. *If total cost of client services is expected to exceed cost cap consistently, client may not be appropriate for CCSP*. For non-CCSP services leave estimated cost blank.

16. Enter the date the CCSP service is ordered/brokered.

17. Enter the date the CCSP service began as indicated on the initial Community Care Notification Form (CCNF). Leave blank at initial face-to-face assessment and enter the date in CHAT when the CCNF is received from the provider(s).

18. Enter the date any service ended/terminated.

19. Enter the payment/fund source for CCSP and non-CCSP services if known. NOTE: This includes Medicaid Home Health Services. Any deviation from the care plan is discussed and explained in Comments section.

20. Signature of care coordinator who completed this care plan.

21. Indicate date care coordinator signed the care plan.

22. Signature of collaborating team member and date signed needed at initial assessment and reassessment. This signature is not needed for CCP reviews and Interim CCPs.

    NOTE: Care coordinator who completes assessment/reassessment signs CCP at time of assessment. Collaboration team member signs prior to form being sent to physician for review and completion.

23. Indicate whether client chooses CCSP or nursing home placement. Have client or representative sign the signature page to indicate the choice.

24. Indicate if client or representative signed signature page.

25. Enter date client or representative signed signature page.

Distribution: At initial assessment and reassessment, send LOC page, medication list, and CCP Service Order to physician for review and completion. Upon return from physician, maintain care plan in client file and send copies to providers delivering services to the client. At care reviews, send copies to providers.

Community Care Services Program

INITIAL HEARING SUMMARY

I. Date verbal request received _____
Date written request received _____

IIA. Client name _____
Social Security number _____
Address _____
_____
Telephone ( ) _____

B. Client Representative _____
Address _____
_____
Relationship to client _____
Telephone ( ) _____

IIIA. Agency name _____
Agency address _____
_____
Telephone ( ) _____

B. Area Agency on Aging (AAA) _____
AAAA address _____
Telephone ( ) _____

C. CCSP providers affected (Attach additional sheets if necessary):
Names Addresses
_____
_____
_____
_____

IVA. Adverse action being appealed:
1. ____ Denial/termination of Level of Impairment
2. ____ Denial/termination of Level of Care
3. ____ Denial/termination based on health and safety risks
4. ____ Reduction/termination of service by DMA Utilization Review
5. ____ Reduction/termination of service by care coordination
6. ____ Other denial/termination
Explanation of other denial/termination being appealed:
_____
_____

B. Services continuing pending hearing ____ Yes ____ No

C. Is Medicaid eligibility affected? ____ Yes ____ No
If "Yes", Was DFCS Notified ____Yes ____ No

V. Suggested hearing site _____

VI. Signed _____ Title_____
Screening Specialist/Care Coordinator signature

Date _____

VII. Other than client, screening specialist or care coordinator, and Division of Aging Services, individuals authorized to receive a copy of hearing notices:
Name_____
Address_____
_____
_____
Telephone (____) _____

Name _____
Address _____
_____
Telephone (____) _____

VIII. The following documents or copies are attached:

1. Completed and signed Request for Hearing, Form 5383

2. Telephone Screening Assessment (DON-R)

3. Most recent Level of Care, MDS-HC, and CCP, if applicable

4. Adverse action notice sent to the client

5. Completed Hearing Summary Form

6. Any documents, medical records, and other materials on which the agency relied for the adverse action

7. Excerpts from regulations supporting the adverse action notice.

Cc: Division of Aging Services

Instructions
Community Care Services Program

INITIAL HEARING SUMMARY

Purpose: The Initial Hearing Summary Form provides the Office of State Administrative Hearings with a summary of critical information necessary for the Administrative Law Judge to prepare for a hearing.

Who Completes/When Completed: The screening specialist or care coordinator completes the hearing summary when initial appeal requests are made, even when the client appeals directly to the DHR Legal Services Office.

Instructions:

I. Enter date verbal request was received.
Enter date written request was received.

IIA. Enter name of person requesting hearing.
Enter social security number of client requesting hearing.
Enter address of person requesting hearing.

B. Enter name of client's authorized representative (if applicable).
Enter address of client's authorized representative (if applicable).
Enter relationship of authorized representative to client (if applicable).

IIIA. Enter name of agency denying or terminating the case.
Enter agency's address.
Enter area code and telephone number of agency.

B. Enter name of AAA, address, and telephone number of AAA in planning and service area where client's appeal will be held.

C. Enter names and addresses of all CCSP providers who are affected by decision being appealed by client.

IVA. Check (T) type of action being appealed.
Enter any other action being appealed which is not listed above.

B. Services continuing pending hearing: check (T) appropriate response.

C. Is Medicaid eligibility affected: check (T) appropriate response.

V. Enter suggested hearing site based on physical and/or mental capability of client.

VI. Enter signature of screening specialist or care coordinator completing this form. Enter date form was completed.

VII. List the name, address, and telephone number of individuals for whom the client has authorized on an Authorization of Release Form.

VIII. Attach all documents or copies included in the list to the Request for Hearing Form.

Distribution: Attach the Hearing Summary Form to the original documents and mail to the DHR Legal Services Office and a copy to the care coordination specialist assigned to your area. File a copy in the client's case record. See Chapter 1000 for reference.

Georgia Department of Human Resources
Division of Aging Services
Community Care Services Program

INITIAL SERVICE AUTHORIZATION DATA ENTRY FORM

Medicaid Number _____ Social Security Number _____-_____-_____

Client's Name _____ Services Begin Date _____/_____/_____

NOTE: If client is MAO, for each provider assigned to collect cost share, enter 99999 as the procedure code for the client's liability.

Services Authorized			**Month /**		**Month /**		**Month /**	
Complete Provider Name	**Service Name**	**Procedure Code**	**Units**	**Client Liab.**	**Units**	**Client Liab.**	**Units**	**Client Liab.**

Care Coordinator: _____ Date: _____/_____/_____ Rev. 10/99

Instructions
Community Care Services Program

INITIAL SERVICE AUTHORIZATION DATA ENTRY FORM

Purpose: The Initial SAF Data Entry Form is used to provide information to data entry for AIMS. This information authorizes the number of service visits, the cost of services and the provider who provides each service.

Who Completes/When Completed: The care coordinator completes the SAF when services or frequency of services are initiated..

Instructions:

Medicaid #: Enter client's Medicaid number. The Community Care Communicator, Form 5590, provides Medicaid number and amount of cost share for MAO clients. *Do not issue a SAF until a client has a Medicaid number.* Review the CCC for months of eligibility, if applicable.

Client's Name: Enter client's name as it appears on Medicaid card.

Soc. Sec. No: Enter client's social security number.

Services Begin Date: Enter date from CCNF that client received first CCSP waivered service.

Services Authorized: Enter provider's complete name, each CCSP service authorized and the appropriate service procedure code.

Month: Enter month and year for each month authorized. Care coordinators may authorize services up to three consecutive months. A newly approved MAO client may require more than one form to authorize CCSP services retroactively.

Units: Enter number of units of service authorized for each service listed.

Client Liability: Enter cost share amount for each month in Client Liability column on line for provider(s) assigned to collect cost share. Begin assigning cost share to the provider(s) who delivers services with the highest dollar amount authorized. Continue to assign cost share to providers until the entire cost share is assigned. The CCC, Form 5590 indicates amount of client's cost share and effective date(s) for liability amount(s).
Enter entire cost share amount even if it exceeds cost of all CCSP services. Enter 0 if client liability is zero.

Enter 99999 as the procedure code, below the row in which you list the provider enrollment number, name, procedure code, etc., for each provider assigned to collect cost share. This identifies all providers and the amount each will collect for the purpose of data entry and SAF generation.

EXAMPLE:
Services Authorized Month

Provider Name	Procedure Code	Units	Client Liability
Visiting Nurses Health Systems, Inc.	Y3801	4	$32.50
Visiting Nurses Health Systems, Inc.	99999		$32.50
Nursing Care, Inc.	Y3832	60	$367.50
Nursing Care, Inc.	99999		$367.50

Care Coordinator: Care coordinator signs form.

Date: Care coordinator dates form when s/he signs it.

Distribution: The completed data entry form is filed in the case record after the care coordinator has verified its accuracy.

Georgia Department of Human Resources

COMMUNITY CARE SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section I - A. Identifying Information	2. Patient's Name (Last, First, Middle Initial):		
1. **CCSP ASSESSMENT TEAM NAME ADDRESS**	3. Home Address:		
	4. Telephone Number;	5. County:	6. PSA:

7. Medicaid Number	8. Social Security Number				9. Mother's Maiden Name:		
	10. Sex	11. Age	12 Birthday	13. Race	14. Marital Status	15. Type of Recommendation 1. ☐ Initial 2. ☐ Reassessment	16. Referral Source

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Resources with necessary information including medical data.

17. Signed _____ 18. Date _____

(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation, and Nursing Care Needed	1. ICD	2. ICD	3. ICD
19. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached) 1. Primary _____ 2. Secondary _____ 3. Other _____ 20. Is Patient free of communicable disease? 1 ☐ Yes 2 ☐ No			

Medications (including OTC)				Diagnostic and Treatment Procedures
21. Name	Dosage	Route	Frequency	22 Type Frequency

23. **COMMUNITY CARE SERVICES ORDERED** :

24. **Diet**	25. **Hours Out of Bed Per Day**	26. **Overall Cond**	27 **Restorative Potential**	28. **Mental and Behavioral Status**		
☐ Regular	☐ Intake ☐ IV	☐ Improving	☐ Good	☐ Agitated	☐ Noisy	☐ Dependent
☐ Diabetic	☐ Output ☐ Bedfast	☐ Stable	☐ Fair	☐Confused	☐ Nonresponsive	☐ Independent
☐ Formula	☐ Catheter Care	☐ Fluctuating	☐ Poor	☐ Cooperative	☐ Vacillating	☐ Anxious
☐ Low Sodium	☐ Colostomy Care	☐ Deteriotating	☐ Questionable	☐ Depressed	☐ Violent	☐ Well Adjusted
☐ Tube Feeding	☐ Sterile Dressings	☐ Critical	☐ None	☐ Forgetful	☐ Wanders	☐ Disoriented
☐ Other	☐ Suctioning	☐ Terminal		☐ Alert	☐ Withdrawn	☐ Inappropriate

29. **Decubiti**	30, **Bowel**	31. **Bladder**	32. **Indicate Frequency** Per Week: **Physical Therapy**	**Occupational Therapy**	**Remotive Therapy**	**Reality Orientation**	**Speech Therapy**	**Bowel Bladder Retrain**	**Activities Program**
☐ Yes	☐ Continent	☐ Continent							
☐ No	☐ Occas, Incontinent	☐ Occas Incontinent							
☐ Infected	☐ Incontinent	☐ Incontinent							
☐ On Admission	☐ Colostomy	☐ Catheter							
☐ Surgery Date									

33 **Record Appropriate**

Legend
1. Severe
2. Moderate
3. Mild
4. None

IMPPAIRMENT					ACTIVITIES OF DAILY LIVING						
	Sight	Hear	Speech	Ltd Motion	Para-lysis		Eats	Wheel-Chair	Trans-fers	Bath	Ambu-lation	Dressing
	☐	☐	☐	☐	☐	1. Dependent 2. Needs Asst, 3 Independent 4. Not App	☐	☐	☐	☐	☐	☐

34.. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services.

35. I certify that this patient ☐ requires ☐ does not require the intermediate level of care provided by a nursing facility.

36. I certify that the attached plan of care addresses the client's needs for Community Care.

37. Physician's Signature _____

38. Physician's Name (Print)

39. Physician's Address (Print)

40. Date Signed By Physician	41. Physician's Licensure No.	42. Physician's Phone No.

ASSESSMENT TEAM USE ONLY

43. Nursing Facility Level of Care ☐ Yes ☐ No 44. L.O.S. Certified Through Date

45. Signed by person certifying LOC: Title Date Signed

Instructions
Community Care Services Program

LEVEL OF CARE

Purpose: The Level Of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for Community Care or other services. In addition, the LOC page represents the physician's order for all waivered services provided by CCSP.

Who Completes Form: Initial assessments are completed by the RN care coordinator. Subsequent reassessments are completed by RN and/or the social services worker. However, the LOC is always assigned by the RN. The client's physician participates in all assessments and reassessments by completing designating sections of the LOC page and signing the form.

When the Form is Completed:
The care coordinator completes the LOC page at initial assessments and reassessments.

Instructions:

SECTION I A. IDENTIFYING INFORMATION
Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address, telephone number, including area code, of care coordination team.

2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.

3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.

4. Enter client's area code and telephone number.

5. Enter client's county of residence.

6. Enter planning and service area (PSA) number where client resides.

7. Enter client's Medicaid number exactly as it appears on the Medicaid card.

NOTE: Potential Medical Assistance Only (PMAO) applicants do not have a current Medicaid number. For PMAO applicants, please leave this item blank.

8. Enter client's nine-digit social security number.
9. Enter client's mother's maiden name.

10, 11, 12. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).

13. Enter client's race as follows:
    A = Asian/Pacific Islander H = Hispanic W = White
    B = Black NA = Native American

14. Enter client's marital status as follows:
    S = Single M = Married W = Widowed
    D = Divorced SP = Separated

15. Check (T) appropriate type of recommendation:
    1. Initial: First referral to CCSP or re-entry into CCSP after termination
    2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.

16. Enter referral source by name and title (if applicable), or agency and type as follows:
    MD = Doctor S = Self HHA = Home health agency
    NF = Nursing facility FM = Family PCH = Personal Care Home
    HOSP = Hospital ADH = Adult Day Health
    O = Other (Identify fully)
    DFCS = Department of Family & Children Services

17, 18. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to care coordinator regarding level of care determination.

SECTION IB. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION
Section B is completed and signed by licensed medical person completing medical report.

19. The physician or nurse practitioner enters client's primary, secondary, and other (if applicable) diagnoses.

NOTE: After the physician or nurse practitioner returns signed LOC page, care coordination team indicates ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Care coordination teams secure codes from ICD code book, local hospitals or client's physician.

20. The physician or nurse practitioner checks appropriate box to indicate if client is free of communicable diseases.

21. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.

22. List all diagnostic and treatment procedures the client is receiving.

23. List all waivered services ordered by care coordination team.

    NOTE: Waivered services ordered by care coordination and approved by the physician are considered physician's orders for CCSP waivered services.

24. Enter appropriate diet for client. If "other" is checked (√), please specify type. Completion of this item is important as this information may serve as the service order for home delivered meals. (Nutrition Screening Initiative (NSI), Appendix 100, is to be completed in conjunction with the LOC page, MDS-HC and CCP.)

25. Enter number of hours out of bed per day if client is not bedfast. Check (√) intake if client can take fluids orally. Check (√) output if client's bladder function is normal without catheter. Check (√) all appropriate boxes.

26. Check (√) appropriate box to indicate client's overall condition.

27. Check (√) appropriate box to indicate client's restorative potential.

28. Check (√) *all* appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.

29. Check (√) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.

30. Check (√) appropriate box.

31. Check (√) appropriate box.

32. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.

33. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.

34. Care coordination team or the admitting/attending physician indicates whether client's condition could or could not be managed by provision of Community Care or Home Health Services by checking (√) appropriate box..

    NOTE: If physician indicates that client's condition cannot be managed by provision of Community Care and/or Home Health Services, the physician may complete and sign a

DMA-6

35. Care coordination team or the admitting/attending physician certifies that client requires level of care provided by an intermediate care facility.

36. Admitting/attending physician certifies that CCP, plan of care addresses patient's needs for Community Care. If client's needs cannot be addressed in CCSP and nursing facility placement is recommended, the physician may complete and sign a DMA-6.

37. This space is provided for signature of admitting/attending physician indicating his certification that client needs can or cannot be met in a community setting. **Only a physician (MD or DO) or nurse practitioner may sign the LOC page.**

    NOTE: Physician or nurse practitioner signs within 60 days of care coordinator's completion of form. Physician or nurse practitioner's signature must be original. Signature stamps are not acceptable. UR will recoup payments made to the provider if there is no physician's signature. "Faxed" copies of LOC page are acceptable, if there is documentation that a hard copy is forthcoming.

38, 39, 40, 41, 42. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided.

NOTE: The date the physician signs the form is the service order for CCSP services to begin. UR will recoup money from the provider if date is not recorded.

43, 44, 45. REGISTERED NURSE (RN) USE ONLY

43. The registered nurse checks (√) the appropriate box regarding Nursing Facility Level of Care (LOC). When RN denies a level of care, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.

44. LOS - Indicate time frame for certification, i.e., 3, 6, 12 months. LOS cannot exceed 12 months.
    Certified Through Date - Enter the last day of the month in which the length of stay (LOS) expires.

45. Licensed person certifying level of care signs in this space and indicates title (R.N.) and date of signature.

NOTE: Date of signature must be within 60 days of date care coordinator completed assessment as indicated in Number 18. Length of stay is calculated from date shown in Number 44. The RN completes a recertification of a level of care prior to expiration of length of stay.

Sample Letter

CCSP Office
Letterhead

Telephone Number (____)_____
Date_____

Applicant Name_____

Address _____

_____

_____

NOTICE
DENIAL OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that you require the level of care provided in a nursing facility. This letter is to notify you that according to our evaluation, your medical condition does not require the level of care provided in a nursing facility because_____

_____

_____

_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services for you through the Community Care Services Program will be denied unless additional medical information justifies a need for the services.

You may obtain a review of this decision by sending additional medical information within ten (10) days of the date of this letter. Contact your attending physician or your original referring agency if you need help with your request. You must submit all information to the Community Care Services Program at the address shown above.

If you do not send additional medical information within ten (10) days, this decision will become effective on_____. If you choose not to send additional medical information but you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request orally, you must submit a written request within fifteen (15) days from the date of your oral request. An Administrative Law Judge will conduct the hearing in your county. At that hearing, you may represent yourself or use legal counsel, a friend, a relative or any other spokesperson to represent you.

You should contact this office immediately at the address and phone number above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Georgia Department of Human Resources.

Sincerely,

Care Coordinator_____

Title_____

Telephone Number (___)_____

cc Area Agency on Aging (Name)

Instructions
Community Care Services Program

NOTICE OF DENIAL OF LEVEL OF CARE - COMMUNITY CARE SERVICES PROGRAM (CCSP)

Purpose: This form is used to notify applicants that evaluation of their medical condition does not require the level of care provided in a nursing home.

Who Completes/When Completed: This form is completed by the care coordinator RN and mailed to the client immediately after the RN determines that the applicant does not meet the level of care.

Instructions:

1. Use the care coordination agency letterhead stationary with the information in the sample letter to notify applicants of the denial of level of care.

2. Telephone Number: Enter the telephone number of the care coordination agency.

3. Date: Enter the date the notice was prepared and mailed.

4. Applicant's Name: Enter the applicant's name.

5. Address: Enter the applicant's mailing address.

6. Denial Reason: State specifically in the space provided why the applicant does not meet the level of care.

7. Effective Date: Enter the last day for which the applicant may submit additional information for reconsideration of the denial decision. This date is 10 days from the date the denial letter was prepared and mailed.

8. Sincerely: Enter the signature of the person authorized to sign on behalf of the agency.

9. Care Coordinator: Enter the name of the care coordinator RN who assessed the applicant and denied the level of care.

10. Title: Enter the title of the care coordinator RN.

11. Telephone Number: Enter the telephone number of the care coordinator RN who assessed applicant and denied the level of care.

Distribution: Original to the client, copy to the AAA, copy filed in applicant's case record.

Sample Letter

CCSP Office Letterhead

Telephone Number ( ) _____

Date _____

Applicant Name _____

Address _____

_____

_____

DENIAL OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM
SECOND REVIEW

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that you require the level of care provided in a nursing facility. This letter is to notify you that after careful review of the additional medical information submitted, our evaluation is that your medical condition does not require the level of care provided in a nursing facility because _____

_____

_____

_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services to you under the Community Care Services Program are hereby denied.

If you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request orally, you must submit a written request within fifteen (15) days from the date of your oral request.

The hearing will be conducted in your county by an Administrative Law Judge of the Office of State Administrative Hearing. At the hearing, you may represent yourself or have legal counsel, a friend, a relative or any other spokesperson represent you.

You should contact this office immediately at the address listed above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Department of Human Resources.

Sincerely,

Care Coordinator _____

Title _____

Telephone Number _____

cc Area Agency on Aging (Name)

Instructions
Community Care Services Program

DENIAL OF LEVEL OF CARE COMMUNITY CARE SERVICES PROGRAM- SECOND REVIEW

Purpose: This form is used to notify an applicant that a level of care has been denied a second time after review of additional medical information.

Who Completes/When Completed: The care coordinator RN completes the notification letter and mails it immediately after reviewing additional information and determining that applicant still doesn't meet a level of care for nursing home care.

Instructions:

1.	Use the letterhead of the care coordination agency.	
2.	Telephone Number:	Enter the telephone number of the care coordination agency.
3.	Date:	Enter date the denial notification is prepared and mailed.
4.	Applicant Name:	Enter the applicant's name.
5.	Address:	Enter the applicant's mailing address.
6.	Denial Reason:	State specifically why the applicant does not meet the level of care on second review.
7.	Sincerely:	Enter signature of the person authorized to act for the agency.
8.	Care Coordinator:	Enter the name of the care coordinator RN.
9.	Title:	Enter the title of the care coordinator RN.
10.	Telephone Number:	Enter the telephone number of the care coordinator RN.

Distribution: Original to the applicant, copy to the AAA, copy filed in applicant's case record.

Sample Letter

CCSP Office
Letterhead

Telephone Number (___)_____

Date _____

Client Name_____

Address _____

_____

_____

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that you require the level of care provided in a nursing facility. This letter is to notify you that according to our evaluation, your medical condition no longer requires the level of care provided in a nursing facility because_____

_____

_____

_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services for you through the Community Care Services Program will be terminated unless additional medical information justifies your remaining in Community Care.

You may obtain a review of this decision by sending additional medical information within ten (10) days of the date of this letter. Contact your attending physician or your original referring agency if you need help obtaining additional medical information to submit with your request for reconsideration. You must submit all information to the Community Care Services Program at the address shown above. You will not lose your right to a hearing if you send additional medical information. If you do not send additional medical information within ten (10) days, this decision will become effective_____ .

If you choose not to send additional medical information but you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request verbal request for a hearing, you must submit a written request within fifteen (15) days from the date of your oral request. If you request a hearing in writing within ten (10) days from the date of this letter, you may continue to receive Community Care Services. An Administrative Law Judge will conduct the hearing in your county. At that hearing, you may represent yourself or use legal counsel, a friend, a relative or any other spokesperson represent you.

You should contact this office immediately at the address above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Georgia Department of Human Resources.

If you choose to continue receiving Community Care Services while waiting for the hearing decision and if the hearing official denies, your appeal, you may be required to repay the Department of Community Health Legal Services Office the cost of any services received after the original termination date.

Sincerely,

Care Coordinator_____

Title_____

Telephone Number _____

cc County DFCS (if MAO)
Area Agency on Aging (Name)

Instructions
Community Care Services Program

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM

Purpose: This form letter is used when a client's medical condition no longer meets the level of care provided by a nursing home.

Who Completes/When Completed: The care coordinator completes and mails this form immediately after the care coordinator RN determines that a client no longer meets the level of care criteria for nursing home care.

Instructions:

1. Use the letterhead of the care coordination agency with the information in sample letter.

2. Telephone Number: Enter the telephone number of the coordination agency.

3. Date: Enter the date the termination letter was prepared and mailed.

4. Client Name: Enter the client's name.

5. Address: Enter the client's mailing address.

6. Termination Reason: State specifically why the client no longer meets the level of care.

7. Effective Date: Enter the last day in which a client may submit additional information for a second review of the termination of a level of care. This date is 10 days from the date of the letter.

8. Sincerely: Enter the signature of the person authorized to act for the care coordination agency.

9. Care Coordinator: Enter the name of the care coordinator assigned to the client's case.

10. Title: Enter the title of the care coordinator assigned to the client's case.

11. Telephone Number: Enter the telephone number of the care coordinator assigned to the client's case.

NOTE: Services continue uninterrupted while additional medical information is evaluated by the care coordination team.

Distribution: Original to client, copy to AAA, copy to DFCS (if MAO), copy in client's case record.

Sample Letter

CCSP Office
Letterhead

Telephone Number (_____)_____

Date _____

Client Name_____

Address _____

_____

_____

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM
SECOND REVIEW

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that require the level of care provided in a nursing facility. This letter is to notify you that, and after careful review of the additional medical information submitted, our evaluation is that your medical condition no longer requires the level of care provided in a nursing facility because_____
_____
_____
_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services for you through the Community Care Services Program are hereby terminated effective _____.

If you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request orally, you must submit a written request within fifteen (15) days from the date of your oral request. If you request a hearing in writing within ten (10) days from the date of this letter, you may continue to receive Community Care Services.

An Administrative Law Judge will conduct the hearing in your county. At that hearing, you may represent yourself or have legal counsel, a friend, a relative or any other spokesperson represent you.

You should contact this office immediately at the address above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Georgia Department of Human Resources.

If you choose to continue receiving Community Care Services while waiting for the hearing decision and if the hearing official denies your appeal, you may be required to repay the Department of Community Health Legal Services Office, the cost of any services received after the original termination date.

Sincerely,

Care Coordinator_____

Title_____

Telephone Number (___)_____

cc County DFCS (if MAO)
Area Agency on Aging (Name)

Instructions
Community Care Services Program

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM-
SECOND REVIEW

Purpose: This form letter is used to notify client that a review of additional information was evaluated and did not change the original determination of termination of level of care.

Who Completes/When Completed: The assigned care coordinator completes and mails the second review termination notice immediately after the care coordination team makes the decision.

Instructions:

1. Use the letterhead of the care coordination agency with the information in this sample letter.

2. Telephone Number: Enter the telephone number of the care coordination agency.

3. Date: Enter the date the second review termination notice was mailed.

4. Client Name: Enter the client's name.

5. Address: Enter the client's mailing address.

6. Termination Reason: State specifically the reason for termination after second review.

7. Effective Date: Enter the effective date of termination. This is 30 days from the date the termination was prepared and mailed.

8. Sincerely: Enter the signature of the person authorized to act for the agency.

9. Care Coordinator: Enter the name of the care coordinator assigned to the client's case.

10. Title: Enter the title of the care coordinator assigned to the client's case.

11. Telephone Number: Enter the telephone number of the care coordinator assigned to the client's case.

Distribution: Original to the client, copy to AAA, copy to DFCS (if MAO), copy in client's case record.

MINIMUM DATA SET - HOME CARE (MDS-HC)

Assessment Detail

Assessment:

Personal Items

Client has advanced medical directives in place

- Yes ☐
- No ☐

Referral Items

Lived in nursing home at anytime in past 5 years

- Yes ☐
- No ☐

Moved to current residence within the past 2 years

- Yes ☐
- No ☐

Cognitive Patterns

Memory

- Memory OK ☐
- Memory Problem ☐

Cognitive Skills for Daily Decision-Making

- Independent ☐
- Modified Independence ☐
- Moderately Impaired ☐
- Severely Impaired ☐

Sudden change in mental function

- No ☐
- Yes ☐

Agitated to extent safety is endangered

- No ☐
- Yes ☐

Communication/Hearing Patterns

Hearing

- Hears Adequately ☐
- Minimal Difficulty ☐
- Hears in Special Situations Only ☐
- Highly Impaired ☐

Making Self Understood

- Understood ☐
- Usually Understood ☐
- Sometimes Understood ☐
- Rarely/Never Understood ☐

Ability to Understand Others

- Understands ☐
- Usually Understands ☐
- Sometimes Understands ☐
- Rarely/Never Understands ☐

Vision Patterns

Vision

- Adequate ☐
- Impaired ☐
- Moderately Impaired ☐
- Highly Impaired ☐
- Severely Impaired ☐

Visual Limitation/Difficulties

- No ☐
- Yes ☐

Vision Decline

- No ☐
- Yes ☐

Indicators of depression/Anxiety

A feeling of sadness or being depressed

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Persistent anger with self or others

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Expressions of unrealistic fears

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Repetitive health complaints

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Repetitive anxious complaints or concerns

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Sad, pained, worried facial expressions

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Recurrent crying, tearfulness

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Withdrawal from activities of interest

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Reduced social interaction

- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Assessment Detail

Assessment:

Behavioral Symptoms

Wandering
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Verbally abusive behavioral symptoms
- Did not occur in last seven days ☐
- Occurred,easily altered ☐
- Occurred, not easily altered ☐

Physically abusive behavioral symptoms
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Socially inappropriate/disruptive behavior
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Aggressive resistance of care
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Changes in behavior symptoms
- No change in behavioral symptoms ☐
- Yes ☐

Involvement

Client is at ease with others
- At ease ☐
- Not at ease ☐

Openly expresses conflict or anger
- No ☐
- Yes ☐

Change in social activities

Decline in participation in social activities
- No decline ☐
- Decline, client not distressed ☐
- Decline, client distressed ☐

Isolation

Length of time client is alone during the day
- Never or hardly ever ☐
- About one hour ☐
- Long periods of time ☐
- All of the time ☐

Client indicates that he/she feels lonely
- No ☐
- Yes ☐

Primary Helper

Lives with client
- Yes ☐
- No ☐
- No such helper (skip other items) ☐

Relationship to client
- Child or child-in-law ☐
- Spouse ☐
- Other relative ☐
- Friend/neighbor ☐

Provides advice or emotional support
- Yes ☐
- No ☐

Provides IADL Care
- Yes ☐
- No ☐

Provides ADL Care
- Yes ☐
- No ☐

Willing to increase emotional support
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase IADL care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase ADL Care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Assessment Detail

Assessment:

Secondary Helper

Lives with client
- Yes ☐
- No ☐
- No such helper (skip other items) ☐

Relationship to client
- Child or child-in-law ☐
- Spouse ☐
- Other relative ☐
- Friend/neighbor ☐

Provides advice or emotional support
- Yes ☐
- No ☐

Provides IADL care
- Yes ☐
- No ☐

Provides ADL Care
- Yes ☐
- No ☐

Willing to increase emotional support
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase IADL care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase ADL care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Caregiver Status

A caregiver is unable to continue in caring activities
- Yes ☐
- No ☐

Primary caregiver is not satisfied with support
- Yes ☐
- No ☐

Primary CG expresses distress/anger/depression
- Yes ☐
- No ☐

Meal Preparation

Self Performance
- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty
- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little/no involvement is possible ☐

Unmet Need
- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Laundry

Self Performance
- Performs all of the activity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need
- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Ordinary Housework

Self Performance
- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty
- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Unmet Need
- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Assessment Detail

Assessment:

Managing Finance

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Managing Medications

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Phone Use

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/ fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Shopping

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/ fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Transportation

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/ fatigues ☐
- Great Difficulty- little or no involvement possible ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Mobility in Bed

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Transfer

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Locomotion in Home

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Assessment Detail

Assessment:

Dressing

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Eating

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Toilet Use

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Personal Hygiene

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Bathing

Self Performance

- Independent - did on own ☐
- Supervision - oversight help only ☐
- Received Assistance in Transfer Only ☐
- Received Assistance in Part of Bathing Only ☐
- Total Dependence ☐
- Activity Did Not Occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Routine Health

Self Performance

- Performs all of the acitvity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Special Health

Self Performance

- Performs all of the activity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need

- Need Is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Being Alone

Self Performance

- Performs all of the activity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Assessment Detail

Assessment:

Primary Modes of Locomotion

Indoors

- No assistive device ☐
- Cane ☐
- Walker/crutch ☐
- Scooter (e.g. Amigo) ☐
- Wheelchair ☐
- Activity did not occur ☐

Outdoors

- No assistive device ☐
- Cane ☐
- Walker/crutch ☐
- Scooter (e.g. Amigo) ☐
- Wheelchair ☐
- Activity did not occur ☐

Stair Climbing

How well Client went up and down stairs

- Up and down stairs without help ☐
- Up and down stairs with help ☐
- Not go up and down stairs-could without help ☐
- Not go up and down stairs-could do with help ☐
- Not go up and down stairs-no capacity ☐
- Unknown-assessor unable to judge capacity ☐

Stamina

Days client went out of house

- Every day ☐
- 2-6 days a week ☐
- 1 day a week ☐
- No days ☐

Hours of Physical Activities (last 7 days)

- Two or more hours ☐
- Less than two hours ☐

Functional Potential

Client believes he/she capable of more

- Yes ☐
- No ☐

Caregiver believes client capable of more

- Yes ☐
- No ☐

Improved health status expected

- Yes ☐
- No ☐

Bladder Continence

Control of urinary bladder function

- Continent ☐
- Usually Continent ☐
- Occasionally Incontinent ☐
- Frequently Incontinent ☐
- Incontinent ☐

Bladder Devices

Use of pads or briefs to protect against wetness

- Yes ☐
- No ☐

Use of an indwelling catheter

- Yes ☐
- No ☐

Bowel Incontinence

Control of bowel movement

- Continent ☐
- Usually Continent ☐
- Occasionally Incontinent ☐
- Frequently Incontinent ☐
- Incontinent ☐

Assessment Detail

Assessment:

Disease Diagnosis

Cerebrovascular accident (stroke)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Congestive Heart Failure
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Coronary heart failure
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Hypertension
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Irregularity irregular pulse
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Peripheral vascular disease
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Alzheimer's
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Dementia other than Alzheimer's disease
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Head trauma
- Not Present ☐
- Present-not treated/monitored by nurse ☐
- Present-monitored/treated by nurse ☐

Multiple sclerosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Parkinsonism
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Arthritis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-treated/monitored by nurse ☐

Hip Fracture
- Not Present ☐
- Present- not monitored/treated by nurse ☐
- Present-treated/monitored by nurse ☐

Other fractures (e.g., wrist, vertebral)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Osteoporosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Cataract
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Glaucoma
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Any psychiatric diagnosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

HIV infection
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Pneumonia
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Tuberculosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Urinary tract infection (in last 30 days)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Cancer (in past 5 yrs) not including skin cancer
- Not Present ☐
- Present- not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Diabetes
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Emphysema/COP/Asthma
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Renal failure
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Thyroid disease (hyper or hypo)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Assessment Detail

Assessment:

Other Current/Detailed Diagnosis

Other disease #1

Record under comments ☐

Other disease #2

Record under comments ☐

Other disease #3

Record under comments ☐

Other disease #4

Record under comments ☐

Preventative Health

Blood Pressure Measured in past 2 years

Yes ☐

No ☐

Received Influenza vaccination in past 2 years

Yes ☐

No ☐

If female, had breast exam or mammography

Yes ☐

No ☐

Problem/Conditions - 2 of last 7 days

Diarrhea

Yes ☐

No ☐

Difficulty urinating,urinating 3+ times/night

Yes ☐

No ☐

Fever

Yes ☐

No ☐

Loss of appetite ☐

Yes ☐

No ☐

Vomiting

Yes ☐

No ☐

Problem/Conditions in Last Week

Change in sputum production

Yes ☐

No ☐

Chest pain at exertion or pain/pressure at rest

Yes ☐

No ☐

Constipation in 4 of last 7 days

Yes ☐

No ☐

Dizziness or lightheadedness

Yes ☐

No ☐

Edema

Yes ☐

No ☐

Shortness of breath

Yes ☐

No ☐

Delusions

Yes ☐

No ☐

Hallucinations

Yes ☐

No ☐

Pain

Frequently complains or show evidence of pain

No Pain ☐

Pain less than daily ☐

Pain daily ☐

Pain is unusually intense

Yes ☐

No ☐

Pain intensity disrupts usual activities

Yes ☐

No ☐

Character of pain

No Pain ☐

Localized-single site ☐

Multiple sites ☐

Pain controlled by medication

No Pain ☐

Medication offered no control ☐

Pain is partially/fully controlled by medication ☐

Falls Frequently

Number of times fell in last 180 days

0 ☐

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

7 ☐

8 ☐

9 or more ☐

Assessment Detail

Assessment:

Danger of fall

Unsteady gait

- Yes ☐
- No ☐

Limits going outside due to fear of falling

- Yes ☐
- No ☐

Life Style (Drinking and Smoking)

Felt the need/was told to cut down on drinking

- Yes ☐
- No ☐

Had to have a drink first thing in morning

- Yes ☐
- no ☐

Number of days client had one or more drinks

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Number of drinks consumed per day

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Smoked or chewed tobacco daily

- Yes ☐
- No ☐

Health status indicators

Client feels he/she has poor health (when asked)

- Yes ☐
- No ☐

Has conditions/problems that make them unstable

- Yes ☐
- No ☐

Has had a flare-up or recurrent or chronic problem

- Yes ☐
- No ☐

Treatments changed due to new acute episode

- Yes ☐
- No ☐

Prognosis of less than 6 months to live

- Yes ☐
- No ☐

Other status indicators

Fearful of family member or caregiver

- Yes ☐
- No ☐

Unusually poor hygiene

- Yes ☐
- No ☐

Unexplained injuries,broken bones,or burns

- Yes ☐
- No ☐

Neglected, abused or mistreated

- Yes ☐
- No ☐

Physically restrained

- Yes ☐
- No ☐

Weight Change

Unintended weight loss

- Yes ☐
- No ☐

Consumption

4 of last 7 days, ate 1 or less meals a day

- Yes ☐
- No ☐

Decrease in amt of food/liquids client consumes

- Yes ☐
- No ☐

Insufficient fluid

- Yes ☐
- No ☐

Assessment Detail

Assessment:

Nutritional treatments

days IV/infusion therapy - hydration

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Fluids by mouth

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Parenteral nutrition (TPN or lipids)

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Enteral -tube feeding

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Oral Status

Problem chewing or swallowing

- Yes ☐
- No ☐

Mouth is dry when eating a meal

- Yes ☐
- No ☐

Problem brushing teeth or dentures

- Yes ☐
- No ☐

Skin Condition

Troubling skin conditions or changes

- Yes ☐
- No ☐

Pressure Ulcer

- No Ulcer ☐
- Stage 1 ☐
- Stage 2 ☐
- Stage 3 ☐
- Stage 4 ☐

Stasis Ulcer

- No Ulcer ☐
- Stage 1 ☐
- Stage 2 ☐
- Stage 3 ☐
- Stage 4 ☐

Burns

- Yes ☐
- No ☐

Open lesions other than ulcers,rashes,cuts

- Yes ☐
- No ☐

Skin tears or cuts

- Yes ☐
- No ☐

Surgical wound site - thorax

- Yes ☐
- No ☐

Surgical wound site - abdomen

- Yes ☐
- No ☐

Surgical wound site - extremities

- Yes ☐
- No ☐

Surgical wound site - other

- Yes ☐
- No ☐

History of resolved pressure ulcer

- Yes ☐
- No ☐

Assessment Detail

Assessment:

Wound/Ulcer Care

Days rec'd Antibiotics, systemic or topical

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Dressing

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Pressure reduction,relieving devices

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Nutrition or hydration

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Turning/repositioning

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Debridement

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Surgical wound care

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Foot problems

Corns,calluses,structural problems,infections,fungi

- Yes ☐
- No ☐

Open lesions on the foot

- Yes ☐
- No ☐

Foot not inspected in 90 days by client or others

- Yes ☐
- No ☐

Home Environment

Lighting in evening

- Yes ☐
- No ☐

Flooring and carpeting

- Yes ☐
- No ☐

Bathroom and toiletroom

- Yes ☐
- No ☐

Kitchen

- Yes ☐
- No ☐

Heating and cooling

- Yes ☐
- No ☐

Personal safety

- Yes ☐
- No ☐

Access to home

- Yes ☐
- No ☐

Access to rooms in house

- Yes ☐
- No ☐

Living Arrangement

Client now lives with other persons

- Yes ☐
- No ☐

Believes client would be better in new environment

- No ☐
- Client only ☐
- Caregiver only ☐
- Client and caregiver ☐

Assessment Detail

Assessment:

Treatments

Alcohol/drug treatment program
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Blood transfusions
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Chemotherapy
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Cardiac rehabilitation
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Continuous positive airway pressure (CPAP)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Dialysis-peritoneal (CAPD)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Dialysis-renal
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Holter monitor
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

IV infusion - central
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

IV infusion - peripheral
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Medication by injection
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Ostomy care
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Oxygen therapy - intermittent
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Oxygen therapy- continuous (concentrator)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Oxygen therapy -continuous (other)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Radiation therapy
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Respiratory therapy
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Tracheostomy care
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Ventilator
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Assessment Detail

Assessment:

Therapies

Exercise therapy
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Occupational therapy
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Physical therapy
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Respiratory therapy (including suctioning, IPPB)
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Programs

Day center
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Day hospital
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Hospice care
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Physician or clinic visit
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Respite care
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Special procedures done in home

Daily nurse monitoring (e.g.,EKG,urinary output)
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Nurse monitoring less than daily
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Medical alert bracelet or electronic security alert
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Skin treatment
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Special diet
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Other
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Management of equipment

Oxygen
- ☐ Not used
- ☐ Managed on own
- ☐ Managed on own if laid out/ with reminders
- ☐ Partially performed by others
- ☐ Fully performed by others

IV
- ☐ Not used
- ☐ Managed on own
- ☐ Managed on own if laid out/with reminders
- ☐ Partially performed by others
- ☐ Fully performed by others

Catheter
- ☐ Not used
- ☐ Managed on own
- ☐ Managed on own if laid out/with reminders
- ☐ Partially performed by others
- ☐ Fully performed by others

Assessment Detail

Assessment:

Visits

Number of times admitted to hospital

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Number of emergency room visits

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Emergency care

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Treatment goals

Any treatment goals that have been met

- Yes ☐
- No ☐

Change in care needs

Self sufficiency has change significantly

- No change ☐
- Improved - receives fewer supports ☐
- Deteriorated - receives more support ☐

Trade offs

Client made financial trade-offs

- Yes ☐
- No ☐

Number of medications

Record the number of different medications

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 ☐

Psychotropic medication

Antipsychotic

- Yes ☐
- No ☐

Antianxiety

- Yes ☐
- No ☐

Antidepressant

- Yes ☐
- No ☐

Hypnotic

- Yes ☐
- No ☐

Medical oversight

Physician reviewed medications as a whole

- Discussed with one MD (or no medications taken) ☐
- No single MD reviewed all medications ☐

Compliance with medications

Compliant all or most of the time with medications

- Always compliant ☐
- Compliant 80% of time and more ☐
- Compliant less than 80% of time ☐
- No medications prescribed ☐

Instructions
Community Care Services Program

MINIMUM DATA SET- HOME CARE (MDS-HC)

Purpose: This form is used to assess a client's needs, strengths and preferences for home care.

Who Completes/When Completed: Care coordinators complete the MDS-HC at initial assessment and reassessment.

Instructions:

Use MDS-HC to complete assessments and reassessments in CHAT.
Print the short version of MDS-HC with client's responses for client files and providers.
If the long version is used for the interview with the client, key the responses before printing the short version.

NOTE: Care coordinators use the instructions in RAI-Home Care Assessment Manual to become familiar with completing the MDS-HC.

Georgia Department of Human Resources

NOTICE OF DENIAL, TERMINATION, OR REDUCTION IN SERVICE FROM THE COMMUNITY CARE SERVICES PROGRAM, FORM 5382

To_____ Date _____

_____

_____

Your participation in the Community Care Services Program (CCSP) has been given careful consideration. In accordance with the Code of Federal Regulations, 42 CFR 431 subpart E, the following determination has been made:

A. You have been determined ineligible for Community Care Services because

_____

_____

B. You have been determined no longer eligible for Community Care Services because

_____

_____

C. You have been determined to require fewer services because

_____

_____

If for any reason, you think the proper consideration has not been given to your situation, or if you disagree with this decision, you have the right to a hearing conducted by the Office of State Administrative Hearings. You may request a hearing orally or in writing by notifying the Area Agency on Aging or the care coordination agency listed at the bottom of this letter within 30 days of the date of this form. If you want a hearing, call your Area Agency on Aging or care coordination agency or send your written request to the address listed below. If you are currently receiving Community Care Services and have been sent a notice advising termination or reduction of services, you must request a hearing within 10 days of the date of this form to continue receiving service at the current level. If you are appealing a denial, you must wait for the Office of State Administrative Hearings to conduct a hearing and rule in your favor before you can receive Community Care Services.

If you request a hearing within the time frames stated above, it will be held in your county by an Administrative Law Judge employed by the Office of State Administrative Hearings.

You have the right to be represented at such hearing by a legal representative, friend, or other spokesperson. Contact the person indicated below for information about legal services which may be available in your community without cost to you.

_____ (____)_____

Screening Specialist/Care Coordinator Telephone

AAA or care coordination agency address:

_____

_____

_____

_____

Instructions
Community Care Services Program

NOTICE OF DENIAL, TERMINATION, OR REDUCTION IN SERVICE
FORM 5382

Purpose: This form is used to notify applicant/client of CCSP eligibility status or service reduction.

NOTE: Do not use this form to notify a client of a Level of Care denial or termination.

Who Completes/When Completed: The telephone screening specialist or care coordinator completes this form to advise a client of adverse action.

Instructions:

To: Enter name and address of the person to whom correspondence is being mailed.

Date: Enter date correspondence is mailed.

A. Enter the reason why applicant is not eligible for CCSP. Indicate which eligibility criteria are not met. Enter the reason for denial.

B. Complete this section when client is no longer eligible for any other reason other than level of care. Indicate which eligibility criteria are not met. Enter the reason for termination.

C. Complete this section when client is determined to be eligible for fewer services or units of service than s/he is currently receiving.

NOTE: Form 5382 is not mailed to client when Utilization Review determines a client is inappropriate or reduces or terminates service.

Screening specialist or care coordinator completing the form signs on appropriate line.

Telephone: Enter area code and telephone number of screening specialist or care coordinator completing form.

Distribution: Original is mailed to the client. Copy is filed in case record.

NOTICE OF RIGHT TO APPEAL DECISIONS REGARDING
COMMUNITY CARE SERVICES PROGRAM, FORM 5381

_____ _____
Client's Name Date

As an applicant for services or an individual receiving services through the Community Care Services Program (CCSP), you have the right to appeal any decision with which you disagree in regard to your participation in the Community Care Services Program. If you are receiving services, any or all services may change due to any of several reasons. If you disagree with a decision to change your current services or feel that a mistake has been made with regard to the services you are receiving in the Community Care Services Program, you have the right to a hearing.

You may request a hearing either orally or in writing within thirty (30) days of the adverse action by notifying the care coordinator, whose address and telephone number are at the bottom of this letter. If you are currently receiving Medicaid services under the CCSP and wish them to continue at the current level, you must request a hearing within ten (10) days of the date of the letter you receive advising you of the decision. The hearing will be held in your county by an Administrative Law Judge from the Office of State Administrative Hearings. The care coordinator will be available to provide the necessary forms and to assist you in preparing for the hearing.

You have the right to be represented at your hearing by an attorney, a relative or friend, or other spokesperson. Contact the care coordinator for information about legal services which may be available in your community without cost to you.

Care Coordinator _____
Telephone Number (_____) _____

Address _____

_____

_____

Form 5381, Rev. 7/2002

Instructions
Community Care Services Program

NOTICE OF RIGHT TO APPEAL DECISIONS REGARDING CCSP, FORM 5381

Purpose: Form 5381 is used to advise client at the initial face-to-face assessment of the right to appeal any adverse action decision.

Who Completes/When Completed: The RN completes this form.

Instructions:

Enter client's name.

Enter date the form is mailed or given to client.

Enter care coordinator's name, telephone and address of the care coordination agency.

Distribution: During the initial assessment, the original is given to client. A copy is filed in the client's case record.

OSAH FORM 1

This form is available online at http://www.ganet.org/osah/form.html or by telephone request at (404)657-2800.

OSAH USE ONLY DOCKET NO:	AGENCY CODE AGING	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE

NAME OF REFERRING AGENCY: DIVISION OF AGING (AGING) -DEPARTMENT OF HUMAN RESOURCES

Use ONLY For COMMUNITY CARE SERVICE PROGRAM Cases

SELECT ONE CASE TYPE:
- ☐ CCSP-SERV-(Community Care Services Program -- Services)
- ☐ CCSP-ELIG– (Community Care Services Program – Eligibility)

COUNTY OF NON-AGENCY PARTY'S RESIDENCE:

DATE OF REQUEST FOR HEARING:

CONTACT PERSON IN REFERRING AGENCY and ATTORNEY:

NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	POSITION	EMAIL PAGER
ATTORNEY NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	GEORGIA BAR NO	EMAIL PAGER

NON-AGENCY PARTY and ATTORNEY

NAME OF EMPLOYEE	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE ON HEARING REQUEST		EMAIL PAGER
ATTORNEY NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	GEORGIA BAR NO	EMAIL PAGER

FOR PURPOSES OF THIS HEARING, The PETITIONER will be the ☐ REFERRING AGENCY ☐ NON-REFERRING AGENCY PARTY
(check one)

DOCUMENT INITIATING THE HEARING: ☐ As "Attachment 1" to this form, attach the document initiating the hearing.

ISSUES TO BE RESOLVED: ☐ As "Attachment 2", attach an outline of the legal issues and factual matters to be resolved at the hearing including specific statutes or rules to be applied at the hearing

SPECIAL REQUIREMENTS: ☐ As "Attachment 3", attach a sheet identifying any statutes or rules (state or federal) establishing any specific time deadlines or procedures that are to be applied by OSAH in resolving the matter referred.

SERVICE OF DOCUMENTS: In addition to routine service on the agency's attorney, the agency contact person requests the following:

☐ No service of documents prior to certification of the file to the agency after a decision.
☐ Service of all documents prior to certification of the file to the agency after a decision.
☐ Service of a copy of the notice of hearing.
☐ Service of a copy of a continuance.
☐ Service of copy of any interim orders.

All documents will be mailed to the referring agency at the address indicated for the contact person to the contact person's attention unless written instructions provide an alternative place for service.

Instructions
Community Care Services Program

OSAH FORM 1

Purpose: This form is used as a cover letter for CCSP appeals submitted to Legal Services Office (LSO).

Who Completes/When Completed: AAA staff and care coordinators complete this form when submitting appeals from applicants and participants in the CCSP.

1. Indicate the name of the AAA or care coordination agency as the referring agency.
2. Write the client's name in the section used for the name of the employee.

Distribution: The original is used as the cover sheet to the appeal packet of information submitted to LSO and a copy is filed in the client's case record with a copy of the appeal packet.

Determine Your Nutritional Health

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Add up the numbers in the "YES" column for those that apply for you.

	YES
I have an illness or condition that made me change the kind and / or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 2 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and / or feed myself.	2
Total	

Total your Nutritional Score: If it's-

0-2 **GOOD!** Recheck your nutritional score in 6 months

3-5 **You are at Moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Check your score again in 3 months

6 or more **You are at high nutritional risk** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk to them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Turn to the page to learn more about the Warning Signs of poor nutritional health.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

Disease

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

Eating Poorly

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruits and vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruits and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

Tooth Loss/Mouth Pain

A healthy mouth, teeth and gums are needed to eat. Missing, loose, or rotten teeth or dentures which don't fit well or cause mouth sores make it hard to eat.

Economic Hardship

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or chosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

Reduced Social Contact

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

Multiple Medicines

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

Involuntary Weight Loss/Gain

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight also increases your chance of poor health.

Needs Assistance to Self Care

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

Elder Years Above Age 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

Reprinted with permission from the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association and the National Council on the Aging, Inc., and funded in part by a grant from Ross Products Division, Abbott Laboratories.

Instructions

Community Care Services Program

NUTRITIONAL SCREENING INITIATIVE (NSI) NUTRITIONAL HEALTH CHECKLIST

Purpose: The purpose of the NSI Checklist is to identify individuals who are at high risk of nutritional problems or who have poor nutritional status.

Who Completes/ When Completed: The care coordinator does not use the NSI checklist when completing an assessment or reassessment; instead, the RN or care coordinator completes the NSI in CHAT. Based on the client's score the NSI checklist may be completed between assessments.

NOTE: Referral sources include but are not limited to physicians, dietitians or other health professionals, social services, oral health, mental health, nutrition education, support or counseling services.

Instructions:

For each of the ten statements, read and circle the appropriate number in the "Yes" column which describes each client/ client representative response. Total the numbers circled to identify the client's nutritional score.

Based on the total score, make the appropriate referrals, if indicated, as suggested in the reference - Nutrition Interventions Manual for Professionals Caring for Older Americans Executive Summary 1992. Document all activity relative to the NSI checklist referral, such as follow-up and outcome results. Complete the NSI checklist as needed.

Distribution: A copy is filed in the client's case record along with documentation regarding any deviation from normal, specific instructions or referral information.

Community Care Services Program

POTENTIAL CCSP MEDICAID MAO FINANCIAL WORKSHEET

Client's name _____ Date of birth _____

Section I. INCOME	AMOUNT
Social Security	$_____
VA benefits	$_____
Retirement/Pension	$_____
Interest/Dividends	$_____
Other (specify)	$_____
TOTAL INCOME	$_____

NOTE: If monthly income exceeds the limit, stop here

Section II. RESOURCES	ESTIMATED VALUE
Cash	$_____
Checking account	$_____
Savings account	$_____
Credit Union account	$_____
Certificate of Deposit or IRA $_____	
Stocks or bonds	$_____
Patient fund account (held by nursing home)	$_____
House or property other than home, place that is not producing income	$_____
Other (specify)	$_____
TOTAL RESOURCES	$_____
Subtract Individual or Spousal Impoverishment Resource Limit	- $_____

NOTE: Use the Spousal Impoverishment Resource Limit when one spouse is in CCSP and the other is not in CCSP, nursing home or other institutional living arrangement.

List any resource (including home place) that has been transferred in the last 36 months:

_____

_____

_____

Section III. Statement of Intent: Cost Responsibility

I have applied for services through the Community Care Services Program. I am aware that I am responsible for the cost of services under the Community Care Services Program until the Department of Family and Children services determines my eligibility for Medicaid and cost share amount. I understand that I must apply for CCSP Medicaid benefits through the county Department of Family and Children Services (DFCS). If

DFCS determines that I have to pay a cost share, I will pay the monthly cost share to the appropriate provider(s). While waiting for DFCS to determine my cost share amount, I agree to pay to the appropriate provider(s) the full cost of services or the ESTIMATED cost share indicated on the line below, whichever the provider chooses.

$ _____

ESTIMATED COST SHARE: Based on the information provided by the client/representative, this is an estimate of the client cost share. This estimated cost share was discussed with the client/representative. They agree to apply for CCSP Medicaid at DFCS, and understand the DFCS will determine Medicaid eligibility and exact cost share amount.

If DFCS determined that I am ineligible for Medicaid, I will pay provider full cost of services.

ALL THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Client / Client Representative's signature Date

This form is not an application for Medicaid benefits. The care coordinator will advise you when to apply for Medicaid.

_____ _____

Care Coordinator Date

rev. 9/01

Instructions

Community Care Services Program

POTENTIAL CCSP MEDICAL ASSISTANCE ONLY (MAO) FINANCIAL WORKSHEET

Purpose: The Financial Worksheet is completed at the initial assessment of MAO or PMAO clients and when a change in income or resources may affect eligibility for the CCSP.

Who Completes/When Completed: The RN completes at the initial assessment. The care coordinator completes thereafter when income or resources change.

Instructions:

Section I. Income--record total income reported by client.

Section II. Resources--record client's statement of all resources based on current market value and total.

Section III. Statement of Intent: Cost share Responsibility--Explain cost share responsibility to client and include information that DFCS determines cost share amount. Give client written information about Medicaid and DFCS. Indicate the estimated cost share and discuss with client.

Distribution: Send a copy of this form to DFCS with the CCC and LOC. File the original in the client's case record.

PRIOR AUTHORIZATION REQUEST*

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
P.O. BOX 38409, ATLANTA, GEORGIA 30334

FOR DMA USE ONLY

Include This Number On All Claim Forms →

PRIOR AUTHORIZATION NO. 325303

1. Recipient Name (Last, First, Init.)

2. Medicaid ID No.

rthdate | 4. Sex | 5. Address

Nursing Home ☐ Yes ☐ No

6. Telephone (Area Code/Number)

7. Prescribing Physician/Practitioner Name And Address

8. Medicaid Provider Number

9. Telephone (Area Code/Number)

10. Provider Of Service(s) Name And Address

11. Medicaid Provider Number

12. Telephone (Area Code/Number)

☐ HOME HEALTH ☐ PODIATRIST ☐ OPTOMETRIST ☐ PHYSICIAN ☐ PSYCHOLOGIST ☐ DME/OP ☐ DDS ☐ PHARMACY

13. Authorization Period: From ____ Through ____

14. Description Of Service(s) Requested

DEPT. USE ONLY

15. Rec. Type | 16. Qty. Of Svc.

17. Primary Diagnosis Requiring Service(s)

18. ICD-9-CM

19. Justification And Circumstances For Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S)

LINE NO.	21. Description Of Procedures, Drugs, Equipment Or Other Services	22. Procedure/ Drug Code	23. Requested Or Estimated Price Per Unit	24. Bill. Units	25. Months or Units Of Service	26. Units Per Claim Max.	26. Units Per Claim Min.	27. Max. Units Per Month
2								
3								
4								
5								
6								
7								
8								

28. PROVIDER'S SIGNATURE

29. DATE SUBMITTED

30. REQUEST: ☐ APPROVED ☐ DENIED ☐ PENDING/ADDITIONAL INFORMATION ☐ APPROVED AS AMENDED

31. DMA SIGNATURE

32. DATE APPROVED

33. Explanation to Provider

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.

DMA-80 (6/86) COPIES: WHITE: DMA; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER

Instructions

Community Care Services Program

PRIOR AUTHORIZATION REQUEST, DMA-80

Purpose: The DMA-80 is a request from the provider to provide client services which exceed the cost cap. All services exceeding the cost cap must by approved by the Division of Aging

Who Completes/When Completed: The care coordinator completes the DMA-80 and sends it to the Division of Services for approval. No SAF can be released to reimburse the provider for services that exceed the cost cap until the Division of Aging Services approves the request and the SAF is un pended.

NOTE: Do not send DMA-80s for MAO clients to the Division of Aging when the net amount after deducting the cost share clients does not exceed the cost limit.

Instructions:

1. Recipient name: Enter client's last name, first and middle initial exactly as it appears on Medicaid card.

2. Medicaid number: Enter client's Medicaid number exactly as it appears on Medicaid card. Medicaid number for SSI recipient is his/her social security number followed by letter "S". Medicaid number for MAO recipient does not resemble the social security number at all and ends with letter "P". Providers verify Medicaid number every month since Medicaid eligibility may change from month to month. Claims are not paid by the Division of Medical Assistance for services provided to ineligible recipients.

3. Birth date: Enter client's birth date.

4. Sex: Enter sex of client.

5. Address: Enter client's complete address.

6. Telephone number: Enter area code and telephone number of client.

7. Prescribing physician/ Practitioner name and address: Enter name and address of physician who prescribed service requested.

8. Medicaid provider number: Enter 10 digit Physician Medicaid Number. If physician is not enrolled in Medicaid program, enter his/her state license number.

9. Telephone number: Enter area code and telephone number of prescribing physician.

10. Provider of service name and address: Enter CCSP provider's agency’s name and address.

11. Medicaid provider number: Enter CCSP provider's ten (10) digit provider enrollment number.
12. Telephone number: Enter area code and telephone number of CCSP provider of service(s).

13. Authorization period: Enter month for which service(s) is requested. Complete a DMA for each month requesting prior approval.

14. Description of service(s) requested: Enter type of Service(s) requested (ALS, ADH, ERS, HDM, HDS, PSS, RC).

15. **For Department Use Only:** Do not write in this space.

16. **For Department Use Only:** Do not write in this space.

17. Primary diagnosis requiring service(s): List diagnosis and describe condition briefly.

18. ICDA-8: Enter diagnosis code for International Classification of Diseases - leave blank if not known.

19. Justification and circumstances for required service(s): Enter justification of service. Justification includes he length of time cost of services is expected to exceed DHR/DMA maximum monthly amount. Explain *short term* nature of request and include descriptions of unusual or extenuating circumstances.

20. Line number: List each service on a separate line.

21. Description of procedures: List all CCSP waivered services to be reimbursed by Title XIX provided to client on separate lines, including those that are billed to a 3rd party (For example - Medicare).

22. Procedure/Drug code: Enter appropriate procedure code.

23. Requested or estimated price per unit: Enter charge per unit of service.

24. Billing unit: N/A.

25. Requested units of service: Enter number of units of procedure provided.

26. Units per claim: Use this space to calculate total cost of each service during service month.

    Enter total cost of each procedure by multiplying #23 x #25. Enter total cost of all services on Line 20-8.

27. Maximum units per month: N/A.

28. Provider's signature: Care coordinator signs form.

29. Date submitted: Enter date request is made from care coordinator's office.

FOR DIVISION OF AGING SERVICES USE ONLY

30. Request: Division of Aging staff will designate action to be taken by checking (T) one block in this section.

31. DMA signature: This section contains the signature of DHR Division of Aging Services Prior Authorization Staff.

32. Date approved: Date of approval is entered by DHR Division of Aging Services prior authorization staff.

33. Explanation to the provider: Comments from DHR Division of Aging Services prior authorization staff concerning this request are entered in this section.

Distribution: Original and all copies are forwarded to the Division of Aging Services, Upon approval, the original is maintained in the client's file at the Division of Aging Services. Three copies are mailed back to the care coordinator where the green copy is maintained in the client's case record at the PSA level and the yellow and pink copies are mailed to providers.

Community Care Services Program

PROVIDER ROTATION LOG

SSI, MAO, and PMAO Clients

SERVICE _____ **COUNTY** _____

PROVIDER NAME	PROVIDER ID NUMBER	CLIENT NAME	DATE SERVICE BROKERED	REFERRAL ACCEPTED/ DECLINED

Instructions
Community Care Services Program

PROVIDER ROTATION LOG
SSI, MAO, and PMAO Clients

Purpose: This form is used when a client does not choose a provider. New providers are added to the rotation log within three business days of the notification of the provider number from the AAA.

NOTE: There is one log, per county, per service.

Who Completes/When Completed: The care coordinator selects a provider from the top of the rotation log when the client does not select a provider. If the provider refuses to accept a client for any reason they are placed at the bottom of the rotation list for that complete rotation.

Instructions:

Service: Enter the service provided on this rotation log (e.g., Alternative Living Services, Adult Day Health).

County: Enter the county where this service is provided.

Provider Name: Enter each provider name as they are approved to provide CCSP services.

Provider ID Number: Enter each provider's ID number assigned by DMA.

Client Name: Enter the name of the client assigned to a provider by the rotation system.

Date Service Brokered: Enter the date the service was brokered and accepted by the provider.

Accepted or Declined: Enter A if the provider accepted the referral and enter D if the provider declined.

NOTE: If the provider declines the referral after accepting it, enter D and the date the referral was declined.

Distribution: This is an interoffice form and not distributed for any reason.

Georgia Department of Human Resources
Community Care Services Program

REQUEST FOR HEARING, FORM 5383

I request that the Department of Human Resources hold a fair hearing to review the adverse action taken in regard to my claim for assistance as provided under the Community Care Services Program.

The reason I want a hearing is:

_____

_____

_____

_____

Check one:

( ) I want to continue to receive CCSP services at the level that I am currently receiving.

( ) I do NOT want to continue to receive CCSP service.

_____ _____

Date Client's Signature or Mark*

_____ _____

Authorized Representative Signature of Witness*

_____

_____

Address of Witness*

* The signature and address of one (1) witness must appear above when the claimant signs with a mark (x).

Please return this completed form to your care coordinator whose address and phone number are indicated at the top of the denial, termination, or reduction in services letter from the Community Care Services Program.

FOR STATE OFFICE USE ONLY

Client's SSN: _____

Date Received: _____ Received by: _____

Date received by LSO _____

Form 5383

Instructions
Community Care Services Program

REQUEST FOR HEARING, FORM 5383

Purpose: Form 5383 is used by applicants or clients to begin the appeal process for denial, termination, or reduction in CCSP services. Clients may appeal orally with a formal written request within 15 days.

Who Completes/When Completed: The applicant/client or representative completes Form 5383 within 30 calendar days from the date of the notice of adverse action and forwards to the care coordinator or directly to the Legal Services Office.

Instructions:

The reason I want a hearing is: Client or client representative indicates reason for requesting a hearing and why s/he believes adverse action to be in error.

NOTE: Use of this form, while recommended, is optional with the client. Any written or oral request for an appeal must be accepted. A client need not state a reason for the request.

Date: Enter date request form is completed and signed.

Client's signature
or mark: Have client sign or enter his/her mark (X). If client signs by mark (X), a witness is required.

Client representative: Enter signature of client representative, if applicable.

Signature of witness: Enter signature of witness if client signs by mark (X).

Address of witness: Enter address of witness if client signs by mark (X).

Last Update Date

DHR - Division of Aging Services
Community Care Services Program
Service Authorization Form

Instructions

Print date:

Print time:

Case Manager:

Client Name: **SAF #:** **Version:**

Medicaid #: **SSN:**

Date of Birth: **County:**

Services Begin Date: **Services End:**

SAF Month: **Reason:**

Provider/ID	Procedure	Rate	Units	Amount	Net Amount

Gross Total:

Client Liability

Net Total:

Authorization and Approval

The Department of Human Resources agrees to reimburse the Department of Community Health for the State share of the services authorized above.

Case Manager: **Phone #:**

Authorizing Signature: _____ **Date:** ____/____/_____

Authorization and Approval

This service authorization has been Pended until a DMA-80 number has been approved by the Division of Aging Services

Case Manager: **Phone #:**

Instructions

Community Care Services Program

SERVICE AUTHORIZATION FORM (SAF)

Purpose: This is a printed computer form generated by AIMS after initial SAF data has been entered and for each month thereafter that services are authorized. This form is printed by the CCSP for providers to authorize reimbursement of services rendered. It is sent to the service provider and is used by the provider to obtain reimbursement from DMA's fiscal agent.

Who Completes/When Completed: Each CCSP client has a SAF for each month service is received. The care coordinator provides service information to data entry on a monthly basis or as needed basis to update AIMS.

Instructions:

Last Update Date: This is the date that the last change was made to the SAF.

Print Date/Time: This is the date/time that the SAF was generated.

Case Manager: This is the care coordinator for the client.

Client Name: This is the client's name (Last, First, Middle Initial if available).

Medicaid Number: This is the client's Medicaid number. The SAF cannot be generated without a valid Medicaid number.

Date of Birth: This is the client's date of birth as shown on Medicaid card.

Services Begin Date: This is the date the first Medicaid waivered service was provided.

SAF Month: This is the service month.

SAF #: This number is a unique identifier assigned when the SAF is generated. It is used for tracking purposes.

SSN: This is the client's social security number.

County: This is the county where the client resides.

Services End: This is the last date of service and only completed when a client is terminated.

Reason: This is the eligibility status listed in AIMS for the reason for termination.

SAF Version #: This is a new number which is assigned consecutively every time the SAF is updated /changed with in the service month. Version numbers start over each month. It is used for tracking purposes.

Provider Name/ID: This is the provider name and enrollment number for the authorized provider(s).

Procedure: This is the code for the service type. See Appendix T of Part II - Provider General Manual for the service procedure codes.

Rate: This is the service rate per unit. See Appendix T of Part II - Provider General Manual for the unit cost of services.

Units: This is the total number units of service ordered on the Comprehensive Care Plan.

Amount: This is the total cost per individual service calculated by AIMS.

Net Amount: This is the change in amounts between versions.

Gross Total: This is the total of all services authorized on the SAF.

Client Liability: A client must be a MAO client to have a client liability.

Provider Name/ID: This is the provider(s) that the care coordinator has determined to collect the cost share.

Amount: This is the amount of the cost share assigned to the provider(s).

Net Amount: Is the change in the amounts of cost share between versions.

Client Liability Total: This is the total amount of the client liability to be collected by the provider(s).

Net Total: This is the net amount, for which the provider may bill Medicaid after deducting the client liability.

Care Manager: This is the care coordinator's name.

Phone #: This is the care coordinator's phone number.

Authorizing Signature: This is the signature of the person authorizing payment of the SAF.

Date: This is the date the SAF was authorized.

DETERMINATION OF NEED- REVISED (DON-R)

Function	Level of Impairment	Unmet Need for Care	Comments
1. Eating			
2. Bathing			
3. Grooming			
4. Dressing			
5. Transferring			
6. Continence			
7. Managing Money			
8. Telephoning			
9. Preparing Meals			
10. Laundry			
11. Housework			
12. Outside Home			
13. Routine Health			
14. Special Health			
15. Being Alone			
Total 1-6 (ADL)			
Total 7-15 (IADL)			
Total 1-15 (ADL+ IADL)			

Instructions
Community Care Services Program

TELEPHONE SCREENING

Purpose: The TS is a pre-screening tool to determine appropriateness for services based on the applicant's medical and financial status.

Who Completes/When Completed: The CCSP screening specialist completes within three business days of receiving the referral. This action may occur at the care coordination or at the AAA level.

Inform applicant of screening process before you begin.

Complete the Client Detail Report and Screening Detail found in the Client Health Assessment Tool (CHAT).

Instructions for completion of the Determination Of Need-Revised (DON-R) Functional Assessment are outlined below.

DETERMINATION OF NEED - REVISED FUNCTIONAL ASSESSMENT (DON-R)

The Determination of Need (DON) defines the factors which help determine a person's functional capacity and any unmet need for assistance in dealing with these impairments. The DON-R allows for independent assessment of both impairment in functioning on Basic Activities of Daily Living (BADL) and Instrumental Activities of Daily Living (IADL) and the need for assistance to compensate for these impairments.

Assess both Column A Level of Impairment, and Column B Unmet Need for Care on all applicants. A minimum score of 15 is required in Column A Level of Impairment along with identified Unmet Need for Care in Column B, before a client is referred to care coordination for assessment. If the Level of Impairment score is less than 15 refer client for HCBS or other available resources.

The central question to determining the level of need for care is whether a person can perform activities of daily living (ADL). Table 1 presents the list of ADL included in the DON under two headings: BASIC AND INSTRUMENTAL.

Table 1 - Activities of Daily Living Included in the Determination of Need (DON) Functional Assessment

BASIC ACTIVITIES OF DAILY LIVING (BADL)	INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
Eating	Managing Money
Bathing	Telephone

Grooming	Preparing Meals
Dressing	Laundry
Transfer (In and Out of Bed/Chair)	Housework
Bowel/Bladder Continence	Outside Home
	Routine Health
	Special Health
	Being Alone

ITEM DEFINITIONS

1. EATING:

A. Is the client able to feed himself/herself?

Assess the client's ability to feed oneself a meal using routine or adapted table utensils and without frequent spills. Include the client's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages. When a special diet is needed, do not consider the preparation of the special diet when scoring this item (see "preparing meals" and "routine health" items).

B. Is someone available to assist the client at mealtimes?

If the client scores at least (1) in Column A, evaluate whether someone (including telephone reassurance) is available to assist or motivate the client in eating.

2. BATHING

A. Is the client able to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene as needed for the client's circumstances?

Assess the client's ability to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, and frequent profuse nose bleeds. Consider ability to get in and out of the tub or shower, to turn faucets, regulate water temperature, wash and dry fully. Include douches if required by impairment.

B. Is someone available to assist or supervise the client in bathing?

If the client scores at least (1) in Column A, evaluate the continued availability of resources to assist in bathing. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

3. GROOMING

A. Is the client able to take care of his/her personal appearance?

Assess client's ability to take care of personal appearance, grooming, and hygiene activities. Only consider shaving, nail care, hair care, and dental hygiene.

B. Is someone available to assist the client in personal grooming tasks?

If the client scores at least (1) in Column A, evaluate the continued personal assistance needed, including health professionals, to assist client in grooming.

4. DRESSING

A. Is the client able to dress and undress as necessary to carry out other activities of daily living?

Assess the client's ability to dress and undress as necessary to carry out the client's activities of daily living in terms of appropriate dress for weather and street attire as needed. Also include ability to put on prostheses or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or winter coat. Do not include style or color coordination.

B. Is someone available to assist the client in dressing and undressing?

If someone scores at least one (1) in Column A, evaluate whether someone is available to help dressing and/or undressing the client at the times needed by the client. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

5. TRANSFER

A. Is the client able to get into and out of bed or other usual sleeping place?

Assess the client's ability to get into and out of bed or other usual sleeping place, including pallet or armchair. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Include ability to adjust the bed or place/remove handrails, if applicable and necessary. When scoring, do not consider putting on prostheses or assistive devices.

B. Is someone available to assist or motivate the client to get in and out of bed?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, (including telephone reassurance and friendly visiting) to assist or motivate the client in getting into and out of bed.

6. CONTINENCE

A. Is the client able to take care of bladder/bowel functions without difficulty?

Assess the client's ability to take care of bladder/bowel functions by reaching the bathroom or other appropriate facility in a timely manner. Consider the need for reminders.

B. Is someone available to assist the client in performing bladder/bowel functions?

If the client scores at least (1) in Column A, evaluate whether someone is available to assist or remind the client as needed in bladder/bowel functions.

NOTE: When using the MDS-HC, the DON question regarding continence is incorporated in the MDS-HC question for toilet use.

7. MANAGING MONEY

A. Assess the client's ability to handle money and pay bills. Include ability to plan, budget, write checks or money orders, exchange currency, and handle paper work and coins. Include the ability to read, write and count sufficiently to perform the activity. Do not increase score based on insufficient funds.

C. Is someone available to help the client with money management and money transactions?

If the client scores at least (1) in Column A, evaluate whether an appropriate person is available to plan and budget or make deposits and payments on behalf of the client. Consider automatic deposits, banking by mail, etc.

8. TELEPHONING

A. Is the client able to use the telephone to communicate essential needs?

Assess the client's ability to use a telephone to communicate essential needs. The client must be able to use the phone: answer, dial, articulate and comprehend. If the client uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment. Do not consider the absence of a telephone in the client's home. (Note: the use of an emergency response system device should not be considered.

B. Is some available to assist the client with telephone use?

If the client scores at least (1) in Column A, evaluate whether someone is available to help the client reach and use the telephone or whether someone is available to use the telephone on behalf of the client. Consider the reliability and the availability of neighbors to accept essential routine calls and to call authorities in an emergency.

9. PREPARING MEALS

A. Is the client able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the client can eat?

Assess the client's ability to plan and prepare routine hot and/cold, nutritionally balanced meals. Include ability to prepare foodstuffs, to open containers, to use kitchen appliances, and to clean up after the meal, including washing, drying and storing dishes and other utensils in meal preparation. Do not consider the ability to plan therapeutic or prescribed meals.

B. Is someone available to prepare meals as needed by the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources (including restaurants and home delivered meals) to prepare meals or supervise meal preparation for the client. Consider whether the resources can be called upon to prepare meals in advance for reheating later.

10. LAUNDRY

A. Is the client able to do his/her laundry?

Assess the client's ability to do laundry including sorting, carrying, loading, unloading, folding, and putting away. Include the use of coins where needed and use of machines and/or sinks. Do not consider the location of the laundry facilities.

B. Is someone available to assist with the performing or supervising the laundry needs of the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of laundry assistance, including washing and/or dry cleaning. If public laundries are used, consider the reliability of others to insert coins, transfer loads, etc.

11. HOUSEWORK

B. Is the client able to do routine housework?

Assess the client's ability to do routine housework. Include sweeping, scrubbing, and vacuuming floors. Include dusting, cleaning up spills, and cleaning sinks, toilets, bathtubs. Minimum hygienic conditions for client's health and safety are required. Do not include laundry, washing and drying dishes or the refusal to do tasks if refusal is unrelated to the impairment.

C. Is someone available to supervise, assist with, or perform routine household tasks for the client as needed to meet minimum health and hygiene standards?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, including private pay household assistance and family available to maintain the client's living space. When the client lives with others, do not assume the others will clean up for the client. This item measures only those needs related to maintaining the client's living space and is not to measure the maintenance needs of living space occupied by others in the same residence.

12. OUTSIDE HOME

A. Is the client able to get out of his/her home and to essential places outside the home?

Assess the client's ability to get to and from essential places outside the home. Essential places may include the bank, post office, mail box, medical offices, stores, and laundry if nearest available facilities are outside the home. Consider ability to negotiate stairs, streets, porches, sidewalks, entrance and exits of residence, vehicle, and destination in all types of weather. Consider the ability to secure appropriate and available transportation as needed, will increase the score. However, in scoring, do not consider the inability to afford public transportation.

B. Is someone available to assist the client in reaching needed destinations?

If the client scores at least one (1) in Column A, evaluate the continued availability of escort and transportation, or someone to go out on behalf of the client. Consider banking by mail, delivery services, changing laundramats, etc., to make destinations more accessible.

NOTE: When using the MDS-HC, the DON question regarding outside home is incorporated in the

MDS-HC question for transportation.

13. ROUTINE HEALTH CARE

A. Is the client able to follow the directions of physicians, nurses, or therapists, as needed for routine health care?

Assess the client's ability to follow directions from a physician, nurse, or therapist, and to manipulate equipment in the performance of routine health care. Include simple dressings, special diet planning, monitoring of symptoms and vital signs (e.g., blood pressure, pulse, temperature and weight), routine medications, routine posturing and exercise not requiring services or supervision of a physical therapist.

B. Is someone available to carry out or supervise routine medical directions of the client's physician or other health care professionals?

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to remind, supervise or assist the client in complying with routine medical directions. If the assistance needed involves intimate care , and the care giver is inappropriate and/or opposed by the client, consider the assistance unavailable.

14. SPECIAL HEALTH CARE

A. Is the client able to follow directions of physicians, nurses or therapists as needed for specialized health care?

Assess the client's ability to perform or assist in the performance of specialized health care tasks which are prescribed and generally performed by licensed personnel including physicians, nurses, and therapists. Include blood chemistry and urinalysis; complex catheter and ostomy care; complex or non-routine posturing/suctioning; tub feeding; complex dressings and decubitus care; physical, occupational and speech therapy; intravenous care; respiratory therapy; or other prescribed health care provided by a licensed professional. Score "0" for clients who have no specialized health care needs.

B. Is someone available to assist with or provide specialized health care for the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of specially trained resources as necessary to assist with or perform the specialized health care task required by the client.

15. BEING ALONE

A. Can the client be left alone?

Assess the client's ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the client's ability to evacuate the premises or alert others to the client's need for assistance, if applicable, and to use appropriate judgment regarding personal health and safety.

B. Is someone available to assist or supervise the client when the client cannot be left alone?
If the client scores at least one (1) in Column A, evaluate the continued availability of someone to assist or supervise the client as needed to avoid danger and respond to emergencies. Consider friendly visiting, telephone reassurance, and neighborhood watch programs.

BADL's refer to those activities and behaviors that are the most fundamental self-care activities to perform

and are an indication of whether the person can care for his or her own physical needs.

IADL's are the more complex activities associated with daily life. (They are applications of the BADL's.) Information regarding both BADL and IADL are essential to evaluating whether a person can live independently in the community.

The DON-R Functional Assessment is a unique measure of functional assessment in that it differentiates between impairment in functional capacity and the need for care around a particular functional capacity. Furthermore, it is an ordinal scale with clearly defined meanings for each level of unmet need for care and each functional activity. Because of its ordinal nature, it permits quantification of scores so that changes in scores in subscales for BADL's and IADL's and for Total Impairment represent actual changes in impairment, and changes in scores for unmet need for care in BADL's, IADL's and Total Unmet Need for Care represent actual changes in unmet need for care.

Ask if client has a medical/health problem/diagnosis with functional impairment. Take the following action as appropriate:

1. If answer is "no", inform applicant of CCSP ineligibility and right to appeal. If applicant agrees, complete TS and refer client to other resources as appropriate.

2. If applicant's answer is yes, continue screening process answering each area with appropriate number (0-3).

Some general comments about the DON-R are provided to assist in the completion of the instrument.

The "Case Comments" space to the right of Column B in the functional status section is used to:

- Note special reasons for impairment or unmet need.

- Describe the type of service, caregiver support or assistive devices that decreases the client's unmet need.

- Record the primary care giver's name or other pertinent information.

Column Rules:

Use the following criteria to decide when to stop asking questions for a particular Functional Status item or when to skip Column B:

1. Ask each Functional Status item, starting with Column A, Level of Impairment.

2. If Column A, "level of impairment" is scored "0", score Column B "0".

3. If Column A is scored greater than "0", ask Column B, Unmet Need for Care.

Column A: Level of Impairment

Each one of the BADLs and IADLs needs to be discussed in terms of level of impairment. How the assessor mentions functional impairment is not as important as encouraging the client to report difficulties with the activity. Sample questions could include:

- Are you able to do...?

- How much difficulty do you have in doing...?

NOTE: If an applicant is living in a personal care home or nursing home, determine Impairment Level using Column A of the DON-R.

The objective is to gather sufficient information to determine the most appropriate score.

Answers to these questions should address the degree of unmet need for care if discharge occurs.

Score 0 - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of function remains; or
- Activity is not required by the client (IADLs: medication management, routine and special health only); or
- Client may benefit from but does not require verbal or physical assistance.

Score 1 - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- Experience minor, intermittent fatigue in performing the activity; or
- Take longer than would be required for an unimpaired person; or
- Require some verbal prompting to complete the task**Score 2** - Cannot perform most of the essential components of the activity, even with an assistive device, and /or requires a great deal of verbal or physical assistance to accomplish the activity.

This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; or
- Take an excessive amount of time to perform the activity; or
- Must perform the activity much more frequently than an unimpaired person; or
- Require frequent verbal prompting to complete the task.

Score 3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant verbal or physical assistance.

Column B: Unmet Need for Care

In scoring this column, the idea is both to obtain information from the applicant about his or her

perceptions regarding need for care and to use observational skills to determine the impact on the applicant should care or assistance not be provided, or a caregiver is unable to continue providing care at the current level. The availability of an appropriate caregiver also needs to be assessed.

Assess the degree to which the caregiver feels overwhelmed or burdened by the caregiving situation. The Zarit burden scale or the Caregiver Hassels Scale are formal assessments that may be used to assess caregiver burden.

Questions that might be asked of applicants and caregivers are:

- Do you feel burdened by providing care to your family member or friend?
- How often do you feel this way: frequently (daily), occasionally (weekly), sometimes (monthly), rarely (less than monthly?
- How long will you be willing/able to provide care at the current level?

Questions that might be asked of applicants and caregivers are:

- Can you tell me if you are getting enough help in meeting your needs with...?
- Do you think you need more help with...?

If the applicant is living in a personal care home or nursing home, score the applicant according to the care he would receive if discharged. To determine the future need for care, include the following questions:

a. Who will/would provide care in the home if the person was discharged?
b. How much care will the person need?
c. How much can the person do for him/herself?
d. How often will assistance be provided/available?
e. How long would this plan last?

NOTE: Answers to these questions should address the degree of unmet need for care if discharge occurs. Observe the applicant's mobility, level of clutter, personal appearance, unpaid bills, forgetfulness, etc., to assess the level of risk to health or safety if current levels of assistance are not maintained, or if additional assistance is not added.

Score 0 - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health:

and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

Comments - Ask applicant "If you don't get CCSP services, what will happen" and record the answer in applicant's own words.

Distribution: Export the file from CHAT to the care coordinator for initial assessment.

CCSP WAITING LIST

QUARTERLY STATUS REPORT

AAA Service Area _____

Date Submitted _____

Quarter Ending
(Check one): _____ 9/30/ _____ 12/31/ _____ 3/31/ _____ 6/30/

A. Number on waiting list at end of previous quarter _____

B. Number added to waiting list this quarter _____

C. Number removed from waiting list this quarter, by reason

1. _____ Admitted to CCSP
2. _____ Admitted to a nursing facility
3. _____ Admitted to non-CCSP services
4. _____ Death
5. _____ Other, please specify reasons below:
   Needs Inappropriate, Needs too Great, Refused Services,
   Unable to contact client, Refused Cost Share

Total removed (C1 + C2 + C3 + C4 + C5) _____

D. Number on waiting list at end of this quarter (A + B + C) _____

E. Of those on the waiting list at the end of the quarter (D above),
how many are receiving non-CCSP services pending CCSP admission? _____

F. Average number of months those admitted to CCSP (C.1.)
were on waiting list before admission to CCSP _____

Instructions
Community Care Services Program

CCSP WAITING LIST QUARTERLY STATUS REPORT

Purpose: To provide to the Division of Aging Service basic information on individuals who have been on the waiting list in the previous quarter.

Who Completes/ When Completed: The AAA or care coordination contractor completes the report each quarter.

Instructions:

1. Enter AAA service area and date submitted.

2. Enter a check mark in the appropriate quarter.

3. Enter number of individuals remaining on waiting list at the end of the previous quarter.

4. Enter number of individuals added to waiting list this quarter.

5. Enter number of individuals removed from waiting list this quarter, by reason (1-5) identified on report. Add number listed for each reason to obtain total number removed.

6. Enter total number on waiting list this quarter by adding numbers from A and B above. From that number subtract number listed in item C.

7. Enter the number of individuals on waiting list who are receiving non-CCSP services pending CCSP admission.

   NOTE: Use CHAT to obtain information regarding individuals receiving formal services.

8. Enter average number of months those admitted to CCSP were on waiting list prior to admission to CCSP.

Distribution: A copy of the report is sent to the Division of Aging Services each quarter.

Georgia Department of Human Resources
Community Care Services Program

NOTICE OF STATUS OF REQUEST FOR SERVICES FROM THE COMMUNITY CARE SERVICES PROGRAM

To: _____

_____

_____

Date of Request: _____

Based on your telephone screening assessment, you have been determined eligible for the Community Care Services Program (CCSP). We have added your name to the list of individuals waiting to be served through the CCSP.

When funds become available, a nurse will contact you to make an appointment to visit you to work with you in developing a service plan that meets your needs. **Your name will remain on the waiting list until otherwise notified.**

If you have questions about this information or your situation changes, please contact the person listed below.

_____ _____( )_____
Screening Specialist Telephone

_____ _____
Area Agency on Aging Fax

_____
Address

_____

_____
Date

Rev. 08-08-01

Instructions
Community Care Services Program

NOTICE OF STATUS OF REQUEST FOR SERVICES FROM THE COMMUNITY CARE SERVICES PROGRAM

Purpose: The Notice of Status form is used to notify applicants of their CCSP eligibility and placement on the waiting list.

Who completes/When completed: The screening specialist completes the form when notifying an applicant of the waiting list status.

Instructions:
Enter the applicant's name and address.

Enter the date of the applicant's request or the referral for CCSP.

Enter the name and phone number of the screening specialist.

Enter the name, address, fax number of the Area Agency on Aging and the date the letter is being mailed.

Distribution: The screening specialist completes this form and sends it to the applicant or representative. Indicate in the case notes that the form was sent to the applicant.

Revised 8/8/01

YOUR LETTERHEAD HERE

Date _____

To: _____

Client Name : _____

DOB _____

SS# _____

1. Documentation of client's symptoms or observations that require medical assessment and diagnosis.

_____

_____

_____

2. Reported Medical Problems

_____ _____

_____ _____

_____ _____

_____ _____

3. Indicate Mental Retardation/Mental Health diagnosis

_____

We have assessed/reassessed this client to assess for services through the Community Care Services Program (CCSP). CCSP is a waivered service under Medicaid that provides services in the community for the client who, otherwise, would qualify for nursing home placement. Attached you will find the client's problems and needs identified. Please review these documents.

Please sign and return forms to our office as soon as possible to allow us to arrange/continue to arrange for delivery of services.

Respectfully,

_____
Care Coordinator

Original PHYSICIAN'S or NP SIGNATURE REQUIRED FOR APPROVAL of Level of Care
Please return no Later than _____

Instructions
Community Care Services Program

COVER LETTER FOR LEVEL OF CARE (LOC) FORM

Purpose: The intent of the letter is to identify medical problems, signs and symptoms, and observations to assist the physician in the diagnosis.

Who Completes/When Completed: The care coordinator completes the cover letter and attaches it to the Level of Care (LOC) form and care plan sent to the physician at the time of the initial assessment or reassessment of the client.

Instructions:

Date: Enter date care coordinator completes LOC cover letter.

To: Name of primary physician responsible for medical oversight.

Client Name: Enter name as it is written on Level of Care form.

Date of Birth: Enter same DOB as is written on LOC form.

Social Security Number: Enter client Social Security number.

1. Enter any pertinent information required to meet the Intermediate Level of Care. This area applies to sign/symptoms/observations the physician may need to assess in the absence of a diagnoses. An example may be short-term memory loss with resulting ADL deficits

2. Enter diagnosis included on the referral form and those stated by the client and/or family. The priority of diagnosis listing should be reflective of those diseases that result in deficits that meet the criteria of the intermediate LOC.

3. Enter any known or stated mental health and or mental retardation diagnosis.

The care coordinator signs the form.

Enter date the signed form is required to be returned to meet the SOP.