STATE OF MICHIGAN

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Adult Services Policy Manuals

Issued: 10-5-2016

STATE OF MICHIGAN

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADULT SERVICES TRAINING REQUIREMENTS

This manual item outlines training requirements for all adult services (AS) supervisors and workers. This includes core program training and in-service training hours.

AS Core Training Requirements

All **new** AS program managers, supervisors and workers **must complete** AS core training, provided by the Office of Workforce Development and Training (OWDT), within the first twelve (12) months they work in AS. The three AS program areas are:

- Adult community placement.
- Adult protective services.
- Independent living services.

Program managers must complete core training for all AS programs. Supervisors and workers must complete core training for all AS programs unless they work in a county where AS staff are specialized by program. If a supervisor or worker only works within one program and their duties do not overlap, they are only required to complete core training for their respective program(s).

In-Service Training Requirements

All AS supervisors and workers that have been in adult services for twelve (12) months must complete a minimum of **eight (8) in-service training hours** each calendar year beginning January 1, 2016. Staff should satisfy the eight-hour training requirement by November 30 of each calendar year. This will allow time at the end of each calendar year to accommodate unexpected absences, training cancellations, etc.

Note: New AS employee in-service training hour requirements begin on January 1 following their first twelve (12) months in AS.

Approved In-Service Training

Each employee and his/her manager or supervisor must identify training needs and include those in the employee's yearly employee performance review. Trainings, conferences, webinars, etc. that are provided by the MDHHS, local partners, other professionals

may be utilized to meet in-service training hours, if the subject(s) enhance staff's knowledge and skills in working with AS clients.

Note: Activities that do not count toward in-service training hours include:

- Routine staff meetings.
- Coursework completed toward a degree.
- Reading a book.
- Watching a movie.

Tracking In-Service Training Hours

Each AS manager and supervisor must track completion of in-service training requirements, for the employees they supervise, utilizing the OWDT, Learning Management System (LMS). Training on access and use of LMS is available on the OWDT website.

Note: AS staff must be profiled correctly on the Adult Services Comprehensive Assessment Program (ASCAP) for managers and supervisor to access their information on LMS.

OVERVIEW

Adult Community Placement is the Medicaid State Plan for personal care services provided to residents in a licensed facility. The purpose of the Adult Community Placement (ACP) program is to provide a range of support and assistance related services to enable individuals to live safely in the least restrictive community-based care setting.

MISSION STATEMENT

The vision of Adult Community Placement is to:

- Ensure client choice and personal dignity.
- Ensure clients are safe and secure as much as possible.
- Encourage clients to function to the maximum degree of their capabilities.

To accomplish this vision MDHHS will:

- Act as resource brokers for clients.
- Advocate for equal access to available resources.
- Develop and maintain fully functioning partnerships that educate and effectively allocate limited resources on behalf of the clients.

SERVICES AVAILABLE

Medicaid related ACP services include personal activities of daily living (ADLs) and medication (IADL).

Non-Medicaid ACP services are available to individuals upon request regardless of income. Non-Medicaid services include all services listed below:

- General information and referral of community sources such as available licensed facilities for private pay individuals.

- Protection (for adults in need of a conservator or a guardian, but who are not in any immediate need of protective intervention).

- Money management (Referrals to Social Security Administration).

- Assistance with applying for Medicaid.

PROGRAM GOALS

Adult Community Placement services are directed toward the following goals:

- To encourage the client's right and responsibility to make informed choices.
- To ensure the necessary supports to assist clients to live with dignity in the least restrictive community based setting.
- To recognize and encourage the client's natural support system.
- To ensure flexibility in service planning, respecting the client's right to determine what services are necessary.
- To provide the necessary tools to enable client self-advocacy.

PROGRAM OUTCOMES

Program goal attainment will be measured by:

- **Client referrals**: clients will be referred to appropriate programs/ resources. The status of referrals will be closely monitored.
- **Client safety**: each ACP client will be safely maintained in the least restrictive setting which meets his/her needs.
- **Client service supports**: as a client's functionality declines, progressively increased service supports may be needed to enable the resident to live in the least restrictive setting.

SERVICE DELIVERY METHODS

Personal care services are delivered by the case management methodology. See **ASM-030, Service Methodology** for a description.

HANDLING OF INFORMATION

Any information received by the MDHHS that suggests the presence of abuse, neglect or exploitation must be processed as an Adult Protective Services (APS) referral. Contact Centralized Intake (CI) at 1-855-444-3911 to make an APS complaint. The investigation of complaints should be coordinated with APS and the Bureau of Community and Health Services (BCHS) within Licensing and Regulatory Affairs (LARA); see **ASM-210 and ASM-250**.

If the complaint involves a client of community mental health services or one that resides in a CMH licensed home, then the Office of Recipient Rights (ORR) must be notified there is an APS referral regarding a CMH client. In order to determine the correct ORR to contact, a list is available at the Adult Services Intranet home page under Reference Materials link.

LEGAL AUTHORITY

Title XIX of the Social Security Act, 42 USC 1346 et seq.42 CFR 440.170 (f)

Social Welfare Act, 1939 PA 280, as amended, MCL 400.14(1) (p)

Medicaid State Plan is the state's contract with the federal government to provide a Medicaid program. Adult Community Placement is the Medicaid State Plan for personal care services provided to residents in a licensed facility. The Michigan Department of Health and Human Services is the single state agency for Medicaid.

REASONABLE ACCOMMODATIONS

The following information is an excerpt from the **Non-Discrimination in Services** document.

The requirements of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) apply to all Michigan Department of Health and Human Services (MDHHS) programs services and activities. These requirements involve screening and assessment as well as redeterminations and the appeal of negative actions.

MDHHS must furnish reasonable accommodations if necessary to afford a qualified individual with a disability an equal opportunity to participate in and receive the benefits of available services, programs, or activities. Reasonable accommodations or reasonable modifications in this context mean:

- Modification (when possible) of deadlines, rules, policies and practices.
- Removal of architectural, communication or transportation barriers.
- Provision of auxiliary aids and services necessary for a person with a disability to obtain public services.

All disability related barriers or limitations and all reasonable and necessary accommodations must be prominently noted in the case file in a location where they will be immediately obvious to any MDHHS staff that accesses the file.

Access to this information is to ensure that accommodations will be provided in all instances, including when cases are transferred or the regular caseworker is unavailable.

This information also must be disclosed prominently when the client or case is referred to another MDHHS entity or staff person, including the Office of Child Support, Recoupment Specialist, Administrative Hearings, etc.

Notification of right to request reasonable accommodations

If the client discloses a disability, or if the adult services worker feels an accommodation is accessed for participation, the adult services worker will inform the client that it is the client's right to request a reasonable accommodation.

Adult services worker will provide the client with form **DHS-4428-A**, **Client Reasonable Accommodation Request**. This form can be obtained in the MDHHS Forms Library.

All MDHHS adult services worker are expected to inform the client that disclosure of disability information is voluntary and that the information may be shared pursuant to the administration of the program. MDHHS cannot provide extra help or services, or modify procedures to accommodate a disability of any household member, unless the disability is disclosed.

Adult services workers must explain that information about disabilities will be used to make sure all eligible individuals are able to receive benefits available through programs administered by MDHHS, but that disclosure of a disability is not an automatic approval of Medicaid or other services.

If an individual chooses not to disclose a disability that is not otherwise obvious, MDHHS is not responsible for providing an accommodation.

Disclosure of a disability is always voluntary.

The entire **Non-Discrimination in Service Delivery** document is available on the Adult Services Intranet home page under the link Reference Materials.

PERSON CENTERED CASE PLANNING

The adult services worker views each client as an individual with specific and unique circumstances and will approach case planning holistically from a person-centered, strength-based perspective.

Person-centered, strength-based case planning focuses on the following:

- Client as decision-maker in determining needs and case planning.
- Client strengths and successes, rather than problems.
- Client as their own best resource.
- Client **empowerment**.

The adult services worker's role includes being an advocate for the client. **As advocate, the worker will**:

- Assist the client to become a self-advocate.
- Assist the client in securing necessary resources.
- Inform the client of options and educate him/her on how to make the best possible use of available resources.
- Promote services for clients in the least restrictive environment.
- Ensure that community programming balances client choice with safety and security.
- Advocate for protection of the frail, disabled, and elderly.
- Promote employment counseling and training services for developmentally disabled persons to ensure inclusion in the range of career opportunities available in the community.

PARTNERSHIPS

The adult services worker works cooperatively with other agencies to ensure effective coordination of services; see **ASM-085, Coordination with Other Agencies**.

GENERAL CLIENT ELIGIBILITY

An individual 18 years of age or older qualifies for Adult Community Placement (ACP) program services.

Medicaid eligible services

ACP services for a personal care supplement payment are available if the client meets all eligibility requirements. ACP eligibility requirements include all of the following:

- Medicaid (MA) eligibility.
- Certification of medical need.
- Verification of the client's medical need by a Medicaid enrolled medical professional on the DHS-54A, Medical Needs form.
- A completed DHS-324, Adult Services Comprehensive Assessment (in ASCAP). An individual residing in a community placement facility is eligible for personal care services if they score level 2 or above on any Activities of Daily Living (ADL), or Instrumental Activity of Daily Living (IADL) of medication.

Non-Medicaid eligible services

An ACP case may be opened to supportive services for non-Medicaid related services that would include:

- Providing information and referral for community placement facilities.
- Medicaid application assistance while pursing ACP program supplement payment benefit.

MEDICAID DETERMINATION

Clients not on Medicaid who have a determined need for a Medicaid personal care supplement payment should be referred to an Eligibility Specialist (ES) for Medicaid (MA) determination.

If the Medicaid eligibility is not determined within the 45 day standard of promptness (SOP), then the adult services worker must

make a case disposition determination. An adult services worker can:

- Open a case to supportive services to give a Medicaid determination more time.
- Deny a pending application due to the applicant not receiving Medicaid benefits.

No personal care supplement payments can be paid until the Medicaid eligibility has been approved.

Payments can be paid retroactive up to 365 days from the application date to cover extreme delays in Medicaid determinations.

MEDICAID SCOPE OF COVERAGE (MA)

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- Medicaid deductible obligation has been met.

The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).
- 3G (Healthy Michigan).

Clients with a scope of coverage 20, 2C, or 2B are not eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

Medicaid personal care option

Clients residing in community placement settings can meet their deductible by utilizing the MA personal care option. Medical personal care option in an ACP facility requires the following:

- The licensed provider must determine a daily dollar amount for personal care provided to the residents, which is separate from the room and board costs.
- Licensed provider must submit documentation of the personal care provided to the eligibility specialist.
- The eligibility specialist uses this documentation to approve the client for ongoing Medicaid.
- The licensed provider is then able to submit a claim for the personal care supplement payment.
- Medicaid is authorized from the first day of the month; see **BEM-545, MA Group 2 Income Eligibility**, Exhibit ID.

Note: No portion of the personal care supplement payment to the AFC provider can be used to meet a Medicaid deductible.

APPROPRIATE LEVEL OF CARE STATUS

Verify the client's level of care (LOC) to make sure there will be no duplication of services which causes the client being ineligible for the ACP program.

The level of care information can be found in ASCAP under the **Bridges Search** or **Bridges Eligibility** module, **MA History** tab. When searching for level of care directly in the Bridges program, the information can be found under the Bridges section **INTERFACES**-level of care tab.

Level of Care Codes (LOC)

The following list is a description of each level of care codes:

Level of Care-02 Long Term Care Facility

A client with a level of care of 02 is receiving services in:

- Nursing facility.
- County medical facility.
- Hospital long-term care facility.
- Hospital swing bed.

Clients with this level of care status **are not** able to receive any personal care supplement through the ACP program or be in one of the listed facilities and an AFC/HA at the same time.

Note: If the client transfers from a nursing facility to an AFC setting or transfers from the AFC to a nursing facility, the LOC needs to be changed to the proper code by the eligibility specialist to allow for any partial or prorated amounts to be paid to the AFC setting.

Level of Care-07 Medicaid Health Plan

A client with the level of care 07 indicates the client has Medicaid benefits and the ACP personal care payment can be made to the licensed facility.

MI Health Link Integrated Care -07

If a client is enrolled in MI Health Link Integrated Care (ICO) they will not be eligible for ACP as those services will be provided by their ICO. In these cases the LOC code will show 07 **AND** they will have one of the following provider ID codes following the 07:

- Aetna Better Health of MI, Provider ID 2836392 or 2836393
- AmeriHealth Michigan, Provider ID 2836401 or 2836397
- Fidelis SecureCare of MI, Provider ID 2836406 or 2836407
- HAP Midwest Health Plan, Provider ID 2836404 or 2836405
- Meridian Health Plan, Provider ID 2836394 or 2836396
- Molina HealthCare, Provider ID 2836399 or 2836400
- UP Health Plan, Provider ID 2836390 or 2836403

Note: This is a 3 year (2015-2018) demonstration project that only applies to the following counties:

- All Upper Peninsula counties
- Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
- Wayne & Macomb

PACE- 07 level of care

The level of care for Program of All-Inclusive Care for the Elderly (PACE) recipients is also 07. Please see **ASM-085, Coordination with Other Agencies** for a list of medical providers that will help identify if a client is receiving PACE. PACE recipients **are not** able to receive the personal care supplement payment through ACP.

Level of Care-16 Hospice

A client with a level of care 16 is receiving hospice services. A person can receive hospice services and personal care supplement payments at the same time. Personal care payment is paid using State funds and not Title XIX funds. See **ASM-065, ACP Payments, Warrants, and Recoupment** for a description of Title XIX and State Fund sources.

Level of Care-22

A client with a level of care 22 is receiving services from the MI Choice waiver program. The client will not be able to receive the personal care supplement payment through the ACP program with a level of care 22 as this is a duplication of Medicaid personal care services.

Level of Care-32 Institutional Care

A client with a level of care 32 is living in a detention facility. A client with level of care 32 is not eligible for Medicaid.

DETERMINATION OF ACP ELIGIBILITY

Written Notification of Application Disposition

The following forms are documented under ASCAP contacts when they are generated within ASCAP and are used for notification of program eligibility for the client. These documents act as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice
- DHS-1212A, Adequate Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

Note: The adult services worker must sign the bottom of the second page of all notices (DHS-1210 and DHS-1212A) before they are mailed to the client.

Services Approval Notice (DHS-1210)

If ACP services are approved, the DHS-1210, Services Approval Notice, is used and generated in ASCAP indicating that services have been authorized for the personal care supplement payment to be paid to the licensed facility.

Adequate Negative Action Notice (DHS-1212A)

The DHS-1212A, Adequate Negative Action Notice, is used and generated in ASCAP when ACP services have been denied. Appropriate notations must be entered in the comment section to explain the reason for the denial.

Adequate Negative Action Notices **do not** require a 10 business day notice to the client.

APPLICATION FOR SERVICES (DHS-390)

The client or authorized representative must complete and sign a DHS-390, Adult Services Application, to receive the personal care supplement for the community placement where they reside.

The adult services worker **must not** sign the DHS-390 on behalf of the client.

A client unable to write may sign with an X, witnessed by one other person (for example, a relative or department staff).

It is important for the licensed facility to have the client or the authorized representative complete the application in a timely manner, usually immediately after the client moves in to the facility.

Best practice is to leave a copy of the DHS-390 application form at the licensed facility to ensure timely application for new residents.

The DHS-390 remains valid unless the case record is closed for over 90 days.

MEDICAL NEEDS FORM (DHS-54A)

The DHS-54A, Medical Needs, form is required for **all** clients receiving Medicaid personal care services. The DHS-54A must be signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an existing enrolled Medicaid provider and hold one of the following professional licenses:

- Physical (M.D. or D.O).
- Nurse practitioner.
- Occupational therapist
- Physical therapist.
- Physician Assistant (PA).

Medical Needs form (DHS-54A) - continued

The medical needs form is only required at the initial opening for SSI recipients and disabled adult child (DAC). All other Medicaid recipients must have a DHS-54A completed at the initial opening and when health changes are reported after the initial assessment.

The client or their representative is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and not the client. The National Provider Identifier (NPI) number must be entered on the form by the medical provider and the medical professional must indicate whether they are a Medicaid enrolled provider.

The medical professional certifies that the client's need for service is related to an existing medical condition. **The medical professional does not prescribe or authorize the actual personal care services.** The list of available services on the form is there for medical reference only.

If the medical needs form has not been returned, the adult services worker should follow up with the client and/or medical professional.

The DHS-54A must be received and certified by the medical professional before Title XIX is established as the funding source for the personal care supplement payment.

Note: For ACP client's only-Personal care supplement payments can be authorized **prior to the receipt of the DHS-54A** after the case opening and the client is **approved for Medicaid**. These types of payments will be paid 100 percent of state funds instead of Title XIX federal funds.

It is important to obtain the signed, authorized DHS-54A as soon as possible after the application is received and the signature date must be entered in the **Medical** tab in **ASCAP**. This allows the payment to be made using Title XIX funds.

The medical needs form does not serve as the application for services. If the signature date on the DHS-54A is before the date on the DHS-390, payment for the personal care supplement must begin on the date of the application and not prior to the placement date in the community placement setting.

If the case was closed or denied and reopened within 90 days of the original certification date on the DHS-54A, there is no need to obtain a new medical needs form unless there are changes in the condition of the client.

Veteran's Administration (VA)

The Michigan Department of Health and Human Services (MDHS) will accept a DHS-54A completed by a Veteran's Administration physician or a VA medical form (10-10M) in lieu of the DHS-54A.

REFERRAL INTAKE

A referral can be received by phone, mail, or in person at the local Michigan Department of Health and Human Services (MDHHS) office. The referral must be entered on ASCAP upon receipt or entered using the document date stamp of receipt to the MDHHS office as the referral date. The referral source does not have to be the individual in need of the services.

Commonly, the MDHHS office will receive referrals or applications from the Adult Foster Care (AFC) or Homes for the Aged (HA) facilities. The AFC/HA's should be encouraged to send in applications as soon as they have any new residents who may be eligible or already receiving Medicaid.

Registration and Case Disposition

Action

Register the client on ASCAP by completing a **thorough** search for any previous cases. Enter as much of the information of the client (complete name, address, date of birth, or recipient identification number) in the ASCAP client search.

ASCAP also allows an adult services worker to conduct a Bridges search to locate any existing data on an individual who has been assigned a recipient identification (ID) number.

Note: When using the Bridges search located under the Bridges tabs in ASCAP, exhaust all information before adding the client as new in order to avoid assigning duplicate recipient ID numbers or the incorrect recipient ID number.

- If client name is found with the same date of birth and other information on the referral, select that client name from the list and ASCAP will populate the client information screen with the Bridges information.
- If the client name and referral information is not found in the resulting search list, then the client can be added and Bridges will assign a recipient ID number.

Complete the **Basic Client** tab and then enter the application date in the **Referral Details** tab making sure it matches the stamped receipt date on the DHS-390, Adult Services Application (if the application was received by mail). Otherwise, enter the date the

information was gathered by phone or personal visit as the correct referral date).

Make sure the correct date is entered before leaving the Referral information screen or before hitting the save button as it cannot be changed after the screen is updated by the adult services worker. If changes to the referral date are required, it must be done by the supervisor.

Note: If the application is received after the referral, there is an area to enter the application date on the disposition module in ASCAP.

A supervisor or office designee assigns the referral to the adult services worker.

Documentation

Print the ACP introduction letter, the DHS-390, Adult Services Application, (if not already received) and the DHS-54A, Medical needs form, (if not received) and send to the client. The introduction letter allows the client 21 calendar days to return the documentation to the local office.

Note: The introduction letter **does not** serve as adequate notification if personal care services are denied. The adult services worker must send the client a **DHS-1212A, Adequate Negative Action Notice.** See **ASM-010, ACP Program Eligibility**.

Standard of Promptness (SOP)

The adult services worker must determine eligibility within the **45 day standard of promptness** which begins from the time the referral is received and entered on ASCAP. The referral date entered on ASCAP must be the date the referral was received into the local office. The computer system calculates the 45 days beginning the day after the referral date and counting 45 calendar days. If the due date falls on a weekend or holiday, the due date is the next business day.

When a signed DHS-390 serves as the initial request for services, the referral date must be the date the application was received in the local office not when the application was signed by the client

Note: A medical need form **does not** serve as an application for services. If the local office receives the DHS-54A, a referral must be entered on ASCAP for the date the DHS-54A was received in

the local office and a DHS-390 application sent to the individual requesting services.

After receiving the assigned case, the adult services worker gathers information through an eligibility search, contacts, etc. to make a determination to:

- **Open**-The adult services worker enters the date on the day they open the case in the ASCAP disposition tab.
- **Deny or withdraw** the referral- See **ASM-010, ACP Program Eligibility,** for information on correct letter to send to the client.

ACP Referral Transfer process

The ACP referral needs to be initiated in the county where the adult is currently found. If the adult has a permanent address in another county, the referral is registered in the county were the adult is physically found and then transferred to the county where the adult returns or to the county of the AFC where the adult decides to live.

Before any referral or open case is transferred to another county, make sure detailed comments of important information are included in the general narrative and any other information updated in the other sections of ASCAP. A call to the receiving county supervisor to alert them a referral is arriving is a best practice and courtesy to follow.

INTRODUCTION

The DHS-324, Adult Services Comprehensive Assessment is the primary tool for determining the need for services. The comprehensive assessment must be completed on all Adult Community Placement (ACP) cases.

ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information must be entered on the computer program.

REQUIREMENTS

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the client at the Adult Foster Care or Home for the Aged (AFC/HA) facility.
- An interview must be conducted with the home manager/owner.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- Observe a copy of the client's social security card when assisting the client to obtain Medicaid (the AFC/HA may already have a copy in their files).
- Secure the provider's signature on the ACP Service Plan **DHS-324-B**.

Note: The client should sign the **DHS-324-B** form if present during this portion of the process. Provide a final copy of the Service Plan, **DHS-324-A** to the client with all signatures on the Service Plan signature page, **DHS-324-B,** and place a copy in the case record. A copy must be provided within five business days of the assessment or review date to the AFC/HA facility.

- A copy of the initial assessment and all review assessments thereafter need to be in the case file since ASCAP does not contain history of past review information.

- The comprehensive assessment indicates a functional limitation of **level 2** or greater in at least one ADL and/or the IADL of medication, then eligibility for the personal care supplement is established.
- The assessment must be updated as often as necessary, but at minimum at each six month review.
- The assessment is confidential and must be kept separate from companion adult protective services cases; **see SRM-131, Confidentiality**.

A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department.

- Use the **DHS-27, Authorization to Release Information**, when requesting client information from another agency.
- Use the **DHS-1555-fp, Authorization to Release Protected Health Information**, if requesting additional medical documentation. This form is primarily used for APS cases.

FUNCTIONAL ASSESSMENT

The Functional Assessment module of the ASCAP comprehensive assessment is the basis for service planning and for the personal care supplement payment.

Conduct a functional assessment to determine the client's ability to perform the following activities:

Activities of Daily Living (ADL)

- Bathing.
- Dressing.
- Eating.
- Grooming.
- Mobility
- Toileting
- Transferring.

Instrumental Activities of Daily Living (IADL)

- Taking Medications.

The only IADL that will be ranked for the client in the AFC/HA setting is **Medications**. Licensed AFC/HA settings are responsible by licensing rules to keep client **prescriptions** and **any over-the-counter (OTC) medications** in a locked container or area. The medications are distributed to the client at the appropriate time. Functional assessment rank for medications is a 5.

All of the IADLs should be ranked in the ACP Function module based on the comprehensive assessment with the client even if the adult AFC/HA is providing the assistance as a part of their monthly housing fee.

Functional Ranking Scale

ADLs and IADLs are assessed according to the following five point scale:

1. Independent.

   Performs the activity safely with no human assistance.

2. Verbal Assistance.

   Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some human assistance.

   Performs the activity with some direct physical assistance and/or assistive technology.

4. Much human assistance.

   Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent.

   Does not perform the activity even with human assistance and/or assistive technology.

Personal Care

Personal care services (for Title XIX payments) are paid using Medicaid Title XIX funds for Medicaid recipients. Below are definitions of personal activities of daily living:

- **Bathing**: The process of washing the body or body parts, including getting to or obtaining the bathing water and or equipment whether this is in bed, shower, or tub.

- **Dressing**: The process of putting on, fastening, and taking off all items of clothing, braces, and artificial limbs that are worn daily by the individual. This includes obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual. Individuals who wear pajamas or gowns with robes and slippers as their usual attire are considered dressed.

- **Eating/Feeding**: The process of getting food by any means from the receptacle (plate, cup, glass) into the body. This activity describes the process of eating after food is placed in front of an individual.

- **Grooming**: The activity associated with maintaining personal hygiene and keeping one's appearance neat, including care of teeth hair, nails, skin, etc.

- **Mobility**: The process of moving about on foot or by means of a device.

- **Toileting**: The process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination, and adjusting clothes. A commode in any location may be considered the toilet room only if in addition to meeting the criteria for toileting the individual empties, cleanses, and replaced the receptacle without assistance from another person(s).

- **Transferring**: The process of moving horizontally and/or vertically between the bed, chair, wheelchair, and/or stretcher.

- **Assistance with self-administered medication**: The process of assisting the client with medications which are ordinarily self-administered, when ordered by the client's physician.

Domiciliary Care

Domiciliary Care. Supplemental Security Income (SSI) or State Disability (SDA) Payment--Domiciliary care means that the client is in need of supervision only, has no need for personal care (ADL) and has no medication (including over the counter-OTC-medications).

Definition of Personal Care

There are three different definitions of personal care in a licensed setting. Each is described below to clarify differences:

- **SSI/SDA personal care** establishes the basis for authorizing the SSI/SDA payment rate for the client. For this purpose, personal care means need for assistance with activities of daily living (ADL), supervision of medication, or supervision because of extensive behavior problems in addition to room and board.

- **MA Title XIX personal care** establishes client eligibility for a provider payment. For this purpose, personal care means the need for assistance with ADL, including verbal prompts or supervision or IADL medication. Consequently clients can be eligible for and receive SSI personal care rate because of behavior problems and not be eligible for MA personal care Title XIX personal care supplement.

- **AFC Licensing** definition of personal care establishes an expectation for Adult Foster Care licensees. For this purpose, personal care means personal assistance provided by the licensee or an agent or employee of the licensee to a client who requires assistance. This includes guiding and directing with dressing, personal hygiene, grooming, maintenance of a mediation schedule as directed and supervised by the client's physician, or the development of those personal and social skills required living in the least restrictive environment. Consequently, a client may be appropriate for care in an AFC facility and be ineligible for both SSI at the personal care rate and MA personal care.

Specialized Needs

Specialized needs must be authorized by Bureau of Community and Health Services (BCHS) before they can be offered to any client wishing to live in a licensed AFC/HA. The licensing board will give a facility special certification for developmental or mentally ill residents. This certification is used for facilities wishing to utilize Community Mental Health funds; **see ASM-050, ACP Legal Statute, Definitions, and Facility descriptions**.

Complex Care

Complex care tasks can be assessed for a resident whose medical diagnoses or conditions require more management. There is no

additional payment available to the AFC/HA setting for these extra services and the facility or home should indicate they are trained to deliver complex care needs. The client service plan should list any complex care provided by the AFC/HA setting. The adult services worker must document the training or knowledge obtained to provide the complex care service.

The adult services worker must assist the adult in seeking out alternative assistance if they have complex care needs. The **MI Choice** waiver program is available for a complex care client living in a licensed setting as well as various programs through the Community Mental Health (CMH) agency; **see ASM-085, Coordination with other Agencies**.

Note: Most AFC/HA's are not specially licensed, staffed or equipped to provide complex care needs so it is important to check prior to moving into the setting. Complex care needs are as follows:

- Bowel program.
- Catheters or leg bags
- Colostomy care.
- Eating and feeding (by special device, tubes, bags, massaging).
- Injections
- Peritoneal dialysis.
- Range of motion exercises.
- Respiratory treatment.
- Specialized skin care.
- Suctioning.
- Ventilators.
- Wound care.

Time and Task

Clients in Adult Foster Care (AFC) facilities, congregate care homes, or Home for the Aged (HA) qualify for the personal care supplement payment if assessed at **a level 2, verbal prompt** or

higher. **All level of ability must** accurately be documented in ASCAP to reflect the personal care needs of the client. Unlike the Independent Living Services (ILS) program, in ACP there is only a flat rate amount of personal care supplement paid monthly to the AFC/HA qualified resident for each ranked task. To find the current personal care supplement payment amount; **see ASM-077, ACP SSI/SDA Provider Rates.**

CASE MANAGEMENT METHODOLOGY

Case management is the primary service delivery method. All ongoing cases in which the client is receiving Medicaid or has an active Medicaid deductible case will be eligible for the case management services delivery method.

Case management is an ongoing process which assists adults to access needed medical, social, vocational, rehabilitative, and other services.

Core Elements

- Comprehensive assessment to identify all of the client's strengths and limitations in the areas of physical, cognitive, social, and emotional functioning as well as financial and environmental needs.
- Comprehensive individualized services plan to address the identified strengths and limitations of the client using the information obtained in the assessment.
- Mobilization and coordination of providers, family, authorized representatives, and community resources to implement the service plan by authorizing/arranging for needed services or advocating for the client to access needed government or community services.
- Ongoing monitoring of services to maintain regular contact with the client, informal caregivers and other service providers to evaluate whether the services are appropriate, of high quality, and are meeting the client's current needs.
- Regular assessment and follow-up as a formal review of the client's status to determine whether the person's situation and functioning have changed and to review the quality and appropriateness of services.

SUPPORTIVE SERVICES METHODOLOGY

Supportive services are defined as those services which typically are targeted to meet specific needs which require limited involvement of the adult services worker.

Core Elements

- Assessment focused on presenting problem.
- Service plan focused on objectives to meet presenting problem.
- Face-to-face visit in the home a minimum of every six months.
- Regular redetermination of eligibility.

Eligibility for supportive services is determined primarily by the nature of the need presented by a client and identified in the assessment.

However, this service delivery method is primarily used for clients who are not receiving Medicaid currently but are pending to Medicaid while still residing in a licensed setting.

Protective intervention

This methodology is used in Adult Protective Services (APS) cases for protective intervention and this methodology is not used when opening or maintaining an Adult Community Placement (ACP) case.

SERVICE PLANNING

A service plan must be developed for all ACP cases. The service plan is formatted in the customer, medical, functional, and provider/payments modules in ASCAP and interacts with the comprehensive assessment.

The service plan directs the movement and progress toward goals identified jointly by the client, the facility and by the adult services worker.

Service planning is person-centered and strength-based.

Areas of concern need to be identified in the comprehensive assessment to properly develop a plan of service.

Participants in the plan should involve not only the client, but also family, significant others, and the caregiver.

Service plans are to be completed on all new cases and updated as often as necessary. Minimally the updates occur at the six month review.

A copy of the ACP service plan (**DHS-324-A and DHS-324-B**) must be given or mailed to the AFC provider within **five business days** of the home visit.

SERVICE PLAN DEVELOPMENT PRACTICES

Service plan development practices will include the use of the following skills:

- Actively **listen** to the client.
- Actively **communicate** with the licensed homeowner/or home manager.
- Encourage clients to **explore options** and select the appropriate services and supports.
- Monitor for congruency between case assessment and services plan.
- Provide the necessary **supports** to assist clients in applying for resources.

- Continually **reassess** case planning.
- Enhance/preserve the client's **quality of life**.
- **Monitor** the status of all **referrals** to community resources to **ensure quality outcomes**.
- Behavioral plans **must be addressed** in the service plan **prior to implementation** per licensing regulations.

MANAGING THE CASE LOAD

The adult services worker must monitor his/her case load to ensure timely contacts with the client for reviews and that provider payments are authorized. ASCAP provides easy access to much of the information needed to effectively manage the case load. Adult services workers and supervisors have the ability to access information on the status of contacts, reviews, payments, and provider management. Reports can be generated on ASCAP that will aid the adult services worker's case management strategy.

Reports

Contact Summary Report

To view the Contact Summary:

1. On the ASCAP menu, click **Reports** icon.
2. On the **Reports** menu, click **Contact Schedule-Worker** and then enter the current month.

The report will show all current reviews that need to be done as well as all overdue contacts (or those where there was no entry of an updated review date on the ASCAP disposition screen).

Pay Expiration Report (NA-052)

The Pay Expiration Report (NA-052) report lists:

- Authorizations for Home Help and Adult Community Placement (service codes 301 and 401) that expired last month, expire this month or expire next month.
- The report lists the case name, service code, provider number/ name, and the authorization end date.
- The list is in load number order, then by authorization end date.

Six Month Review

ACP cases must be reviewed every six months. A face-to-face contact is required with the client and should include the provider.

Note: Adult services workers must have a face-to-face contact with the client as often as needed, but at least every six months. If the

contact with the client is at a place outside of the facility, then the facility provider must also be contacted. The adult services worker is to update ASCAP screens and review dates for any information that has changed since the last review.

Requirements for the review contact must include a review of the current comprehensive assessment and service plan.

Prior to the scheduled visit, the adult services worker reviews the existing service plan on ASCAP. It may be helpful to print all or part of the plan to take on the home visit. Appropriate questions to be discussed with the client, provider, and collateral sources are topics such as community services or sheltered workshops. Continuation of any services, progress toward stated goals, and necessary modifications need to be addressed during this review process including:

- Follow-up with collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

Review the Bureau of Community and Health Systems (BCHS) forms at the Adult Foster Care/ Home for the Aged (AFC/HA) home. Some of the BCHS specific numbered forms are ***required*** for use by the facility. However, there are some forms the AFC home may develop an approved equivalent form in lieu of the BCHS form. See also **ASM-060, BCHS Rules for Records and Forms.**

Resident Funds Record Part I and II (**BCAL 2318 and 2319 REQUIRED forms**)-AFC homes often will not take overall responsibility for resident funds, but they must document at minimum the intake of monies for the monthly payment of the resident as well as any petty cash the client has been given while living at the facility. The AFC must document the credit and debit of payments each month per licensing rules and use the required BCAL form.

> **Note:** The adult services worker examines these facility forms to protect the client's rights for an accurate accounting of monies received and expended on their behalf. When a client is totally dependent on Medicaid to pay for their living arrangements, the AFC is to make sure the client retains the allotted personal care money per month for personal spending money;

see **ASM-077, ACP SSI/SDA Provider Rates,** for the designated amounts due to the client.

- **Assessment Plan for AFC Residents** (**BCAL 3265 or approved equivalent**)-This specific numbered form is not required by BCAL for the AFC to have in the resident file. The adult services worker must sign the BCAL form or the facility form when the resident is on the ACP program.

- **Resident Care Agreement** (**BCAL 3266 REQUIRED FORM**)-The facility Resident Care Agreement must be completed and available for the adult services worker to review and sign as the responsible agency. Information contained on this form indicates any specialized help and what the facility will or will not provide that client while living at that facility.

- **Medication Record** (**BCAL 3267 or approved** equivalent)-The facility ***must*** document medication distribution. The adult services worker must examine the client's medication record to ensure that the provider/staff are documenting distribution of medications. This form also will list the current medications the resident is taking so the adult services worker can indicate any additions, deletions, or changes since the last review.

- **Weight record** (**BCAL 3485 or approved** equivalent)-The facility ***must*** maintain continuous weight record of the residents. It is important to review the weight record as an indication of the client's health status. Substantial changes in weight not ordered by a physician may indicate a problem and should be monitored. As sustained weight loss may suggest inadequate food intake or an undiagnosed medical condition. Unplanned weight increases should also be evaluated by a physician. An adult services worker must initial and date the weight log at each review.

The following list of BCHS numbered forms are not used frequently, but are necessary to be present in a client file for certain circumstances or incidents in an AFC facility. These reports documenting special information are:

- **AFC Incident/Accident Report (BCAL 4607) REQUIRED-only this form can be used by the licensed facility)**.

- **Resident Health Care Appraisal (BCAL 3947 REQUIRED-only this form can be used by the licensed facility).**
- **Appointment of Designated Representative (BCAL 3268 and BCAL 3268-I or APPROVED equivalent).**

A copy of **AFC Incident/Accident Report** (**BCAL 4607**) that involves incidents or accidents of an ACP resident is to be sent to the MDHHS. If the report suggests abuse, neglect, or exploitation then an APS referral must be made.

Home for the Aged

The BCHS forms listed in the case management sections for review are ***not*** used in **Home for the Aged (HA)** facilities. HA facility forms are described in **ASM-060, BCHS Rules for Records and Forms**.

CASE DOCUMENTATION

All reviews include:

- Update the disposition screen in ASCAP.

A review of all ASCAP screens and update the information as needed.

Print out current information for the file before making changes until history is available in ASCAP. Currently, no history of the client case is saved in ASCAP so it is important to keep the six month reviews as they are updated in the file. This printout can be done two ways:

- Print the current DHS-324 on record to take to the review and manually record on the copy changes, then file that working copy after you make updates in ASCAP.

Or

- Enter all changes and information in ASCAP after the review is done and print a clean copy to submit for the file.

Note: Once the adult services worker decides the manner of saving historical information via hard copy, they must remember to follow the same format or make sure the most recent information is kept in the client file.

- Change the status dates on the appropriate screens or disposition screen.
- Enter a brief statement of the nature of the contact and who was present in the contact details.
- Record expanded details of the contact in the general narrative.
- Record the summary of case progress in the service plan. Indicate the date of the review when recording changes in the service plan.
- Update the payment authorization dates.

Note: In ACP cases, state funds can be used to pay the personal care supplement while waiting for the DHS-54A certification date. When the certification date is entered in ASCAP, a transfer to Title XIX Federal funding occurs as indicated below:

- If there is a physician certification date listed on the Medical tab in ASCAP, then the funding source is Title XIX.
- If there is no physician certification date, the adult services worker must obtain a Medical Needs Statement (**DHS-54A**) from the resident's doctor as soon as possible.

After receiving the physician certification, enter the 54A signature date in the Medical module under "Diagnosis" tab in ASCAP. End date any current payment authorizations that have been paid out of state funds.

Enter a new payment authorization for the facility effective with the date the medical needs form was signed which will trigger the switch to Federal Title XIX funds.

A new authorization is entered to prevent any overlap of payments.

- Send a copy of the 324-A service plan and 324-B service plan signature page to the home provider within **five business** days of the home call to meet BCHS requirements.

The review process is an excellent opportunity to give feedback to the provider regarding resident care, record management and licensing compliance.

Positive observance should be awarded verbally to the home provider. Any areas of concern should also be brought to the provider's attention so they can be corrected to avoid any potentially serious incidents.

If providers are not complying with licensing rules, the adult services worker is to notify the licensing consultant. It is important to maintain regular contact with the licensing consultant assigned for the county.

If there is any suspected abuse, neglect or exploitation of an adult in the licensed facility, a referral to **Adult Protective Services (Centralized Intake number 1-855-444-3911**) must be made as well as reporting a complaint to BCHS. When a referral is received, the adult protective services worker will investigate an assigned referral in conjunction with the licensing consultant if possible.

Note: Adult services worker must still follow APS standard of promptness (SOP) of a face to face contact within 72 hours which may require going out without the licensing consultant.

Any new, relevant data the adult services worker obtains concerning the resident should also be shared with the provider. The adult services worker must maintain a good working relationship with the home provider/owner and the licensing consultant to provide the best overall service to the resident.

DHS-1212 NEGATIVE ACTION LETTER

During case management, an adult services worker may have a need to suspend or terminate personal care supplement payments on an active case. A **DHS-1212, Advance Negative Action Notice,** must be sent to the client.

The DHS-1212, Advance Negative Action Notice, is used and generated in ASCAP when there is a suspension or termination of ACP services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

- **Suspended** - payments stopped but the case will remain open.
- **Terminated**- case closure.

The client may appeal the negative action by requesting an administrative hearing. A **DHS-0092**, **Request for Hearing,** form is generated with a negative action notice in ASCAP and must be mailed with the negative action notice. For more information on hearing procedures; see the **Bridges Administrative Manual (BAM) 600, Hearings** for more information.

The negative action letter effective date must be 10 business days after the date the adult services worker typed the letter and the notice must be placed in the department mail the same day the negative action notice is generated.

If the adult services worker has not been contacted for a hearing on the action, then the specialist will complete the action on the date that was stated in the DHS-1212 letter.

If the specialist is made aware of a hearing request prior to the negative action date, the case remains open and payments continue to the license facility as long as the client resides in the facility until the hearing.

Note: When the local office receives a hearing request as a result of negative action, all attempts to resolve the issue at the local level must take place; **see BAM-600, Hearings, Local Office Review, pages 16-19**.

The ACP program payment will cease immediately when the negative action involves an unlicensed facility. Title XIX is only allowed to be paid to current, licensed facilities.

The ten business day effective date is not required if the notice is sent due to:

- Client death.
- Licensee death.
- Client moved.
- Client request to stop services.

Note: When the client leaves the facility, end date the authorization the day **before** the client left the facility. Medicaid

pays a facility for the day in to the facility, not the day out of the facility.

Legal Base

Administrative Rule 400.901 and 902 (Hearings and Appeals).

INTRODUCTION

The adult services worker working with Adult Community Placement (ACP) clients is to act as an advocate for the client but is not to make the actual placement decision unless special circumstances exist.

PRE-PLACEMENT ACTIVITIES

The adult services worker is to inform the client, the authorized representative and family (interested parties) of the adult services program principle of the least restrictive community based care setting by explaining the benefits between the different licensed facilities.

Pre-placement activities serve two categories of individuals:

- Adults who do not currently reside in a licensed facility, but are no longer able to remain in their present living situation safely on their own. Usually a physical and/or mental deterioration has occurred where the adult needs someone available 24 hours.
- Adults who are currently residing in a licensed facility, but now need to move to another licensed facility of the same or different type.

Pre-placement activities include information and referral options as well as assessment of the client's needs and abilities.

Face-to-Face Interview

Conduct a face-to-face interview with the client and interested parties. Obtain information necessary to suggest those facilities that best match needs and choice of the client. Discuss the type of care and services required with the client and interested parties. The greater the client's involvement, the more likely his or her needs and desires will be met. The client and interested parties should be involved in contributing information that will be included in the Adult Services Comprehensive Assessment Program (ASCAP).

The adult services worker needs to consider the physical and emotional needs of the adult along with other client preferences such as:

- Location of the facility (urban, suburban, or rural).

- Facility size (family home, small or large group, or congregate).
- Desire for activities and social interactions (large facilities may have more organized activities than a family home).
- Desire for same gender or mixed gender facility.
- Desire to access public transportation.
- Desire for access to out-of-home programs or activities such as church, recreation or shopping.
- Desire for or aversion of pets.
- Desire for or aversion of smoking.

The more information that can be learned at the face-to-face assessment will assist in locating a facility best suited to the client's needs. The assessment pre-placement interview will allow the adult services worker to locate facility housing resources and options to present to the adult and the interested parties.

Pre-placement process

The adult services worker can contact prospective facilities to inquire if they have vacancies where a referral can be made to have the client and their interested parties contact for admission. Visits to the available facilities are encouraged so the client and their family can make an informed decision.

Payment for care is decided between the facility and the client; however, the adult services worker should initiate the discussion of what is provided with the monthly rate. The client and the facility need to understand what is expected of each other prior to final admission.

The client’s source of funding is also an item to be considered. Does the client have private funds to pay the Adult Foster Care/Home for the Aged (AFC/HA) home? If so, arrangements are made between the client and the licensed provider. If the client must rely on federal and state funds for paying the AFC home, the client must discuss with the licensed provider if federal/state funds are acceptable as payment in full.

The two type of federal and state payment fund sources available are:

- Supplemental Security Income (SSI).
- State Disability Assistance (SDA).

Supplemental Security Income (SSI)

If a client is receiving SSI, has social security income or has no income, special payment circumstances may apply for payment of care in a licensed facility. The adult services worker should inform the client his/her total income can be supplemented through Social Security if a licensed facility is chosen and that personal care payment is also available to the facility through the ACP program if the client qualifies for Medicaid. The **DHS-3471, DHS/SSA,** form is used for the request for increase in income.

- SSI funding-If the licensed facility accepts the SSI income amount; the rate available constitutes payment in full by SSI. **No additional funds can be paid to the facility for food, clothing, or shelter.**

Note: Social Security can garnish the SSI payment for previous overpayments. This would affect the total amount received each month and subsequently the total amount to pay an AFC. An adult services worker can check with the guardian and/or payee to see if a garnishment for overpayment is being withheld from the monthly check and inform the potential placement how much the adult would be able to pay the facility.

State Disability Assistance (SDA)

If the client is homeless and does not have any income, then the adult services worker will assist the client in applying for SDA funds by:

- Having the client complete the DHS-1171, Assistance Application.
- Working with the Eligibility Specialist in determining the SDA approval to pay the licensed foster care facility and these rates are set; see **ASM-077, SSI/SDA Provider Rates**.
- The client must apply for any Social Security Disability or other Social Security financial assistance.

For more information on SDA funding refer to **BAM-430, SDA Special Living Arrangement Authorization and Payment,** for eligibility and application information.

In addition to the federal and state rate for AFC/HA monthly payment, a personal care supplement is available to be paid directly to the licensed provider if the client has active Medicaid benefit.

Personal Care Supplement (Title XIX funds)

The personal care supplement includes all activities of daily living (ADL) and one instrumental activity of daily living (IADL) medication. The personal care supplement payment is a set monthly rate paid directly to the licensed provider. For the current rate, see **ASM-077, SSI/SDA Monthly Provider Rates**.

In order for the licensed provider to receive the personal care supplement, the client must be an active ACP client.

Placement

Once the client and the licensed provider have reached an agreement, final arrangements for moving in can be made. The client should have the name, address, and phone number of the adult services worker that helped them in case they have any questions or to report any problem.

After the client moves into the facility, the client or their authorized representative completes the DHS-390 to apply for the Title XIX personal care supplement funds. The adult services worker will visit within 45 days after receipt of the application to complete an assessment of the client. The assessment visit helps determine the needs of the client are being met and the AFC/HA is the best setting.

Responsible Agency

A client moves into a licensed facility applies for the ACP personal care supplement payment. The Michigan Department of Health and Human Services (MDHHS) adult services worker will receive the pending case and assist the client with services. If the client qualifies for the ACP Title XIX personal care supplement, the ACP case is opened. The MDHHS is considered the responsible agency

for that client while he/she resides in the licensed setting and continue to receive Medicaid benefits.

It is important to clarify which agency is responsible for placement and follow up services prior to responding and providing placement assistance.

There are interagency agreements in place that define the department that is responsible to assist the client wishing to have services. If a client has received services from Community Mental Health (CMH) for years and is to be placed in an AFC home as a result of case management from that agency, then it would be the responsibility of the local CMH case specialist to monitor and approve personal care supplement payments for the client.

An adult services worker can contact the local CMH to inquire if the pending MDHHS ACP case client already has an active services case with CMH. When the case is pending in ASCAP, an adult services worker can also check the payment section to see if the personal care supplement payment has already been authorized by CMH. CMH authorizations on the system show 402 in the code column.

Note: If all CMH is doing is medication management, then there is usually no CMH case manager assigned to the resident. In this case, MDHHS becomes the responsible agency.

If there has been no previously established agency relationship, then the MDHHS is to assist the client with services and case management. Misunderstandings could exist between CMH and MDHHS regarding the responsible agency relationships. However, MDHHS must always work on behalf of the client to make sure he/she receive services and determine the responsible agency.

ASSISTED PLACEMENT CRITERIA

The adult services worker may act as a placing agent in specific situations only and then after exhausting every other option. Prior to placing of the client, the adult services worker must first seek assistance from the following potential resources:

- Legal guardian.
- Authorized representative.

- Family members.
- Friends, neighbors, members of the client's church or other social groups.
- Representatives of other agencies, both paid and volunteer, that are involved with the client.
- Any concerned or interested party.

If there appears no resources exist to help the client and the adult services worker believes the client is able to make an informed decision in placement decisions, the adult services worker can provide transportation to visit potential facilities, coordinate resources, and if necessary, assistance with moving the client and possessions.

If the adult services worker believes the adult is not able to make an informed decision and there are no other resources to assist, then a petition needs to be filed to have the local probate court appoint an emergency, temporary, partial, or full guardian.

In an emergency situation, the adult services worker can intervene without exhausting the list of resources to ensure the client has necessary safe protection in a licensed facility.

Placement facility information

The client or guardian has a right to know if there have been any license violations at the licensed facility they are choosing. Facilities that have incurred a violation may be given a set period of time to correct the violation and meet compliance. If the facility does not meet compliance in a specified time, it may result in revocation of the license.

Refer the client and interested parties to the Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems (BCHS) public web site for online lookups for Adult Foster Care Homes (AFC) or Homes for the Aged (HA). Any special investigations will be identified on this website. Search for a facility name and bring up that home's information to determine if there have been any special investigation reports. Information on the facility will allow an informed decision as to whether or not to reside in a certain facility.

Community Resources

Every effort should be made to use community resources to enhance the client's qualify of life. Clients need to have opportunities to participate in community life and whenever possible contribute to the community. A client's abilities and talents can be utilized in various situations to foster feelings of usefulness and increase a sense of well-being.

Voluntary Relocation

A client or an authorized representative may request relocation. The adult services worker does not initiate the relocation procedures unless the client or the designated representative approve. The ultimate decision to relocate is the client's or the authorized representative, however, if it would seem the current or prospective placement would be detrimental to the client, this should be shared with the parties involved.

Out-of-county placements

If a client requests a placement out of the county, both counties will work together on behalf of the client. If a new client prefers placement in another county, the person is referred to that county office for assistance in locating the most suitable facility due to that new county adult services worker being more informed of the type and suitability of the facilities available.

Note: The best practice would be for the adult services worker of the county where the adult currently resides to contact the new county MDHHS office for information on facilities. Then visitations, paperwork or applications of the desired facility can be obtained and provided to the client or the authorized representative.

Out-of-county community resources

For clients who wish to receive mental health services, the adult services worker in the adult's residing county should determine if the receiving county has these types of resources for the client. In the event mental health services are not available in the receiving county, the adult services worker is to advise the client, his guardian, or family of the unavailability of these services. Optional resources should be considered, if available, and provided so the clients and their authorized supports can make an informed decision about the move.

16 and 17 years old in AFC placements

In 1981, Public Act 116 of 1973, as amended, was amended to accommodate placement of a 16 or 17 year old in certain AFC homes. P.A. 116 of 1973, as amended, is a Child Care Organizations Act. This act allows MDHHS to authorize a licensed child placing agency or approved governmental unit to place 16 or 17 year old children in an AFC **family** or **small group home**, if specific conditions have been met.

The definition of an adult as defined in Section 3 of Act 218; Public Acts of 1979 was modified to include such person within its scope.

In order to place a 16 or 17 year old person in an AFC facility, the following conditions must be met:

- The licensed child placing agency or children's services must provide ongoing supervision of the case and prepare certification letters containing the following documentation:
  1. That placement is in the best interest of the child.
  2. That a specifically selected AFC home can meet the particular needs of the child.
  3. That the child will be compatible with the other residents of the AFC home.
- The letter is to be sent to the assigned child welfare and AFC licensing consultants with a copy going to the appropriate AFC family or small group home licensee.
- The child placing agency will periodically reevaluate the placement to determine that all placement criteria continue to be satisfactory.

Responsible Agency when a placed youth turns 18 years old.

Before the 16 or 17 year old youth is placed, the placing agency must determine whether MDHHS adult services program or CMH is to become the responsible agency after the youth turns 18 years old.

The responsible agency will be determined by:

- When the resident turns 18.
- When Michigan Children's Institute (MCI) status ends which must be addressed in the foster care specialists permanency planning report.
- If the facility can meet the resident's needs with the Title XIX supplement in addition to the SSI funds.
- If the facility cannot continue to meet the now adult resident's care needs for the ACP personal care supplement, then CMH must be approached to meet the needs.

Youth aging out of MDHHS Foster Care services

Local office Adult Community Placement specialists **do not** determine SSI level of care or initiate an SSI application, negotiate AFC agreements, service plans or personal care payments prior to the youth reaching age 18.

All questions from providers regarding the foster child's care should be directed to the appropriate children's services placement specialist. Adult service specialists when contacted by MDHHS foster care specialists should assist placement planning by providing information about appropriate vacancies, compatibility with other residents, and any other pertinent, helpful information of licensed facilities.

- Refer to **FOM-722-03C** for more information on youth aging out of the foster care system and special transition to the adult programs.

DHS- 3471 DHS/SSA REFFERAL FORM

This form is completed by an adult services worker for a client who receives SSI income and has moved into an AFC. The client will qualify for an increase in his/her monthly SSI to pay a higher rate for his/her care. Authorization of level of care determination is done in the following ways:

- **Domiciliary-** The client does not need any personal care attention and does not take prescription medications and over-the-counter medications of any kind. The client requires supervision only. This reason is rarely used.
- **Personal-**Clients will fall under this category most of the time as they need IADL and ADL care while residing in an AFC.
- **Home for the Aged Care (HA) -** This is only checked if the client has moved into a HA licensed facility.

The adult services worker should complete this form for any AFC resident that receives SSI whether they assisted in placement or if received a DHS-390 application on a new resident in an AFC. By making sure the form has been completed and sent to the local Social Security office will ensure that the highest possible rate is obtained for the client care at the AFC.

The client receives a portion of the expanded payment for personal expenditures; see **ASM-077, ACP SSI/SDA Provider Rates** section for current year authorized amounts.

LEGAL STATUTE

Adult Foster Care

Adult foster care family homes, small group homes, large group homes and congregate facilities are licensed by the Department of Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) under Act 218 Public Acts of 1979. These facilities provide:

- Room and Board.
- Supervision 24/7.
- Protection.
- Personal care to adults 18 and over who are frail, developmentally disabled, mentally ill, or intellectually or physically disabled.

The individuals that would need supervision on an ongoing basis but not the services of continuous nursing care are the best candidates for Adult Community Placement facilities.

County Infirmaries

MDHHS monitors rule compliance for county infirmaries which were formerly county poor farms. Only two county infirmaries remain in Michigan:

- Midland.
- Monroe.

The county infirmaries follow licensing rules and regulations for congregate Adult Foster Care homes, but are not considered Adult Foster Care facilities.

Note: The county infirmaries **are coded** as an AFC facility for Medicaid purposes and for payment of the personal care supplement.

Homes for the Aged (HA)

Homes for the Aged are licensed facilities that provide room, board, and supervised personal care to individuals 60 years of age or older. Residents receive assistance with activities of daily living (ADL) and medication administration similar to an adult foster care home. They are licensed under the Department of Licensing and

Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) under ACT 368 Public Acts of 1978 as amended.

Licensure as a home for the aged is restricted to freestanding facilities of 21 or more beds or facilities of any bed size when operated in conjunction with and as a distinct part of a nursing care facility. Some homes have specialized dementia care programs.

Prior to accepting individuals for admission, the home must assure that they are able to care for them. The home cannot admit someone who has a mental condition that may be disturbing to the other residents or personnel of that facility.

Before persons can be admitted to a HA, the following must be completed:

- A chest X-ray.
- Physical examination report with diagnosis and special needs defined.
- Doctor certification indicating that the individual has no communicable diseases.

The adult services worker completes an assessment and develops a service plan for the HA resident following the same guidelines as those completed for AFC residents. HA providers receive the personal care supplement for residents on Medicaid.

Age Waiver

The Public Health Code allows for an age waiver when requested by a facility. If it is in the best interest of an individual under the age of 60, a waiver can be granted. Three documents need to be submitted to LARA/BCHS for consideration:

- A letter from the facility administrator explaining the situation and making the request.
- A physician's statement that the proposed residents' needs could be served at that facility.
- A letter of explanation from the proposed resident, his guardian or concerned family member detailing why the waiver should be granted.

Generally, decisions are made within one week of submitting all required documentation to:

LARA/Bureau of Community and Health Systems
AFC & Camp Licensing Division
611 W Ottawa St - Central Office
PO Box 30664
Lansing, MI 48909

Public Acts of 1979 Act 218-Licensing of facilities

Act 218 of the Public Acts of 1979 as amended is known as the Adult Foster Care Facility Licensing Act. Act 193, Public Acts of 1996, the Michigan Do-Not-Resuscitate Procedure Act and Act 192, Public Acts of 1996 amending the Public Health Code also apply to AFC home licensing.

Act 218 states that a regular license is to be valid for two (2) years unless it is revoked or modified.

There are administrative rules that are required to be met prior to the issuance of an Adult Foster Care home license. These are: Michigan Administrative Code R 400.1151-1153, R400.1401-1442, R400.2101-2122, R400.2201-2376, R400.2401-.2475, R400.14101-14601, R400.15101-15411, and R400.16001.

The information in the following sections is to provide the adult services worker general knowledge of licensing rules. Any specific interpretations of P.A. 218 of 1979 as amended or the administrative rules must be discussed with the Adult Foster Care Licensing Consultant.

Definitions in Act 218

Act 218 defines both the adult foster care facility and the term adult.

1. Adult foster care facility - MCL 400.703 (4).

   Adult foster care facility means a governmental or nongovernmental establishment that provides foster care to adults. It includes facilities and foster care family homes for adults who are aged, mentally ill, emotionally, developmentally or physically disabled who require supervision on and ongoing basis but do not require continuous nursing care.

2. Adult - 400.703 (1) (a) and (b).

Adult means:

(a) A person 18 years of age or older.

(b) A person who is placed in an adult foster care family home or an adult foster care small group home pursuant to section 5(6) or (8) of Act no. 116 of the Public Acts of 1973, as amended, being section 722.115 of the Michigan Compiled laws.

3. Four Types of facilities are defined in Act 218.

- ADULT FOSTER CARE **FAMILY HOME** - MCL 400.703 (5)

  Adult foster care family home means a private residence with the approved capacity to receive not more than 6 adults who shall be provided foster care for 5 or more days a week and for 2 or more consecutive weeks. The adult foster care family home licensee shall be a member of the household and an occupant of the residence.

- ADULT FOSTER CARE **SMALL GROUP HOME** - MCL 400.703 (7).

  Adult Foster care small group home means an adult foster care facility with the approved capacity to receive not more than 12 adults who shall be provided foster care.

  Note: A six bed home can be licensed as either a family or small group home depending on whether or not the licensee is an occupant of the residence and a member of the household.

- ADULT FOSTER CARE **LARGE GROUP HOME** - MCL 400.703 (6).

  Adult foster care large group home means an adult foster care facility with the approved capacity to receive at least 13 but not more than 20 adults who shall be provided foster care.

  Note: The AFC rules for family and group homes require the licensee to complete a Resident Care Agreement (BCAL-3266 or an approved equivalent form) for each resident in the facility. **The adult services worker reviews and then signs** the

agreements for those residents who the MDHHS is the responsible agency.

- ADULT FOSTER CARE **CONGREGATE FACILITY** - MCL 400.703 (3).

  Adult foster care congregate facility means an adult foster care facility with the approved capacity to receive more than 20 adults to be provided with foster care. Section 15 of P.A. 218 **prohibits the licensure of new adult foster care congregate facilities**. There are only 10 remaining congregate facilities in the state and those have been grandfathered in. List is provided on the adult services home page.

  - DHS-3422, Adult Foster Care Agreement for Congregate Facilities. The DHS-3422 is a written agreement that identifies the responsibilities of the licensee and the responsible agency. It is required only in congregate adult foster care homes. It should be signed by the local office director or designee and the AFC licensee or designee. This form is not required in AFC family or group facilities; the form is available in the MDHHS Forms Library.

4. Foster Care - MCL 400.704 (6).

   Foster care means provision to **non-related adults** of supervision, personal care and protection **in addition** to room and board for 24 hours a day, 5 or more days a week, and for 2 or more consecutive weeks for compensation.

5. Supervision - MCL 400.707 (7).

   Supervision means guidance of a resident in the activities of daily living including all of the following:

   (a) Reminding a resident to maintain his or her medication schedule as directed by the resident's physician.

   (b) Reminding a resident of important activities to be carried out.

   (c) Assisting a resident in keeping appointments.

   (d) **Being aware of a resident's general whereabouts even though the resident may travel independently about the community.**

6. Personal Care - MCL 400.706 (1).

   Personal care means personal assistance provided by a licensee or an agent or employee of the licensee to a resident who requires assistance with:

   - Dressing.
   - Personal hygiene.
   - Grooming.
   - Maintenance of a medication schedule as directed and supervised by the adult's physician
   - The development of those personal and social skills required to live in the least restrictive environment.

7. Protection - MCL 400.706 (4).

   Protection, subject to section 26a(2) of the Adult Foster Care Facility Licensing Act, Act 218 of 1979, as amended, means the continual responsibility of the licensee to take reasonable action to insure the health, safety, and well-being of a resident; including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the residents' assessment plan states that the resident needs continuous supervision.

8. Licensed hospice program - MCL 400.705(2).

   Licensed hospice program means a health care program that provides a coordinated set of services rendered at home or in an outpatient or institutional setting for individuals suffering from a disease or condition with a terminal prognosis and that is licensed under article 17 of the public health code, 1978 PA 368, 333.201201 to 333.22260 of the Michigan Compiled Laws.

9. Do-not-resuscitate order - MCL 400.704 (6).

   Do-not-resuscitate (DNR) order means a document executed pursuant to section 3 of the Michigan Do-Not-Resuscitate Procedure Act directing that, in the event a resident suffers

cessation of both spontaneous respiration and circulation, no resuscitation will be initiated.

In the case of an accident or sudden severe adverse change in a resident's physical or medical status, such as respiratory or cardiac arrest or life threatening injury, the licensee and/or his/her employees are required to call emergency medical services to the home. The adult foster care licensee and/or his/her employees are not required to resuscitate a resident whose heart and breathing have stopped and who has executed a valid DNR order pursuant to the Michigan Do-Not-Resuscitate Procedure Act, (Public Act 194 of 1996).

If the resident has a valid DNR order and emergency medical services are called to the home, the licensee is to provide the written DNR order to the emergency medical services personnel. Under the provisions of the Michigan Do-Not-Resuscitate Procedure Act, emergency medical services personnel are not required to resuscitate a resident if shown a legally valid DNR order.

In the event that a resident, who is enrolled in a licensed hospice program (and has a DNR order in his/her assessment plan) suffers a cessation of both spontaneous respiration and circulation, the adult foster care facility is allowed to immediately contact the resident's licensed hospice service provider instead of emergency medical services. The licensed hospice provider can then determine the appropriate course of action.

AFC Administrative Rule Variances

Any variance from administrative rules for family, group, or congregate AFC facilities is to be requested by the licensee in writing to the AFC Licensing Consultant. If approved, the variance is to be noted on the services plan citing the specific rule and circumstances related to the variance granted.

1. **WORK**: Small Group Home Rule, Michigan Administrative Code (MAC) R400.14305, Large Group Home Rule R400.15305, and Congregate Care Rule R400.2412 (3) states that all work performed by a resident is to be in accordance with the resident's written assessment plan. A plan may allow

for work other than expected tidiness of one's personal belongings. The tasks must be goal-oriented such as participate in meal preparations to aid in resident's ability to be self-sufficient as assessed with independent living.

2. **PROTECTED RESIDENT ACTIVITIES**: Family Home Rule R400.1409, Small Group Home Rule R400.14304, Large Group Home Rule R400.15304, and Congregate Care Rule R400.2418.

   AFC facilities are intended to simulate an atmosphere of home, family and community life for the continued growth and enrichment of the residents. The following resident activities are protected unless specifically excluded for stated reasons in the services plan, the resident's written assessment plan, or both:

   - Access to mail.
   - Access to telephone.
   - Access to personal clothing and belongings.
   - Private storage space.
   - Visitors during reasonable visiting hours.
   - Opportunity to shop for personal needs.
   - Recreational experiences.
   - Freedom of religious practices.
   - Freedom to select a home of his or her choice.

3. **RESIDENT FUNDS**: Family Home Rule R400.1421, Small Group Home Rule R400.14315, Large Group Home Rule R400.15315, and Congregate Care Rule R400.2421, 2422).

   Residents shall have access to and use of their personal funds in reasonable amounts.

   - Small and large group home residents must have immediate access to at least $20.00 of their personal funds. (Small Group Rule R400.14315 and Large Group Home Rule R400.15315).

   - Congregate care residents must have access to at least $5.00 of their personal funds. (Congregate Care Rule R400.2421). The maximum value of money and valuables a congregate facility shall accept for safekeeping shall not exceed $400 per resident.

- Family home rules do not specifically address the amount of money that must be readily available to a resident (Family Home Rule R400.1421).

In the event circumstances indicate that some other arrangement is needed, the exclusion is to be identified and noted in the resident's assessment plan.

A resident shall receive all of his or her personal funds no later than 5 days after they make the request.

REPORTING

Bureau of Community and Health Systems (BCHS) has a mandatory requirement that facilities utilize **BCAL 4607 Incident and Accident report** when an adult in the facility experiences a harmful circumstance.

BCAL 4607 Incident and Accident Reports

Incident and accident reports are submitted by the licensee or designee to the responsible agency and the licensing consultants are to review these reports and take appropriate action. Incident and accidents that require 48 hour notification are:

- The death of a resident.
- Any accident or illness that requires hospitalization.
- Incidents that involve any of the following:
  - Serious displays of hostility.
  - Attempts at self-inflicted harm or harm to others.
  - Instances of destruction of property.
  - The arrest or conviction of a resident.
  - Medication error by staff or pharmacy.

If incidents and accidents are not reported timely, the adult services worker is to notify the appropriate licensing consultant.

Upon receipt of the report, adult protective services procedures should be followed if the adult services worker has a reasonable belief the incident or accident resulted from abuse, neglect or exploitation.

It is important to consider if the incident or accident could have been prevented and if it could have been prevented an explanation of how.

Example: A violent behavior on the part of a resident may occur because of failure to take medication. Corrective action might take the form of a conference with the staff to discuss the problem of medication management. This information should be shared with the licensee, staff, and client to help prevent the problem in the future.

It is important to make an effort to minimize incidents and accidents.

Monitoring Death Reports

A report of a death in a licensed facility is required by licensing rules for all types of facilities. The form the licensed facility uses is the **BCAL 4607** to report the death. The licensee is to submit the incident of death to the responsible agency and also their license consultant within 48 hours after the death is discovered. The adult services worker is to review as well as monitor the report for information where unnatural causes, accidents, or suspicious events contributed to the death of the resident.

Unnatural Causes of death

It is important to determine what preceded the event of death of a resident in order to possibly protect other residents in the same facility.

Example: Questions to think about would be:

- Was there evidence of unusual behavior such as depression?
- Were appropriate referrals made?
- Was extra supervision available or any general lack of supervision?

Contact should be made with the licensing consultant who will share investigative responsibilities per the BCHS internal policy Adult Foster Care Manual Item 380-Agency Coordination/Information Sharing and Referrals.

If reasonable belief the death resulted from abuse, neglect, or exploitation, the adult services worker must make a referral to BCHS and Law Enforcement if one has not already been made.

Complete the DHS-4712, Death Report Form, for the client's death. Scan the signed report and send to the Adult Services policy mailbox MDHHS-Adult-Services-Policy@michigan.gov. Put "**Death Report**" in the subject line of the email.

The ACP adult services worker is not required to complete the DHS-4712 when the client has died of natural causes.

ADVERSE ACTION NOTIFICATIONS BY LICENSING

Adverse actions by BCHS licensing staff may include license revocation, refusal to renew or denial of a renewal. When a notice of adverse action is received from BCHS, the **adult services workers are to notify all SSI recipients in writing of the areas of noncompliance and offer to assist in relocation.** This notification is a requirement of the Keys Amendment.

The Keys Amendment and Adverse Action process

The Keys Amendment amends Title XVI (Supplemental Security Income) of the Section 1616 of the Social Security act with the goal of ensuring quality of care for SSI recipients by requiring adherence to state care standards. In Michigan, the standards are the AFC rules, adult foster care licensing law, children's foster care family/family group home rules, child caring institution rules, the Child Care Organization law, Homes for the Aged rules and the Public Health Code.

If the department suspends, revokes or refuses to renew and adult foster care license, relocation services shall be provided to all residents of the facility if such assistance is needed.

The responsible agency shall provide the relocation services and if no agency is responsible, then MDHHS will assist.

An individual in need of adult foster care services may not remain in a facility that is no longer licensed under the Adult Foster Care Facility Licensing Act (Public Act 218 of 1979).

The local office will receive copies of all letters which the Bureau of Community and Health Systems (BCHS) sends to the licensees in regard to adverse action.

Notice of Intent (NOI)

The Notice of Intent (NOI) to revoke, refuse to renew, not issue a license letter is sent to the licensee specifying the areas of noncompliance. This is an intent letter signed by the director of

BCHS which transmits a licensing study report. The intent letter allows the licensee 30 days to appeal the decision.

If the licensee has not appealed the Department's decision after the 30 day appeal period, a revocation or refusal to renew letter is sent to the licensee stating the date on which the license is no longer valid. This letter is also signed by the director of BCHS.

The most common **Adverse Actions** notices that the local office supervisors will receive are **Notice of Intent Letters (NOI).** These are usually sent via email to alert of activity related to licensed facilities in the county that are facing a license suspended, revoked, or not renewed. The notices are sent to give the county an advanced warning that residents in those facilities may need assistance with housing relocation should the license facility close after the designated time indicated in the letter. This assistance is provided to all clients residing in the facility.

Summary Suspension

When the adverse action is a summary suspension, the license is suspended upon receipt of the letter by the licensee or by an established date that is stated in the letter. The letter sets an appeal deadline date and informs the licensee to immediately cease providing adult foster care. Upon receipt of this letter, the responsible agency must begin **immediate action** to ensure the relocation of any adult foster care residents.

In cases where the licensee unsuccessfully appeals the revocation or refusal to renew decision and the department director signs the final decision and order, another letter is sent to the licensee indicating the effective date of the adverse action.

In either situation, not appealed or appealed, the adult services worker must notify each resident or designee in writing after the adverse action letter is received stating the effective date of the action. This notice can be created or written on the State of Michigan letterhead template in the MDHHS Forms Library.

- Include with the notice letter, information on the provision of services to relocate, and a reminder that the licensee is prohibited from keeping residents in the facility and attach a copy of the NOI.
- Individuals who require adult foster care services may not continue residing in an unlicensed home.

- If the former licensee continues to serve residents in need of foster care, BCHS will request assistance from the Attorney General in taking legal action to immediately cease further operation of the facility.

Involuntary Transfer or Discharge

This section contains licensing rules description of resident admission and discharge policy, resident rights and licensee responsibilities. Specific areas to be aware of are:

- A licensee shall provide a resident and his or her designated representative with a 30 day written notice before discharge from the facility. See AFC Licensing Rules in the Michigan Administrative Code R400.1407, R400.14302, and R400.15302.
- A licensee may discharge a resident before a 30 day notice when the licensee has determined and documented that any of the following exists (AFC Licensing rules in the Michigan Administrative Code R400.1407, R400.14302, R400.15302):
  - Substantial risk or an occurrence of self-destructive behavior.
  - Serious physical assault
  - Destruction of property.
- The licensee shall confer with the responsible agency, or if the resident does not have a responsible agency, with adult protective services and the local community mental health response service regarding the proposed discharge. If the responsible agency or if the resident does not have a responsible agency; adult protective services does not agree with the licensee that emergency discharge is justified then the resident shall not be discharged from the home (Michigan Administrative Code R400.1407, R400.14302, R400.15302).
- The licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident’s designee or the responsible agency (Michigan Administrative Code R400.1407, R400.14302, and R400.15302).

- A resident has a right to request and receive assistance from the responsible agency in relocating to another living situation (Michigan Administrative Code R400.1409, R400.14304, and R400.15304).

Adverse Action Relocation

Public Act 149 of 1994 amends the Penal Code by adding Chapter XXA which:

- Establishes penalties for harm caused to a vulnerable adult as the result of the actions or failure to act by a caregiver or other person with authority over a vulnerable adult.
- Establishes penalties for an operator of an unlicensed facility, an employee or an individual acting on behalf of an unlicensed facility who violates the licensing act and whose violation is the proximate cause of the death of a vulnerable adult.
- Establishes penalties for a caregiver, person with authority over a vulnerable adult or a licensee who commingles, borrows, or pledges resident funds, interferes with or obstructs a licensing investigation, or files false or misleading information required under the licensing act.
- Establishes penalties for a caregiver, licensee or other person with authority over a vulnerable adult for retaliation against a resident or employee because they make certain disclosures.
- Establishes second or subsequent violation penalties.
- Authorizes community service in addition to or as an alternative to imprisonment within defined parameters.

Public Act 262 of 1990 amends Public Act 218 of 1979 by adding two new subsections (3) and (4) to Section 22 that describe action to be taken when a providers license is revoked, suspended or renewal is refused. Public Act 150 of 1994 further amended subsection (4).

The amendments provide that:

1. The provider shall not keep the current residents or receive new residents **that need foster care**.

2. Providers who violate the law are guilty of a felony, punishable by imprisonment for up to five years or a fine of up to $75,000.00 or both.

3. The department shall determine for each of the residents whether they will be able to relocate with assistance from their designated representative.

4. The department shall provide immediate relocation services for all MDHHS clients as well as those who do not have a responsible agency and will need assistance to relocate.

Once the adverse action steps for revocation or refusal to renew are finalized, as described in The Keys Amendment and Adverse Action process, the residents can be formally notified of the need for relocation.

If the adverse action is a summary suspension, the responsible agency must assure prompt action for the relocation of any residents. If there is no responsible agency, the department is responsible to provide relocation services.

The Adult Foster Care licensing consultant is to be kept informed of the status of relocation efforts.

OVERVIEW

This section lists the Department of Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) rules behind each BCHS necessary forms. The adult services worker who is acting on behalf of the Michigan Department of Health and Human Services (MDHHS) as the responsible agent will be signing BCHS forms that are located at the licensed facility during the six month reviews with the resident.

The adult services worker being familiar with the necessary forms is better equipped to assist the licensee with information on record keeping to be in compliance with state licensing requirements. See **ASM-040, ACP Case Management,** for explanation and description of the information in the necessary forms.

List of Licensed Facilities

BCHS has created a locator tool which allows a search for all licensed adult foster care facilities in the state by facility name, county, city, zip code, and facility type or license number. Visit this link: Department of Licensing and Regulatory Affairs (LARA)/Community and Health Systems/Look up a License/Facilities Adult Foster Care and Homes for the Aged Facilities.

LARA Department of Licensing and Regulatory Affairs/Community and Health Systems/Look Up a License/Facilities Adult Foster Care and Homes for the Aged Facilities

Local Office AFC Facility File Records

A local facility file must contain the **DCH-1625A**, **Adult Foster Care of Home for the Aged Provider Agreement**, the **DHS-2351X, Provider Enrollment**, and a copy of the **DHS-3422, AFC Agreement** (congregate care only). One file can serve for all of the facilities in the county or set up as the best way to access these documents.

There are other kinds of information that may be helpful to provide information about a particular facility. For example, if a list of residents is maintained in the file, it will be available in the worker's absence should questions be raised about vacancies and description of current residents.

It may also be helpful to identify unique factors that affect the placement process, for example, whether or not the provider will accept diabetics with their need for a special diet, help with insulin injections, to identify if the facility is barrier-free or if public transportation is accessible.

Forms not used for ACP MDHHS clients

These DHS titled forms are not to be completed or used with ACP cases:

- **DHS-4771**-This form is for FICA withdrawal of funds from a provider check. FICA is not withheld from an ACP provider check.
- **DHS-4676**-This form is a provider agreement between the client and their Home Help provider with the ILS program. The ACP payment is a flat rate of personal care supplement payment so there is no breakdown for tasks associated with the amount.
- **DHS-721**-The log sheet is no longer necessary for the licensee to complete to document services provided. The licensee bills against the personal care supplement authorization to create a documentation services have been provided.

AFC RESIDENT RECORDS

When MDHHS is the responsible agency, adult services workers assist in the maintenance of facility records by providing timely and accurate information. The contents of the record are described in the administrative rules for AFC facilities. Copies of the rules may be obtained from the AFC Licensing Consultant or found by visiting the BCHS website at: Adult Foster Care and Homes for the Aged. Under the "Applicants" column heading there is a link to Licensing Rules and Statutes.

Note: Adult services workers should note that family homes have several required forms that are different from those required of group and congregate facilities.

Michigan Administrative Code Rules Small Group Home Rule R400.14316, Large Group Home Rule R400.15316, Homes for the

Aged Rule R400.2452(2) require the licensee to complete and maintain a separate record for each resident on file in the home.

Although Public Act 218 of 1979 does not provide for the regulation of responsible agencies, the adult services worker is expected to assist the AFC provider in collecting the necessary information to establish the record.

The adult services worker should work with the AFC provider to ensure continued maintenance of the information and communicate with the licensing consultant if there are problems.

The AFC provider should be encouraged to discuss with their licensing consultant any problems with the responsible agency.

AFC Rules for Family Home Records

A resident record as described in Michigan Administrative Code, Family Home Rule R400.1422 specifies the minimal information to be contained in the record. The following licensing adult community placement forms contain information required by the licensing rules. BCHS requires licensed family type homes to use BCHS specific form in the file where in other situations the specific BCHS forms are not mandatory.

BCHS specific required forms contained in the records.

The AFC Family home **must** use the following numbered forms where no other equivalent will be allowed. For a detailed description of these forms, see **ASM-040, ACP Case Management**:

- **BCAL 3266-Resident Care Agreement**. In accordance with R400.1407 (5), requires upon admission that a resident care agreement be established between the resident and provider.
- **BCAL 2318-Resident Funds I and BCAL 2319 Resident Funds II**. In accordance with R400.1421 which specifies the conditions for handling and recording resident funds.
- **BCAL 4607-The AFC Licensing Division Incident/Accident Report**. Rules R400.1414, R400.1415, R400.1416 (4) (a), (b), (c), R400.1417, R400.1426 require the recording and maintenance of incident and accident reports. Reports are to

be maintained for not less than two years and are to be sent to the responsible agency.

- **BCAL 3947-Health Care Appraisal**. R400.1407 (7) (a), (b), (8) and (9) as well as R400.1416 (2) specifies health data to be kept on file for not less than two years.

Required forms for records, but do not have to be the BCHS number form:

All of the information that is on the following list of BCHS forms must be documented on an equivalent form if the licensee does not wish to use the BCHS specific form.

Licensed family homes have a choice to use their own version of the following forms to have in the resident file as long as what is documented has the same information collected:

- **BCAL 3265-Assessment Plan for AFC Residents-Family Home** or its equivalent**.** R400.1407 (2) (a), (b), (c), (3), (4), specifies that written assessment is required before accepting or retaining a resident for care except in emergency situations.

The ASCAP ACP service plan includes key elements of the comprehensive assessment. In emergencies, the written assessment must be completed within 15 business days of date of MDHHS placement. The AFC licensee is also required to complete their own assessment of each resident.

Note: MCL 400.703 (9) in Public Act 218 of 1979 defines assessment plan as a written statement prepared in cooperation with a responsible agency or person that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavior needs and well-being and the methods of providing the care and services taking into account the preferences and competency of the individual.

- **BCAL 3483-Resident Information and Identification Record** or its equivalent. This form must contain all information as listed according to R400.1422 (1) (a-j).

- **BCAL 3267-Resident Medication Record** or its equivalent. If there are prescribed medications, R400.1418 (a) (b) details instructions for supervising resident medications. A written record must be maintained showing dispensing and any adjustments of the medications.

- **BCAL 3485-Weight Record** or its equivalent. R400.1416 (3) states weight is to be recorded upon admission and monthly thereafter. Records are to be kept on file for two years.

AFC Small and Large Group Home Records

Licensed small (up to 12 residents) and large (13 to maximum 20) group home licensees are also required to use forms to document important information on each resident in their care. The following BCHS forms contain all the required information that must documented in the file:

Small or Large Group Home BCHS numbered required forms in the records:

- **BCAL 3947-Health Care Appraisal** (no equivalent to be used).
- **BCAL 2318 and BCAL 2319**-Resident Funds and Valuables. **REQUIRED** forms to document monies exchanged between the facility and resident.
- **BCAL 4607-The Bureau of Children and Adult Licensing Incident/Accident Report.** This form is ***REQUIRED*** for the facility to use when reporting to BCAL any incident where a resident has been harmed or exposed to harm.

Required forms for records, but do not have to be the BCHS number form:

Note: If the BCHS specific numbered form is not used, the form used must be approved by the licensing department and document the same information contained in the BCHS numbered form.

- **BCAL 3265-Assessment Plan for AFC Residents** or its equivalent. R400.14301 (2) Small Group, R400.15301 (2) Large Group. The ASCAP ACP service plan includes key elements of the comprehensive assessment. In emergencies, the written assessment must be completed within 15 business days of date of MDHHS placement. The AFC licensee is also required to complete their own assessment of each resident.
- **BCAL 3483-Resident Information and Identification Record** or its equivalent.

- **BCAL 3485-Weight Record** or its equivalent.
- **BCAL 3266 Resident Care Agreement** or its equivalent.
- **Resident Register**- R400.14210 and R400.15210. The licensee shall maintain a chronological register of residents who are admitted to the home and shall include all of the following information for each resident:
  - Date of admission.
  - Date of discharge.
  - Place and address to which the resident moved, if known.

Congregate Care Facilities

There are only 10 licensed Congregate Care Facilities in Michigan. New licenses will **not** be granted for Congregate Care facilities per Section 15 of P.A. 218 of 1979. Records are to be kept on each resident in a Congregate Care facility that BCHS requires for Small and Large Group Home rules.

A list of the remaining Congregate Care facility locations and contact information is located on the Adult Services Home page under the section Adult Community Placement.

Congregate Care facility BCHS numbered forms REQUIRED:

- **BCAL 4607- Incident/Accident Report**. This form is **REQUIRED** for the facility to use when reporting to BCHS any incident where a resident has been harmed or exposed to harm.
- BCAL 2318 and BCAL 2319-Resident Funds and Valuables. **REQUIRED** forms to document monies exchanged between the facility and resident.

Required forms for records, but do not have to be the BCHS number form:

- **BCAL 3265-Assessment Plan for AFC Residents** or its equivalent. R400.14301 (2) Small Group, R400.15301 (2) Large Group. The ASCAP ACP service plan includes key elements of the comprehensive assessment. In emergencies, the written assessment must be completed within 15 business days of date of MDHHS placement. The AFC licensee is also required to complete their own assessment of each resident.

- **BCAL 3483-Resident Information and Identification Record** or its equivalent.
- **BCAL 3947-Health Care Appraisal** or its equivalent.
- **BCAL 3485-Weight Record** or its equivalent.
- **BCAL 3266 Resident Care Agreement** or its equivalent.

Homes for the Aged (HFA)

HFA facilities can use forms of their own design as long as all of the following information is contained on the form per BCHS licensing rules:

Medication Log. R 325.1932 Resident medications. Rule 32:

(3) (b) Complete an **individual medication log** that contains all of the following information:

(i) The medication.
(ii) The dosage.
(iii) Label instructions for use.

General Records. R 325.1941 Records; general. Rule 41. A resident register, resident records, accident records and incident reports, and employee records and work schedules shall be kept in the home and shall be available to the director or the director's authorized representative.

The **Resident Record** form and **Resident Register** form differ in that the Resident Record contains individual resident information that includes service plan information. The Resident Register form is a total list of all residents in the HFA with minimum information for each resident.

Resident Record. R 325.1942 Resident records. Rule 42.

(1) A home shall provide a **resident record** for each resident.

(2) A home shall assure that a current resident record is maintained and that all **entries are dated and signed**.

(3) The **resident record** shall include at least all of the following:

(a) Identifying information, including name, marital status, date of birth, and gender.

(b) Name, address, and telephone number of next of kin or authorized representative, if any.

(c) Name, address, and telephone number of person or agency responsible for the resident's maintenance and care in the home.

(d) Date of admission.

(e) Date of discharge, reason for discharge, and place to which resident was discharged, if known.

(f) Health information, as required by MCL 333.20175 (1), and other health information needed to meet the resident's service plan.

(g) Name, address, and telephone number of resident's licensed health care professional.

(h) The resident's **service plan**.

(4) A home shall keep a resident's record in the home for at least 2 years after the date of a resident's discharge from the home.

Resident Register Log. R 325.1943 Resident registers. Rule 43.

(1) A home shall maintain a current register of residents which shall include all of the following information for each resident:

(a) Name, date of birth, gender, and room.

(b) Name, address, and telephone number of next of kin or authorized representative, if any.

(c) Name, address, and telephone number of person or agency responsible for resident's maintenance and care in the home.

(d) Date of admission, date of discharge, reason for discharge, and place to which resident was discharged, if known.

(e) Name, address, and telephone number of resident's licensed health care professional, if known.

(2) A register of all residents shall be maintained at all times for the previous 2 years.

ENROLLMENT PROCESS

All licensed facilities that wish to receive Title XIX funds through the Adult Community Placement (ACP) program need to enroll as providers by:

- Registering online with the state vendor registration department at CPEXPRESS or website address: www.michigan.gov/cpexpress.
- Enrolled by Michigan Department of Health and Human Services (MDHHS) adult services worker via a DHS-2351X form for a Bridges provider identification (ID) number.

No payment can be authorized until the licensed provider is enrolled in Bridges.

When an application for ACP personal care is received by the MDHHS for a resident that is a Medicaid recipient, the licensed facility will be the provider unless there are other services in place such as the MI Choice Waiver program (see **ASM-085, Coordination with other Agencies**) in which case ACP personal care supplement payment cannot be provided.

The client must choose either the ACP or MI Choice waiver program to meet their personal care need. A client may only have one program. To find an existing provider ID number for a licensed facility, the adult services worker does the following:

- Search the ASCAP provider database under the utilities tab and then click “clients for provider”. A pop-up box will appear where the name of the licensed facility can be searched.
- If the name of the licensed facility is not found, the adult services worker can utilize Bridges and select “Inquiry” in the left hand column, then scroll to “Search enrolled provider”. By using the facility’s license number, Bridges can identify if an existing provider number has been assigned for that facility.
- If neither of these searches finds the Adult Foster Care (AFC) home as an existing enrolled provider, then the adult services worker must register the AFC as a new provider by completing and submitting a DHS-2351X enrollment form.

New Provider Registration Process

- **DHS-2351X Provider Enrollment/Change Request Form**. The adult services worker will enroll the provider by completing a DHS -2351X provider enrollment form found in the FORMS tab in ASCAP. The completed form is given to the local office Bridges administrator to be entered into Bridges so a provider ID number will be assigned to the provider. The number is given to the provider so they may follow the next registration steps:
- New licensees register as a vendor for the State of Michigan and complete a W-9 form electronically. The web site to register as a vendor online is www.michigan.gov/cpexpress.
- The new licensee must complete the W-9 with the same exact information, especially the tax ID, as is on their license.

AFC Licensee Enrollment

The AFC licensing system is computerized and provides a database for linking with Bridges. This AFC database the Bureau of Community and Health Systems (BCHS) licensing consultants use is called the Bureau of Information Tracking System (BITS). BITS immediately updates Bridges to reflect any licensing changes. When an AFC provider is enrolled in Bridges, the licensing data is checked and confirmed between Bridges and BITS. A termination of a license automatically terminates the enrollment on Bridges.

If there are issues with an enrollment of an AFC provider, check Bridges to see if the license has been issued. If there is no license information located in Bridges, contact the area licensing consultant for more information on the licensee.

Bridges requires that each licensed facility have their own provider ID number even if they are owned by one corporation. If there is a new owner to an existing licensed facility, the new owner must be enrolled to obtain a new provider ID number. The old licensee must still receive payments on their authorized license and provider number until the new licensee obtains their own provider ID. If the old license closes prior to new license being issued, there will be a lapse of payment.

Updates to AFC Provider Enrollment information.

Changes in the status of the AFC license number, address corrections, or tax ID updates are not automatically updated on the ASAP database.

Therefore, it is necessary to monitor any sales of facilities, address changes, or changes in the license type of the facility. The license end date of any previous license must be dated prior to the eligibility begin date of the new license. This is necessary because the system will not accept overlapping dates. License renewal expiration dates do not affect the eligibility end date, but closure of the facility date does.

When a current licensee needs to make Tax ID changes due to owning more than one facility, each facility needs to have its own provider ID number. The same Federal Employee Identification Number (FEIN) can be used for multiple provider ID numbers.

- A personal licensee social security number (SSN) can only be used on one single provider ID number.
- When a licensee wishes to change their tax ID due to obtaining a FEIN, a copy of the assigned FEIN paperwork needs to be given to their licensing consultant to change on the BITS licensing software system. After BITS is updated with the correct FEIN it notifies Bridges that there is a change on the enrolled license.

Note: The tax ID update occurs in BITS only. The Tax ID information will not automatically update in Bridges. In order to update the Tax ID information in Bridges, send an email to: MDHHS-Provider-Management@michigan.gov requesting an update to the Tax ID information.

Provider Enrollment Updates

Any changes in licensing information adult services workers receive, they should take appropriate action by checking with the licensing consultant for accuracy and forwarding the correct information via email to: MDHHS-Provider-Management@michigan.gov.

Note: Any information changes to a license facility are done by the license consultant and input into BITS. BITS will update Bridges

information automatically. If there is information that does not match or any other concerns with license facility provider enrollment, send an email to: MDHHS-Adult-Services-Policy@michigan.gov and place "**ACP**" in the subject line of the email.

PAYMENT OVERVIEW

The Adult Services Authorized Payments (ASAP) is the payment system that processes adult services authorizations. The adult services worker enters the payment authorizations using the payments module in the ASCAP system.

- Warrants are delivered to the licensed provider each month after they submit a billing to the ASAP system for residents in their facility.
- Payments can be a full or partial month for reasons of temporary absence from the facility such as nursing home rehabilitation or hospital stay.
- The invoice must be entered in ASAP with the exact date of the authorization in ASCAP or the payment will not be processed.
- If at any time a warrant is not received or missing, there is a process to have the payment reissued.
- If the warrant was paid in error, the adult services worker must follow the recoupment process.

Funding Sources

The payments have two different funding sources depending on the needs of the residents.

1. Payments for residents who need personal care services provided in licensed Adult Foster Care (AFC), County Infirmaries (CI) and Home for the Aged (HA) are funded by Title XIX Medicaid funds.
2. Payments for residents who are not in need of personal care services but do need the supervision provided in licensed AFC, County Infirmaries and HA are funded by state dollars - General Fund/General Purpose (GF/GP).

Title XIX

The information on the assessment helps determine the funding source of the personal care supplement payment. If there is a limitation noted in at least one of the Activities of Daily Living (ADL) that is ranked a **level 2**, 3, 4, or 5, the adult services worker needs to have the client's physician complete a DHS-54A, Medical Needs

form. The physician certifies there is a need for personal care by checking "yes" on the form. The DHS-54A physician signature date must be entered into ASCAP to direct the personal care supplement payment dispersing out of Title XIX funds.

For Medicaid clients residing in a license facility, it is not necessary to delay entry of the initial authorization of payment while waiting for the DHS-54A to be obtained. The initial authorization may be put on the system for a short duration-90 days or less- when state funds are used for the payment.

Note: The adult services worker must remember to change the authorization once the DHS-54A is received by entering the date the physician signed and approved the need for personal care in the Medical tab in ASCAP. If state funds were the source, end date that authorization and enter the new 54A date. The ASAP payment system will switch payment to Title XIX funds to pay the licensee provider for services.

State Funded

State funds are used when the client is on Medicaid and has no ADL needs or medication requirements. The personal care supplement is paid using state funds. 54A form signed by the physician that states "no" means the 54A date is **not** entered in ASCAP.

Payment Authorizations

Licensed AFC homes, County Infirmaries and HA residents that have Medicaid are eligible for the personal care supplement payment from either GF/GP state funds prior to the obtaining of a DHS-54A, or from federal Title XIX funds after receipt of a DHS-54A stating the resident requires personal care.

Initial Authorization in ASCAP

The adult services worker will search in the payment module in ASCAP for the AFC provider. The provider is linked to the open ACP case client so the personal care supplement payment can be authorized. Authorizations will error out unless there is an active service case in the ACP program and an open Medicaid case with a scope of coverage of 1F, 2F, or 3G.

The pay start date and pay end date establish the duration of an authorization. Authorizations can be for one day, a partial month,

the current month, the future up to six months to the next review, retroactively or any combination of the above.

The pay begin date for an authorization will typically be the date of admission to the facility or the date the client became eligible for Medicaid after admission. Normally the pay end date is the last day of the month following the second six month review (annually).

Updates to Payment Authorizations

After the initial authorization, the adult services worker will often update the payment authorization at the review. If all information on the client and the provider remain the same, a new authorization is put on ASCAP.

If there is a change in provider, the client moves, or there is a break in services such as hospitalization, the authorization must be terminated with an end date. Each example is explained below:

- **Hospitalization**. When a client is hospitalized more than 24 hours, the adult services worker must stop payment. Medicaid pays the hospital from the date the client enters the hospital through the day prior to discharge. The AFC facility is then paid from the date of return to the home.

Example: The client enters the hospital on 5-18-2016. The AFC would be paid through 5-17-2016. The Adult services worker enters 5-17-2016 as the stop date of payment to the AFC. The hospital will bill Medicaid for the day the resident entered the hospital. When the client returns to the AFC from the hospital, the day of return to the AFC can be entered for the AFC to begin billing.

- **Temporary Absence Other Than Hospital**. Absences up to 104 days a year are permissible without an adverse effect on the AFC-HA personal care supplemental payment. This will eliminate a potential disincentive and encourage family visits, weekends or vacation time away from the facility. Providers will need to record the dates of absences in the facility resident record and adult service workers will monitor this at the time of the six month and annual redeterminations. Absences of more than 8 days a month, but less than 104 days a year must be approved by the Adult services worker and supervisor.

Reinstatement of Authorization

If a client returns to a facility within 90 days after the services case was closed and payment terminated, it is not necessary to have a

new **DHS-390 or DHS-54A Medical Needs** form. A new assessment is recommended. However, the worker is to re-open the case on ASCAP and reinstate the authorization for the personal care supplement payment.

Payments automatically stop

Personal care supplemental authorizations (code 0401) will automatically stop for the following reasons:

- Authorization end date is reached.
- Services case closes.
- Medicaid eligibility ends.
- Provider license ends.
- Level of Care (LOC) code error.
- Medicaid benefit program code is not eligible.

Payments on closed cases

An authorization can be completed on a closed case for a time period the case was open, Medicaid was active and the provider was assigned to the case. A Supervisor will need to approve this authorization.

Note: If the provider was not assigned prior to the case closure, contact the Adult Services Policy Unit for assistance via the policy email at: MDHHS-Adult-Services-Policy@michigan.gov. Please enter **ACP** in the subject line.

Adult Services Policy Unit payment exceptions

The following payment authorizations will be forwarded via ASCAP to the Adult Services Policy Unit for processing:

- Authorization period is more than six months prior to the current date. Payments within six months or future authorizations must be approved locally and cannot be approved as an exception. If the adult services worker happens to have a retroactive payment request that spans six months and beyond the current date (no more than 365 days prior to the current date), the request must be split into two different approval request.

Example: Today's date is July 24th and your licensed facility is requesting Title XIX personal care payments from the date the adult moved in, which was the month of July of the prior year. There would be two payments put in ASCAP, one being July through

December 31 (which would first be approved by your local supervisor and then pended to central office), and the second request from January 1 to the July 24th (which would be approved by your supervisor only).

- Authorizations that occur during the same time period as other adult services program (for example, Adult Protective Services payment and ACP payment). The authorization submitted to central office must only be for the time period the programs overlap.

Example: An APS payment was requested for living cost for a client who moved into an AFC facility November 1st through the 30th. An ACP case was opened also because the client qualifies for Medicaid, has personal care needs, and will remain at the facility permanently. The authorization to central office must reflect the overlap period of November 1 to the 30th on each request.

Whichever authorization is entered first is approved at the local office. The second authorization requires central office approval.

Example: An APS authorization was entered first will be approved by local office. The secondary ACP authorization will pend to central office for approval and vice versa.

- Cases that are closed in ASCAP but was open and active during the authorization period requested.

- The authorization is for a provider in a service period for which another provider has received an erroneous payment.

- Cases where an administrative error occurred. These exceptions must be approved by a local office director or designee in addition to the supervisor.

All payment exception requests sent to the supervisor and central office must have adequate justification explained in the rationale box in ASCAP with details as to why an exception is required.

If clear explanation is not provided with the exception, the payment request will be either delayed with central office asking for clarification or the request will be denied.

Payment authorizations approved by central office will contain the number “9” before the service code (9301, 9302, or 9401) on the payment line in ASCAP. When the payments are approved or denied, the Adult services worker will receive a confirmation E-mail.

ASAP Licensee Monthly Billings

The licensee is required to enroll online at the State of Michigan Vendor Registration (MAIN) at CPEXPRESS or at this address: www.michigan.gov/cpexpress.

The licensee must enroll with the ASAP system. The licensee must have a PIN number prior to accessing the ASAP billing system. To obtain a PIN number, the licensee must call the Provider Hotline at 1-800-979-4662.

Licensee providers will submit billing for services provided each month using one of two methods:

- In order to bill via the internet access, the provider uses the MILogin access or at address https://milogintp.michigan.gov.
- To bill via telephone access, the provider calls 1-800-798-1409.

The services dates authorized by the adult services worker must match what the provider is billing or no payment will be issued.

Web or phone billing access is available 24 hours a day, 7 days a week.

All months with partial service dates will result in a prorated payment to the AFC/HA.

Provider information on how to enroll in MILogin (scroll down to Provider and Advocate column) is available online at the MILogin information page.

AFC/HA providers will be issued a 1099 form each January.

WARRANTS OVERVIEW

Problems receiving the payments can result from the warrant being lost, undeliverable, or received but destroyed by post office machinery. Please see **ASM-160** for complete step-by-step instructions for warrant replacement or cancellation procedures.

Resolving Payment Problems

Some of the reasons of non-payment can be the result of such things as:

- Incomplete information when a licensee submits a claim to ASAP.
- A lack of correct dates on a payment authorization.
- Change in the licensee status from the Bureau of Community and Health Systems (BCHS)

To assist in determining a payment problem, an adult services worker can:

- Review the licensee information shown in ASCAP for incorrect mailing information, tax ID, or payment authorization time periods.
- Verify with the licensee provider that they also enrolled with the State of Michigan Vendor registration at www.michigan.gov/cpexpress.

A Troubleshooting ACP Payment Issues list can be found on the Adult Services intranet ACP home page for reference.

If the adult service worker is not able to determine the problem after following these directions, they should then contact Adult Service Policy Unit via the policy mailbox: MDHHS-Adult-Services-Policy@michigan.gov for additional assistance. In the email subject line enter **ACP payment issue**.

Recoupment

Notification is sent to the MDHHS Medicaid Collections Unit when an overpayment to an AFC has been discovered. The **DHS-567, Recoupment Letter for ACP/HA,** form is used specifically for recoupment of an overpayment to a licensed provider. When the DHS 567 is generated in ASCAP, the form is automatically sent to MDHHS Medicaid Collections Unit. If the adult services worker generates more than one form in error, then the Medicaid Collections unit must be notified with the correct request.

If the AFC is not cooperative regarding the overpayment, notification to the license consultant would be necessary as a rule violation may have occurred.

For more detailed information on the recoupment process, please see **ASM-165, Overpayment and Recoupment Process**.

PROVIDER RATES

Effective January 1, 2016

SUPPLEMENTAL SECURITY INCOME (SSI) AND STATE DISABILITY ASSISTANCE (SDA) ALLOWANCE AND MONTHLY PROVIDER RATES			
Living Arrangement	**Personal Allowance**	**Provider Payment**	**Total**
SSI/Foster Home - Domiciliary Care	$44.00	$776.00	$820.00
SSI/Foster Home - Personal Care	$44.00	$846.50	$890.50
SSI/Home for the Aged	$44.00	$868.30	$912.30
SDA/Foster Care - Domiciliary Care	$49.00*	$771.00	$771.00
SDA/Foster Care - Personal Care	$49.00*	$841.00	$841.00
SDA/Home for the Aged	$49.00*	$383.00	$383.00

Note: * SDA personal allowance checks are sent directly to the client regardless of their living arrangement. Clients who receive both SSI and Social Security (RSDI) checks are eligible for a $20.00 disregard under the Social Security Act, Section 1612(b)(2). The total of this client's two checks will be $20.00 higher than the check of the client receiving just SSI. Therefore, after paying the provider the rate shown above, this client will have an additional $20.00 added to the personal allowance for a total of $64.00.

SSI DAILY RATE

SSI DAILY RATE	
SSI/Foster Home Domiciliary Care	$776.00 x 12 ÷ 365 = $25.51
SSI/Foster Home Personal Care	$846.50 x 12 ÷ 365 = $27.83
SSI/Home for Aged	$868.30 x 12 ÷ 365 = $28.55
SDA/Foster Care Domiciliary Care	**
SDA/Foster Care Personal Care	**
SDA/Home for the Aged	**

Note: Effective 10-01-2014, the AFC/HA personal care supplement payment is $203.92 per month. The monthly supplement payment is in addition to the SSI payment and is a vendor warrant paid directly to the provider.

Note: **See Reference Tables (RFT) 235 for SDA daily rate.

PERSONAL CARE SUPPLEMENT PAYMENT RATE

The current personal care supplement payment rate is $203.92 per month.

OVERVIEW

A nursing care facility is a licensed nursing home, county medical care facility, or a long term care unit in a licensed hospital. Organized nursing care and medical treatment is provided to:

- Seven or more unrelated individuals who are suffering or recovering from illness, injury, or infirmity.
- These persons must be 15 years of age or older except in child caring homes and units.

Nursing care facilities may also be certified for the purpose of becoming eligible for payment from federal or state health programs. Licenses are usually valid for not more than one year after date of issuance.

Adult services workers may assist Medicaid (MA) recipients in locating available vacancies in appropriate nursing care facilities.

1978 P.A. 368, as amended, commonly known as the Public Health Code, Article 17, Facilities and Agencies, contains information in two parts specifically related to nursing care facilities. Part 201 is entitled General Provisions and Part 217 is entitled Nursing Homes.

In addition there are administrative rules that provide for license and certification. The rules contain detailed information necessary to implement the Act 368. Copies of the Public Health Code. The rules may be obtained from the Department of Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS).

Complaints regarding nursing care facility residents

Review the Adult Protective Services policy ASM-210, 250 and 255 for a complete description of procedures for handling APS complaints with regards to nursing care facility residents. Copies of the APS referral regarding residents in a particular nursing care facility are to be sent to Department of Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) at this address:

Michigan Department of Licensing and Regulatory Affairs

Bureau of Community and Health Systems-Health Facility Complaints
P.O. Box 30664
Lansing, MI 48909
Fax: 517-241-0093
1-800-882-6006 Complaint Hotline number.
Email: BCHS-Complaints@michigan.gov

Nursing Care Facility Involuntary Transfers

Section 21773 of the Michigan Public Health Code and Rule 325.20116 discuss in detail the following conditions under which an individual may be involuntarily transferred out of a nursing care facility:

1. For medical reasons.
2. For the patient's welfare or that of other patients or facility employees.
3. For non-payment of a patient stay.

The decision to involuntarily transfer or discharge an individual requires that there be a written notice using ITD-502, Notice of Involuntary Transfer or Discharge form, of a minimum a 30 days prior to discharge except in the following instances:

- If an emergency transfer or discharge is mandated by the patient's health care needs and is in accord with a written order of medical justification by the attending physician.
- If transfer or discharge, mandated by the physical safety of other patients and facility employees, is documented in the clinical record.
- If transfer or discharge is subsequently agreed to by the patient or the patient's legal guardian. Notification must be given to next of kin and the person or the agency responsible for the patient's placement, maintenance and care in the facility.

Once the notice is given to the client or the client's legal representative, the nursing facility must inform the BCHS within 48 hours of serving the notice.

Section 21774 of the Public Health Code allows the patient the right to file a request of a hearing with the Michigan Department of

Health and Human Services (MDHHS), within 10 days following receipt of the written notice of the involuntary transfer.

The ITD-505, Appeal Form Regarding Involuntary Transfer or Discharge, must be provided to the resident by the nursing home, completed and mailed to:

Bureau of Community and Health Systems
Attn: LTC Involuntary Transfer/Discharge Notice
611 W Ottawa Street
Lansing, Michigan 48909
P. O. Box 30664
Bureau Main Phone: 517-241-2638
FAX: 517-241-2635
Division E-Mail: BCHS-help@michigan.gov

The Bureau of Community and Health Systems (BCHS), LTC Involuntary Transfer/Discharge team, reviews and approves involuntary transfers and discharges of residents from licensed nursing care facilities or a distinct part of a nursing facility.

For answers to your questions regarding the involuntary transfer/discharge process, contact the Michigan Long Term Care Ombudsman:

- By telephone: 866-485-9393.
- Mailing instructions are provided on each form.

Nursing Care Facility Closure

Sections 21785 and 21786 of the Michigan Public Health Code outline the responsibilities of a nursing home, and the MDHHS in those situations where a nursing care facility is closing.

- Section 21875 discusses the procedures to be followed when a facility voluntarily proposes to discontinue operation.

  The facility is to notify the MDHHS, in addition to notifying all patients and their next of kin, as well as any patient representatives. These notices shall be given not less than 30 days before the facility proposes to close.

  The facility and MDHHS are responsible for securing a suitable relocation of a patient who does not have a relative or legal representative to assist in his or her relocation. The facility and

MDHHS are to keep informed of the progress in relocating the individuals. The code specifically states that “the Department of Health and Human Services shall make available to the licensee (facility) assistance necessary to assure the effectiveness of efforts to secure a suitable relocation.”

- Section 21786 deals with those situations in which an emergency closing of a home has been ordered or where it is determined by the health department that a facility is “suddenly no longer able to provide adequate patient care.”

  It is the responsibility of MDHHS to notify the local MDHHS office to make arrangements for the orderly and safe discharge and transfer of the patients to another facility.

  The MDHHS will have representatives in the facility on a daily basis to:

- Monitor the discharge to other facilities or locations.
- Insure the rights of the patients are protected.
- Discuss the discharge and relocation with each patient and next of kin or legal guardian, person, or agency responsible for the patient’s placement, maintenance and care in the facility.

  Local MDHHS office staff should assist in any way possible.

  ASM-379H contains the Interagency Agreement for Nursing Facility Closures. Local office responsibilities are further defined in this document.

  NH closure teams are made up of state and local MDHHS adult services staff that follow the NH Best Practice Protocol.

Nursing Care Facility Transition

To ensure clients are appropriately placed or relocated, Adult services workers should maintain open ACP or ILS cases for 90 days for MDHHS clients who have been admitted to nursing care facilities and then return to either their own home or an AFC/HA.

Transitional services should be provided following the initial placement and for all individuals relocated as a result of a nursing care facility closure.

Visit the client at least one time during the 90 day period to assure the client's needs are being met and to update case information.

Supervisors may approve maintenance of these cases beyond 90 days when the service plan supports a need for continued services.

OVERVIEW

The adult services worker has a critical role in developing and maintaining partnerships with community resources. To facilitate these partnerships the adult services worker will:

- Advocate for programs to address the needs of clients.
- Emphasize client choice and quality outcomes
- Encourage access and availability of supportive services.
- Work cooperatively with other agencies to ensure effective coordination of services.
- Coordinate available resources with residents in a licensed setting to develop a service plan that addresses the full range of client needs.

MI Choice Waiver

The MI Choice Home and Community based waiver program may provide additional services to individuals living in licensed Adult Foster Care Homes (AFC) and Home for the Aged (HA) facilities when the residence meets the Federal requirements for home and community based settings.

MI Choice is administered by a local waiver agency in many counties. For a listing of MI Choice waiver agencies, refer to BEM 106.

If a client in the AFC/HA needs more services than what is usual and customary at the AFC/HA or if the client meets the nursing facility level of care, but chooses to remain in their current residence; adult services may contact the local waiver agency to make a referral for the individual.

The waiver agency will assess the individual to determine if they qualify for the MI Choice program. The waiver agency will need to contract with the AFC/HA before the individual can be served in the setting.

The adult services worker will:

1. Assist the client in making informed choices about the most appropriate services program between Adult Community

Placement (ACP) personal care and MI Choice waiver services.

2. Assist the client in contacting the local MI Choice waiver agency.

3. Assist the client in applying for MI Choice waiver services if chosen.

MI Health Link-Integrated Care Demonstration Pilot Program

Effective March 1, 2015 and continuing through 2018, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare and Medicaid Services (CMS), have implemented a new capitated managed care program, called **MI Health Link**. This program will integrate into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid.

The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, and improve quality of care.

Individuals who are eligible to participate are those who are age 21 or older, eligible for Medicare and Medicaid, and reside in one of the four demonstration regions:

- Region 1- Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft.
- Region 4- Barry, Berrien, Branch, Calhoun, Kalamazoo, St. Joseph, and Van Buren.
- Region 7- Wayne.
- Region 9 - Macomb.

CMS and MDHHS will contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and

community based services). The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders.

The MI Health Link program does not cover hospice services. If MI Health Link enrollees require hospice services, they must disenroll from the MI Health Link program and receive the hospice services through original Medicare and Medicaid.

Individuals will have an opportunity to select the ICO in which they enroll, using the ICO provider networks and drug formularies to assist in making choices. If an ICO is not selected prior to the passive enrollment effective date, individuals will be assigned to an ICO, but will have the option to switch ICOs after enrollment if there is another ICO option in the region.

Level of Care Codes for MI Health Link program

MDHHS has developed level of care codes specific to the MI Health Link program. These codes are as follows:

- 03: Individual meets Nursing Facility Level of Care, lives in the community, and participates in the MI Health Link HCBS home and community based services waiver program.
- 05: Resident of any nursing facility or hospital long term care unit (private or county owned) that is not a County Medical Care Facility.
- 07: General population in the community
- 15: Resident of a County Medical Care Facility

Michigan Enrolls

Michigan ENROLLS is the enrollment broker for the MI Health Link program. Michigan ENROLLS does **all enrollments, disenrollment and requests to opt-out** for MI Health Link.

Only phone calls are accepted.

Call Michigan ENROLLS toll-free at **1-800-975-7630**. TTY users may call 1-888-263-5897. The office hours are Monday through Friday (except holidays) 8 AM to 7 PM ET.

Client questions or concerns:

- Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174.
- Medicaid Beneficiary Help Line (Monday through Friday 8 AM to 7 PM) at 1-800-642-3195.
- Email: INTEGRATEDCARE@michigan.gov.

For more information see the Michigan Department of Health and Human Services (MDHHS)/Doing Business with MDHHS/Health Care Providers/MI Health Link

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RESOURCES

Traumatic Brain Injury (TBI)

Traumatic Brain Injury (TBI) clients whose care cost would exceed the ACP Title XIX personal care supplement amount should be referred to a local MI Choice waiver agency. The waiver agency may be able to supplement the usual and customary services provided at the AFC/HA with MI Choice services. Refer to the MI Choice Waiver section above.

Resource information is also available from the Brain Injury Associate of Michigan at:

- 1-800-772-4323
- Website Brain Injury Association of Michigan at www.biami.org.

Food Stamps

Some residents of nonprofit AFC homes may be eligible for food stamps. A facility must be licensed for 16 or fewer residents and be nonprofit as determined by the IRS. Eligible residents must be blind or disabled and receiving benefits under Title II (RSDI) or Title XVI (SSI) of the Social Security Act. Interested providers should contact Food Stamp eligibility specialists for specific information. See **BEM-615, Group Living Facilities** and **BEM-617, FAP in Nonprofit Group Living Facilities**.

Hospice Services

Act 194 (Public Acts of 1996) exempts an AFC licensee who is providing care to a resident who is enrolled in a licensed hospice program from being in non-compliance with the continuous nursing care prohibition.

Medicaid will reimburse enrolled hospice providers for services to MA recipients who are residents of AFC facilities or Home for the Aged (HA) facilities. When a Medicaid resident becomes eligible for these covered hospice services in either an AFC or HA facility, the provider will notify the local adult services worker or case manager.

Note: Since Title XIX funds are used for the hospice services, the personal care supplemental payment must be switched to state funding.

In order to switch the Title XIX payment to state funds, the physician's certification date must be removed from ASCAP. ASAP will automatically pick up the new authorization and pay from state funds.

Volunteer Services

Utilizing volunteers can greatly enrich the lives of AFC residents and currently a wide variety of programs are providing services throughout the state. ACP adult services workers are encouraged to develop programs in conjunction with the volunteer services coordinator.

Generally programs are of two types:

- Groups.
- Individual.

Select activities that allow residents to participate in community events, help maintain old ties (church affiliations, club activities) and help reduce deterioration.

A creative exploration of all types of local events may reveal new ideas. For instance, residents might be able to attend monthly professional theater productions or sporting events free of charge.

Each community offers its own special set of resources that can be accessed to meet resident needs.

Brochure

Adult Foster Care DHS Publication 371. This pamphlet may be very helpful in providing agencies and individuals with general information about this specific resource in the continuum of care.

CASE CLOSURE

The Adult Community Placement (ACP) case must have all documentation and narrative entered in ASCAP before the case is closed. Currently, the paper file must contain certain items to satisfy file retention requirements of Medicaid.

- Case closing information must be entered in ASCAP.
- Any comments that may prove helpful in the future should be included in the closing summary.
- The adult services worker must generate a DHS-1212, Advanced Negative Action Notice, from ASCAP and mail to the client or his guardian/designated representative (If required; see ASM-010, Program Eligibility when no need to send DHS-1212).
- The payments to providers must be terminated in ASCAP.

Closing codes

The case should be closed in ASCAP using the appropriate goal status code. Goal status codes used when closing cases have special program definitions based on type of residential/care setting at time of closure. Descriptions of each choice below:

- Code 1: Died.
- Code 2: Services Not Available.
- Code 3: Refused Services.
- Code 4: Situation Stable, Services no longer needed.
- Code 5: Moved out of State.
- Code 6: Placed in Adult Foster Care (AFC).
- Code 7: Placed in Nursing Home (NH).
- Code 8: Placed in Home for the Aged (HA).
- Code 9: Placed in Independent Living Services (ILS).
- Code 10: Situation Stable, Guardian/Conservator in place.
- Code 11: Customer Request.

- Code 12: Placed in Program of All-Inclusive Care for the Elderly (PACE).
- Code 13: Placed in MI Choice Waiver.
- Code 14: Placed in Integrated Care Organization (ICO).

FILE RETENTION

Certain documents used in the ACP program must be kept on file either in paper form or electronically for a set amount of time after the case is closed. Click here to open a document with adult services file retention requirements manually or to navigate to the site:

1. From the MDHHS intranet select **About MDHHS** tab and then click **Offices and Departments**.
2. Select **Field Operations Administration.**
3. From Services Provided by FOA click **Adult Services**.
4. Under **What's New** click **Reference Materials**.
5. Click **File Retention**.

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LEGAL AUTHORITY

Title XIX of the Social Security Act, 42 USC 1346 et seq.

42 CFR 440.170(f)

Social Welfare Act, 1939 PA 280, as amended, MCL 400.14(1)(p)

Medicaid State Plan is the state's contract with the federal government to provide a Medicaid program. Independent living services (home help) is the Medicaid State Plan for personal care services in the home. The Michigan Department of Community Health is the single state agency for Medicaid.

MISSION STATEMENT

The purpose of independent living services (ILS) is to provide a range of supportive and assistance related services to enable individuals of any age to live safely in the most independent setting of their choice.

The vision of independent living services is to:

- Ensure client choice and personal dignity.
- Ensure clients are safe and secure, as possible.
- Encourage clients to function to the maximum degree of their capabilities.

To accomplish this vision, DHS will:

- Act as resource brokers for clients.
- Advocate for equal access to available resources.
- Develop and maintain fully functioning partnerships that educate and effectively allocate limited resources on behalf of our clients.

PROGRAM GOALS

Independent living services are directed toward the following goals:

- To encourage and support the client's right and responsibility to make informed choices.

- To ensure the necessary supports are offered to assist the client to live independently and with dignity.

- To recognize and encourage the client's natural support system.
- To ensure flexibility in service planning, respecting the client's right to determine what services are necessary.
- To provide the necessary tools to enable client self-advocacy.

PROGRAM OUTCOMES

Program goal attainment will be measured by:

- **Client:** clients will be referred to appropriate programs/resources. The status of referrals will be closely monitored.
- **Client Safety:** clients will be supported, as safely as possible, in the setting of their choice.
- **Client Service Supports:** as a client's functionality declines, progressively increased service supports will be offered to enable living in the least restrictive setting.

SERVICE DELIVERY METHODS

Home help services are delivered by the case management methodology. Services to non-Medicaid individuals are delivered by the supportive services methodology. Refer to ASM 103, Service Methodology for descriptions.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

PROGRAM DESCRIPTION

Independent living services offer a range of payment and nonpayment related services to individuals who require advice or assistance to support effective functioning within their home or the household of another.

Nonpayment Services

Nonpayment independent living services are available upon request, without regard to income or assets, to any person who needs some form of in-home service (except personal care services). Nonpayment services include all services listed below:

- Information and referral.
- Protection (for adults in need of a conservator or a guardian, but who are not in any immediate need of protective intervention).
- Money management (Referrals to Social Security Administration).
- Housing (Referrals for Section 8 Housing).

Payment Services Home Help

Home help services are non-specialized personal care service activities provided under the independent living services program to persons who meet eligibility requirements.

Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.

Home help services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are **not** currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, intermediate care facility (ICF) for persons with developmental disabilities or institution for mental illness.

These activities **must** be certified by a Medicaid enrolled medical professional and may be provided by individuals or by private or public agencies. **The medical professional does not prescribe or authorize personal care services**. Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living (ADL)

- Eating.
- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)

- Taking medication.
- Meal preparation/cleanup.
- Shopping for food and other necessities of daily living.
- Laundry.
- Light housecleaning.

An individual must be assessed with at least one activity of daily living (ADL) ranked 3 or higher or complex care need in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services if assessed at a level 3 or greater.

Example: Ms. Smith is assessed at a level 4 for bathing. However, she refuses to receive assistance or her daughter agrees to assist her at no charge. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

Note: If an individual uses adaptive equipment to assist with an ADL, and without the use this equipment the person would require hands-on care, the individual must be ranked a level 3 or greater on

the functional assessment. This individual would be eligible to receive home help services.

Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The adult services specialist must rank Mr. Jones a 3 or greater under the functional assessment. Mr. Jones would be eligible to receive home help services.

Assistive technology would include such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and handheld showers. This list is not all inclusive.

Expanded Home Help Services (EHHS)

Expanded home help services can be authorized for individuals who have severe functional limitations which require such extensive care that the service cost must be approved by the adult services supervisor/local office designee and/or the MDHHS Long Term Care Policy Section.

Complex Care

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed on clients whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or client may be required in order to perform.

- Eating or feeding assistance.
- Catheters or leg bags.
- Colostomy care.
- Bowel program.
- Suctioning.
- Specialized skin care.
- Range of motion exercises.
- Dialysis (In-home).
- Wound care.
- Respiratory treatment.
- Ventilators.
- Injections.

Home Help Services for Minor Children

When providing for minor children, personal care services must be shown to be a necessary supplement to usual parental care, justified by the high service needs of the family. High service needs are those which arise from a physical, medical, emotional, or mental impairment of the minor child and which require significantly higher levels of intervention than those required by a child of the same age without similar impairments.

Example: It is expected that a one year old child would be incontinent due to age however; a 16 year old minor would likely have a medical or cognitive condition causing incontinence.

Children typically have responsible relatives (parents/adoptive parents) able and available to provide for their care needs. When responsible relatives are **unable** due to a medical condition, or **unavailable** due to employment or school, they can hire a provider to perform the activities of daily living, medication administration and meal preparation required during the parent's absence. Parents **cannot** be the paid provider for their minor children.

Note: A medical needs form must provide verification the responsible relative is unable to provide care due to a medical condition. If the responsible relative is unavailable due to employment or school, they must provide a work or school schedule to verify they are unavailable to provide care.

The adult services specialist **must not** authorize approval for tasks that can be completed by the responsible relative during the time they are available.

Note: A legal guardian is **not** a responsible relative and can be paid to provide home help services to the minor child.

Payments are **only** for the amount of time related to the approved tasks and cannot include time for child care, supervision and monitoring. The specialist must ensure there are no duplication of services.

The adult services specialist must evaluate whether day-care services are appropriate rather than home help services.

Services not Covered by Home Help

Home help services must **not** be approved for the following:

- Supervising, monitoring, reminding, guiding, teaching or encouraging (functional assessment rank 2).
- Services provided for the benefit of others.
- Services for which a responsible relative is **able** and **available** to provide (such as house cleaning, laundry or shopping). A responsible relative is defined as an individual's spouse or a parent of an unmarried child under age 18.
- Services provided by another resource at the same time (for example, hospitalization, MI-Choice Waiver).
- Transportation - See Bridges Administrative Manual (BAM) 825 for medical transportation policy and procedures.
- Money management such as power of attorney or representative payee.
- Home delivered meals.
- Adult or child day care.
- Recreational activities. (For example, accompanying and/or transporting to the movies, sporting events etc.)

Note: The above list is not all inclusive.

PERSON CENTERED PLANNING

The adult services specialist views each client as an individual with specific and unique circumstances, and will approach case planning holistically, from a person-centered, strength-based perspective.

Person-centered, strength-based case planning focuses on the following:

- Client as **decision-maker** in determining needs and case planning.
- Client **strengths and successes,** rather than problems.
- Client as their **own best resource.**
- Client **empowerment.**
- The adult services specialist's role includes **being an advocate** for the client. **As advocate, the specialist will:**
  - Assist the client to become a self-advocate.
  - Assist the client in securing necessary resources.
  - Inform the client of options and educate him/her on how to make the best possible use of available resources.
  - Promote services for clients in the least restrictive environment. Participate in community forums, town meetings, hearings, etc. for the purpose of information gathering and sharing.
  - Ensure that community programming balances client choice with safety and security.
  - Advocate for protection of the frail, disabled and elderly.
  - Promote employment counseling and training services for developmentally disabled persons to ensure **inclusion** in the range of career opportunities available in the community.

PARTNERSHIPS

Work cooperatively with other agencies to ensure effective coordination of services; see ASM 125, Coordination With Other Services.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS)

CASE MANAGEMENT METHODOLOGY

Case management **is** the primary service delivery method. All ongoing cases in which the client is receiving Medicaid or has an active Medicaid deductible case will be eligible for the case management services delivery method.

Case management is an ongoing process which assists adults in need of home and community-based long-term care services to access needed medical, social, vocational, rehabilitative and other services.

Core Elements

- Comprehensive assessment to identify all of the client's strengths and limitations in the areas of physical, cognitive, social and emotional functioning as well as financial and environmental needs.
- Comprehensive individualized service plan to address the identified strengths and limitations of the client using the information obtained in the assessment.
- Mobilization and coordination of providers, family and community resources to implement the service plan by authorizing/arranging for needed services or advocating for the client to access needed government or community services.
- Ongoing monitoring of services to maintain regular contact with the client, informal caregivers and other service providers to evaluate whether the services are appropriate, of high quality, and are meeting the client's current needs.
- Regular assessment and follow-up as a formal review of the client's status to determine whether the person's situation and functioning have changed and to review the quality and appropriateness of services.

SUPPORTIVE SERVICES METHODOLOGY

Supportive services are defined as those services which typically are targeted to meet specific needs which require limited involvement of the adult services specialist.

Core Elements

- Assessment focused on presenting problem.
- Service plan focused on objectives to meet presenting problem.
- Face-to-face visit in the home a minimum of every six months.
- Regular redetermination of eligibility.

Eligibility for supportive services is determined primarily by the nature of the need presented by a client and identified in the assessment. However, this service delivery method is primarily used for clients who are not receiving Medicaid.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

GENERAL

Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened for supportive services to assist the client in applying for Medicaid (MA).

Home help services payments cannot be authorized prior to establishing Medicaid eligibility and completing a face-to-face assessment with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.

Requirements

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.
- Need for service, based on a complete comprehensive assessment indicating a functional limitation of level 3 or greater for at least one activity of daily living (ADL).
- Appropriate Level of Care (LOC) status.

Medicaid/ Medical Aid (MA)

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- MA deductible obligation has been met.

The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).
- 3G (Healthy Michigan Plan).

Clients with a scope of coverage 20, 2C or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

Medicaid Personal Care Option

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and coordinate implementation with the eligibility specialist.

Conditions of eligibility:

- The client meets all Medicaid eligibility factors except income.
- An independent living services case is open.
- The client is eligible for home help services.
- The cost of personal care services is **more** than the MA excess income amount.

If **all** the above conditions have been satisfied, the client has met MA deductible requirements. The adult services specialist can apply the personal care option in ASCAP. The deductible amount is entered on the **MA History** tab of the Bridges **Eligibility** module in ASCAP.

Use the DHS-1210, Services Approval Notice, to notify the client of home help services approval when MA eligibility is met through this option. The notice must inform the client that the home help payment will be reduced by the deductible amount, and that the client is responsible for paying the provider the MA deductible amount each month.

Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.

Changes in the client's deductible amount will generate a system tickler from Bridges.

MA eligibility under this option **cannot** continue if the cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Bridges Eligibility Manual (BEM) 545, Exhibit II, regarding the Medicaid Personal Care Option.

Medical Need Certification

Medical needs are certified utilizing the DHS-54A, Medical Needs, form and must be completed by a Medicaid enrolled medical professional. The medical professional must hold one of the following professional licenses:

- Physician (M.D. or D.O.).
- Physician Assistant.
- Nurse practitioner.
- Occupational therapist.
- Physical therapist.

The DHS-54A or veterans administration medical form are acceptable for individuals treated by a VA physician; see ASM 115, Adult Services Requirements.

Necessity For Service

The adult services specialist is responsible for determining the necessity and level of need for home help services based on all of the following:

- Client choice.

- A completed DHS-324, Adult Services Comprehensive Assessment. An individual must be assessed with at least one activity of daily living (ADL) in order to be eligible to receive home help services.

  Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services if assessed at a level 3 or greater.

  Example: Ms. Smith is assessed at a level 4 for bathing. However, she refuses to receive assistance or her daughter agrees to assist her at no charge. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater

  Note: If an individual uses adaptive equipment to assist with an ADL, and without the use of this equipment the person would require hands-on care, the individual must be ranked a

level 3 or greater on the functional assessment. This individual would be eligible to receive home help services.

Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The adult services specialist must rank Mr. Jones a 3 or greater under the functional assessment. Mr. Jones would be eligible to receive home help services.

Assistive technology includes such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and hand held showers.

- Verification of the client's medical need by a Medicaid enrolled medical professional via the DHS-54A. The client is responsible for obtaining the medical certification of need; see ASM 115, Adult Services Requirements.

Appropriate Level of Care Status

Verify client's level of care to avoid duplication of services. The level of care will determine if the client is enrolled in other programs. The level of care information can be found in ASCAP under the **Bridges Search** or **Bridges Eligibility** module, **MA History** tab; see ASM 125 Coordination With Other Services for a list of level of care codes.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

REFERRAL INTAKE

A referral may be received by phone, mail or in person and must be entered on ASCAP upon receipt. The referral source does not have to be the individual in need of the services.

Registration and Case Disposition Action

Complete a thorough clearance of the individual in the ASCAP client search and Bridges search.

Complete the **Basic Client** and **Referral Details** tabs of the **Client** module in **ASCAP**.

Supervisor or designee assigns case to the adult services specialist in the **Disposition** module of **ASCAP**.

Documentation

Print introduction letter, the DHS-390, Adult Services Application and the DHS-54A, Medical Needs form and mail to the client. The introduction letter allows the client 21 calendars days to return the documentation to the local office.

Note: The introduction letter does **not** serve as adequate notification if home help services are denied. The specialist must send the client a DHS-1212A, Adequate Negative Action Notice; see ASM 150, Notification of Eligibility Determination.

Standard of Promptness (SOP)

The adult services specialist must determine eligibility within the 45 day standard of promptness which begins from the time the referral is received and entered on ASCAP. The referral date entered on ASCAP must be the date the referral was received into the local office. The computer system calculates the 45 days beginning the day after the referral date and counting 45 calendar days. If the due date falls on a weekend or holiday, the due date is the next business day.

When a signed DHS-390 serves as the initial request for services, the referral date must be the date the application was received in the local office.

Note: A medical need form does not serve as an application for services. If the local office receives the DHS-54A, a referral must be entered on ASCAP for the date the form was received in the local office and an application sent to the individual requesting services.

After receiving the assigned case, the adult services specialist gathers information through an assessment, contacts, etc. to make a determination to open, deny or withdraw the referral; see ASM 115, Adult Services Requirements.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS)

APPLICATION FOR SERVICES (DHS-390)

The client must complete and sign a DHS 390, Adult Services Application, to receive independent living services. An authorized representative or other person acting for the client may sign the DHS-390 if the client either:

- Is incapacitated.
- Has a court-appointed guardian.

A client unable to write may sign with an X, witnessed by one other person (for example, relative or department staff). The adult services specialist **must not** sign the DHS-390 on behalf of the client.

The DHS-390 remains valid unless the case record is closed for more than 90 days.

MEDICAL NEEDS FORM (DHS-54A)

The DHS-54A, Medical Needs, form must be signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:

- Physician (M.D. or D.O.).
- Physician assistant.
- Nurse practitioner.
- Occupational therapist.
- Physical therapist.

The medical needs form is only required for home help recipients at the initial opening of a case, unless one of the following exists:

- The specialist assesses a decline in the client's health which significantly increases their need for services.
- The specialist assesses an improvement in the client's ability for self-care, resulting in a decrease or elimination of services and the client states their care needs have not changed.
- The current medical needs form has a specified time frame for needed services and that time frame has elapsed.

At each case review , the specialist must document in the general narrative if a medical needs form is or is not needed.

The client is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and **not** the client. The National Provider Identifier (NPI) number must be entered on the form by the medical provider and the medical professional must indicate whether they are a Medicaid enrolled provider.

The medical professional certifies that the client's need for service is related to an existing medical condition. **The medical professional does not prescribe or authorize personal care services**. Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

If the medical needs form has not been returned, the adult services specialist should follow-up with the client and/or medical professional.

Home help services cannot be authorized prior to the date of the medical professional's signature on the DHS-54A.

The medical needs form does not serve as the application for services. If the signature date on the DHS-54 is **before** the date on the DHS-390, payment for home help services must begin on the date of the application.

Example: The local office adult services unit receives a DHS-54A signed on 1/18/2016 but a referral for home help was never made. The adult services staff enters a referral on ASCAP and mails an application to the client. The application is returned to the office with a signature date of 2/16/2016. Payment cannot begin until 2/16/2016, or later, if the provider was not working during this time period or not enrolled. Refer to ASM 135 for information regarding provider enrollment.

If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary.

Veteran's Administration (VA)

A DHS-54A completed by a Veteran's Administration physician or the VA medical form in lieu of the medical needs form is acceptable.

COMPREHENSIVE ASSESSMENT (DHS-324)

Conduct a face-to-face interview with the client in their home to assess the personal care needs. Complete the DHS-324, Adult Services Comprehensive Assessment, which is generated from the Adult Services Comprehensive Assessment Program (ASCAP); see ASM 120, Adult Services Comprehensive Assessment.

SERVICE PLAN

Develop a service plan with the client and/or the client's representative. Determine the method of service delivery and any use of home help services with other types of services to meet the assessed needs of the client. The ILS service plan is developed whenever an issue is identified in the comprehensive assessment; see ASM 130, Service Plan.

CONTACTS

The specialist must, at a minimum, have a face-to-face interview with the client, prior to case opening, then every six months in the client's home, at review and redetermination.

An initial face-to-face interview must be completed with the home help provider in the client's home or local Michigan Department of Health and Human Services (MDHHS) office. A face-to-face or phone contact must be made with the provider at the next review or redetermination to verify services are being furnished.

Note: If contact is made by phone, the provider must offer identifying information such as date of birth and the last four digits of their social security number. A face-to-face interview in the client's home or local MDHHS office must take place at the next review or redetermination.

NOTIFICATION OF ELIGIBILITY DETERMINATION

If independent living services are approved, complete and send a DHS-1210, Services Approval Notice, indicating what services will be provided. If home help services will be authorized, note the amount and the payment effective date. If home help services are denied, send a DHS-1212A, Adequate Negative Action Notice, stat-

ing the reason for the denial; see ASM 150, Notification of Eligibility Determination.

INTRODUCTION

The DHS-324, Adult Services Comprehensive Assessment, is the primary tool for determining need for services. The comprehensive assessment must be completed on **all open independent living services cases**. ASCAP, the automated workload management system, provides the format for the comprehensive assessment and all information must be entered on the computer program.

Requirements

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the client in his/her place of residence.
- The assessment may also include an interview with the individual who will be providing home help services.
- A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- The assessment must be updated as often as necessary, but **minimally** at the six month review and **annual** redetermination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
    - Use the DHS-27, Authorization To Release Information, when requesting client information from another agency.
    - Use the DHS-1555, Authorization to Release Protected Health Information, if requesting additional medical documentation.. This form is primarily used for APS cases.

- Follow rules of confidentiality when home help cases have companion adult protective services cases; see SRM 131, Confidentiality.

Bridges Eligibility Module

The **Bridges Eligibility** module in **ASCAP** contains information pertaining to the client's type of assistance (TOA) eligibility, scope of coverage and level of care.

Medical Module

The **Medical** module in **ASCAP** contains information regarding the physician(s), diagnosis, other health issues, adaptive equipment, medical treatments and medications. The medical needs certification date is entered on the diagnosis tab, at the initial certification and each time a new medical needs form is obtained.; see ASM 115, Adult Services Requirements.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the home help services payment.

Conduct a functional assessment to determine the client's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating.
- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)

- Taking Medication.
- Meal preparation and cleanup.
- Shopping.
- Laundry.

- Light housework.

Functional Scale

ADLs and IADLs are assessed according to the following five point scale:

1. Independent.

   Performs the activity safely with no human assistance.

2. Verbal assistance.

   Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some human assistance.

   Performs the activity with some direct physical assistance and/or assistive technology.

4. Much human assistance.

   Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent.

   Does not perform the activity even with human assistance and/or assistive technology.

Home help payments may only be authorized for needs assessed at the level 3 ranking or greater.

An individual must be assessed with at least one activity of daily living ranked 3 or higher or a complex care need in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services if assessed at a level 3 or greater.

Example: Ms. Smith is assessed at a level 4 for bathing. However, she refuses to receive assistance or her daughter agrees to assist her at no charge. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

Note: If an individual uses adaptive equipment to assist with an ADL, and without the use of this equipment the person would require hands-on care, the individual must be ranked a level 3 or greater on the functional assessment. This individual would be eligible to receive home help services.

Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The adult services specialist must rank Mr. Jones a 3 or greater under the functional assessment. Mr. Jones would be eligible to receive home help services.

Assistive technology includes such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and hand held showers.

See ASM 121, Functional Assessment Definitions and Ranks for a description of the rankings for activities of daily living and instrumental activities of daily living.

Complex Care Needs

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed on client's whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or client may be required in order to perform.

- Eating and feeding.
- Catheters or legs bags.
- Colostomy care.
- Bowel program.
- Suctioning.
- Specialized skin care.
- Range of motion exercises.
- Peritoneal dialysis.
- Wound care.
- Respiratory treatment.
- Ventilators.
- Injections.

When assessing a client with complex care needs, refer to the complex care guidelines on the adult services home page.

Time and Task

The specialist will allocate time for each task assessed a rank of 3 or greater, based on interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a **guide**. The RTS can be found in ASCAP under the Payment module, Time and Task screen.

An assessment of need, at a ranking of 3 or greater, does not automatically guarantee the maximum allotted time allowed by the reasonable time schedule (RTS). **The specialist must assess each task according to the actual time required for its completion.**

Example: A client needs assistance with cutting up food. The specialist would only pay for the time required to cut the food and not the full amount of time suggested under the RTS for eating.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all instrumental activities of daily living (IADL) except medication. The limits are as follows:

- Five hours/month for shopping.
- Six hours/month for light housework.
- Seven hours/month for laundry.
- 25 hours/month for meal preparation.

Proration of IADLs

If the client does not require the maximum allowable hours for IADLs, authorize only the amount of time needed for each task. Assessed hours for IADLs (except medications) must be prorated by **one half** in shared living arrangements where other adults reside in the home, as home help services are **only** for the benefit of the client.

Note: This does not include situations where others live in adjoined apartments/flats or in a separate home on shared property and there is no shared, common living area.

In shared living arrangements, where it can be **clearly** documented that IADLs for the eligible client are completed separately from others in the home, hours for IADLs do not need to be prorated.

Example: Client has special dietary needs and meals are prepared separately; client is incontinent of bowel and/or bladder

and laundry is completed separately; client's shopping is completed separately due to special dietary needs and food is purchased from specialty stores; etc.

Responsible Relatives

A responsible relative is defined as an individual's spouse or a parent of an unmarried child under age 18.

Activities of daily living (ADL) may be approved when the responsible relative is **unavailable** or **unable** to provide these services.

Note: Unavailable means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. **Unable** means the responsible person has disabilities of their own which prevent them from providing care. These disabilities must be documented and verified by a medical professional on the DHS-54A, Medical Needs form.

Do **not** approve shopping, laundry, or light housecleaning, when a responsible relative of the client resides in the home, **unless** they are unavailable or unable to provide these services. Document findings in the general narrative in ASCAP.

Example: Mrs. Smith is in need of home help services. Her spouse is employed and is out of the home Monday thru Friday from 7a.m. to 7p.m. The specialist would not approve hours for shopping, laundry or house cleaning as Mr. Smith is responsible for these tasks.

Example: Mrs. Jones is in need of home help services. Her spouse's employment takes him out of town Monday thru Saturday. The specialist may approve hours for shopping, laundry or house cleaning.

Expanded Home Help Services (EHHS)

Expanded home help services exists if all basic home help services eligibility criteria are met and the assessment indicates the client's needs are so extensive that the cost of care cannot be met within the monthly maximum payment level of $799.99.

MDHHS Long Term Care Policy Section

When the client's cost of care exceeds $1599.99 for **any** reason, the adult services specialist must submit a written request for approval to the MDHHS Long Term Care Policy Section.

Follow the **Procedures for Submitting Expanded Home Help Requests** found on the Adult Services Home Page. Submit the request with all required documentation to:

Michigan Department of Health and Human Services
Long Term Care Policy Section
Capital Commons Building, 6th Floor
P.O. Box 30479
Lansing, MI 48909

The Long Term Care Policy Section will provide written documentation (DCH-1785) of approval. A new request **must** be submitted to the MDHHS Long Term Care Policy Section whenever there is an increase in the cost of care amount. A new request is **not** require if the cost of care decreases below the approved amount..

Note: If an expanded home help case closes and reopens within 90 days and the care cost remains the same, a new approval is **not** required.

Service Plan

See ASM 130, Service Plan.

ACTIVITIES OF DAILY LIVING

The following charts provide guidance when completing a comprehensive assessment.

Eating - helping with the use of utensils, cup/glass, getting food/drink to mouth, cutting up/manipulating food on plate, swallowing foods and liquids, cleaning face and hands after a meal.

1	No assistance required.
2	Verbal assistance or prompting required. Client must be prompted or reminded to eat.
3	Minimal hands-on assistance or assistive technology needed. Help with cutting up food or pushing food within reach; help with applying assistive devices. The constant presence of another person is not required.
4	Moderate hands-on assistance required. Client has some ability to feed self but is unable to hold utensils, cup, glass and requires the constant presence of another person while eating.
5	Totally dependent on others in all areas of eating.

Toileting - helping on/off the toilet, commode or bedpan; emptying commode, bed pan or urinal, managing clothing, wiping and cleaning body after toileting, cleaning ostomy and/or catheter tubes/receptacles, applying diapers and disposable pads. May also include catheter, ostomy or bowel programs.

1	No assistance required.
2	Verbal direction, prompting or reminding is required.
3	Minimal hands-on assistance or assistive technology needed with some activities. The constant presence of another person while toileting is not necessary.
4	The client does not carry out most activities without human assistance.
5	Totally dependent on others in all areas of toileting.

Bathing - helping with cleaning the body or parts of the body using a tub, shower or sponge bath; including getting a basin of water, managing faucets, soaping, rinsing and drying. helping shampoo hair.

1 No assistance required.

2 Bathes self with direction or intermittent monitoring. May need reminding to maintain personal hygiene.

3 Minimal hands-on assistance or assistive technology required to carry out task. Generally bathes self but needs some assistance with cleaning hard to reach areas; getting in/out of tub/shower. Client is able to sponge bath but another person must bring water, soap, towel. Client relies on a bath or transfer bench when bathing. The constant presence of another is not required.

4 Requires direct hand- on assistance with most aspects of bathing. Would be at risk if left alone.

5 Totally dependent on others in all areas of bathing.

Grooming - Maintaining personal hygiene and a neat appearance; including the combing/brushing of hair; brushing/cleaning teeth, shaving, fingernail and toenail care.

1 No assistance required.

2 Grooms self with direction or intermittent monitoring. May need reminding to maintain personal hygiene

3 Minimal hands-on assistance required. Grooms self but needs some assistance with activities of personal hygiene.

4 Requires direct hands-on assistance with most aspects of grooming. Would be at risk if left alone.

5 Totally dependent on others in all areas of grooming.

Dressing - Putting on and taking off garments; fastening and unfastening garments/undergarments, assisting with special devices such as back or leg braces, elastic stockings/garments and artificial limbs or splints.

1 No assistance required.

2 Client is able to dress self but requires reminding or direction in clothing selection.

3 Minimal hands-on assistance or assistive technology required. Client unable to dress self completely (i.e. tying shoes, zipping, buttoning) without the help of another person or assistive device.

4 Requires direct hands on assistance with most aspects of dressing. Without assistance would be inappropriately or inadequately dressed.

5 Totally dependent on others in all areas of dressing.

Transferring - Moving from one sitting or lying position to another. Assistance from the bed or wheelchair to the sofa, coming to a standing position and/or repositioning to prevent skin breakdown.

1 No assistance required.

2 Client is able to transfer but requires encouragement or direction.

3 Minimal hands-on assistance needed from another person for routine boosts or positioning. Client unable to routinely transfer without the help of another or assistive technology such as a lift chair.

4 Requires direct hands-on assistance with most aspects of transferring. Would be at risk if unassisted.

5 Totally dependent on others for all transfers. Must be lifted or mechanically transferred.

Mobility - Walking or moving around inside the living area, changing locations in a room, assistance with stairs or maneuvering around pets, or obstacles including uneven floors.

1 No assistance required even though the client may experience some difficulty or discomfort. Completion of the task poses no risk to safety.

2 Client is able to move independently with only reminding or encouragement. For example, needs reminding to lock a brace, unlock a wheelchair or to use a cane.

3 Minimal hands-on assistance required for specific maneuvers with a wheelchair, negotiating stairs or moving on certain surfaces. Without the use of a walker or pronged cane, client would need physical assistance.

4 Requires hands-on assistance from another person with most aspects of mobility. Would be at risk if unassisted.

5 Totally dependent on other for all mobility. Must be carried, lifted or pushed in a wheelchair or gurney at all times.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Taking Medication - Taking prescribed and/or over the counter medications

1 No assistance required.

2 Client is able to take all medications but needs reminding or direction.

3 Client is able to take all medication if someone assists in measuring dosages or prepares administration schedule.

4 Client is able to take some medication if another person assists in preparation, but needs someone to assist in administering other medications.

5 Totally dependent on another. Does not take medication unless someone assists in administering.

Meal Preparation - Planning menus. Washing, peeling, slicing, opening packages/cans, mixing ingredients, lifting pots/pans, reheating food, cooking, safely operating stove, setting the table, serving the meal. Washing/drying dishes and putting them away.

1 No assistance required.

2 Verbal direction, prompting or reminding is required for menu planning, meal preparation or clean up.

3 Minimal hands-on assistance required for some meals. Client is able to reheat food prepared by another and/or prepare simple meals/snacks.

4 Requires another person to prepare most meals and do clean-up.

5 Totally dependent on another for meal preparation.

Shopping - Compiling a list, managing cart or basket, identifying items needed, transferring items to home and putting them away, phoning in and picking up prescriptions. Limited to brief, occasional trips in the local area to shop for food, medical necessities and household items required specifically for the health and maintenance of client.

1 No assistance required.

2 Verbal direction, prompting or reminding is required for shopping.

3 Minimal hands-on assistance required for some task (grocery shopping) but client can compile a list and go to nearby store for small items.

4 Requires hands-on assistance from another person with most aspects of shopping but client is able to accompany and select needed items.

5 Totally dependent on another for shopping.

Laundry - Gaining access to machines, sorting, manipulating soap containers, reaching into the machine for wet/dry clothing, operating the machine controls, hanging laundry to dry, folding and putting away.

1 No assistance required.

2 Performs all tasks but needs reminding or direction to do laundry on a regular basis or to do it properly.

3 Minimal hand-on assistance required with some task but is able to do most laundry without assistance

4 Requires hands-on assistance from another person with most aspects of laundry. Is able to perform some laundry tasks such as folding small clothing items or putting clothes away.

5 Totally dependent on another for laundry.

Light Housecleaning - Sweeping, vacuuming and washing floors; washing kitchen counters and sinks; cleaning the bathroom; changing bed linens; taking out garbage; dusting; cleaning stove top; cleaning refrigerator.

1 No assistance required

2 Performs all tasks but needs reminding or direction from another.

3 Requires minimal assistance from another for some tasks due to limited endurance or limitations in bending, stooping or reaching.

4 Requires assistance for most tasks although client is able to perform a few simple tasks alone such as dusting and wiping counters.

5 Totally dependent on another for housecleaning.

GENERAL INFORMATION

Home help services may be provided for the specific purpose of enabling the client to be employed.

- The current assessment process for personal care needs remains unchanged. A separate assessment for the workplace is **not** required.
- The hours approved may be used either in the home or the workplace. Additional hours are not available as a result of employment. Home help services can not be approved for supervision.

The client determines where services are to be provided, whether in the home or the workplace.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS)

PARTNERSHIPS

The adult services specialist has a critical role in developing and maintaining partnerships with community resources.

To facilitate these partnerships the adult services specialist will:

- Advocate for programs to address the needs of clients.
- Emphasize client choice and quality outcomes.
- Encourage access and availability of supportive services.

Work cooperatively with other agencies to ensure effective coordination of services.

Coordinate available resources with home help services in developing a services plan that addresses the full range of client needs.

The Medicaid State Plan program for personal care services is home help. MA recipients seeking personal care services must first apply for home help.

COMMUNITY MENTAL HEALTH (CMH)

Many clients are eligible for home help services while also receiving mental health services through the local community mental health services programs (CMHSPs) or prepaid inpatient health plans (PIHPs).

Clients, who live in unlicensed settings where home help services may be provided, include:

- Own home/apartment, either living alone or with roommates or relatives. Client's name is on the lease or mortgage.
- Home of a family member.
- Supported independent setting (formerly called SIP homes). The lease is held by an individual that is **not** also the provider of other services such as home help.

Note: The instrumental activities of daily living in shared living arrangements must be divided by **one half**.

Community Living Supports (CLS)

Clients eligible for home help services authorized by the adult services specialist may also receive community living supports (CLS) authorized through the local community mental health services programs (CMHSPs) or prepaid inpatient health plans (PIHPs). Community living supports services cannot **duplicate** or **replace** home help services.

The client's plan should clearly identify where home help and community living supports are **complementary**. The adult services specialist determines the need for services based on the DHS-324, Adult Services Comprehensive Assessment. If the client is receiving the maximum authorized through home help and still needs additional hands on assistance with some ADLs and/or IADLs in order to remain at home, community living supports services may be used to provide that additional direct physical assistance which exceeds the cost of care determined by the MDHHS comprehensive assessment.

Unlike home help, which only provides direct hands on assistance with ADLs and IADLs, community living supports services typically are used for skill development or supervision. In such situations, the use of both home help and community living supports is permitted as the services are **different** and **not a duplication**.

The community living supports services may not supplant or replace home help services. The client must exhaust all available services under home help before seeking community living supports.

HOME HEALTH CARE

Home health services, ordered by a physician, are provided by a Medicare certified home health agency. To enroll with Medicaid, home health agencies must be Medicare certified. This is accomplished through an accrediting agency such as Accreditation Commission for Health Care (ACHC) or Community Health Accreditation Partner (CHAP).

Funded By Medicaid

Medicaid will pay for the following services for eligible clients:

- Nursing services provided by or under the supervision of a registered nurse on an intermittent basis including, but not limited to:
  - Administration of prescribed medications which cannot be self-administered.
  - Changing of in-dwelling catheters.
  - Applications of dressings involving prescribed medications and aseptic techniques.
  - Teaching the beneficiary, available family member, willing friend or neighbor and/or caregiver to carry out nursing services.
  - Observation and evaluation of a beneficiary whose condition is unstable or to ensure stability of a beneficiary who has an established disability or frail condition.
- Physical therapy.
- Occupational therapy.
- Medical supplies, durable medical equipment and appliances when provided in conjunction with nursing, physical therapy or occupational therapy services.
- Aide services when provided in conjunction with nursing and /or therapy services.

If aide services are ordered without an accompanying need for nursing services, personal care by a home help provider may be more appropriate. Home health policy does not allow aide services without the need for nursing or physical therapy services.

Questions regarding home health services or possible duplication of services should be directed to:

Michigan Department of Health and Human Services
Long Term Care Services Policy Section
Medicaid Policy Division
Capitol Commons Building
400 S. Pine Street
Lansing, MI 48909
Providersupport@michigan.gov

Funded by Medicare

Medicare may cover home health services for persons who are:

- Over age 65.
- Some disabled people under age 65.
- People of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant).

Medicare can pay for the following part-time and/or intermittent services if medically necessary and ordered by a physician:

- Skilled nursing services.
- Physical therapy.
- Speech therapy.
- Medical social work.
- Home health aide.
- Occupational therapy.

If the client needs any of the above services Medicare may also cover medical supplies and/or durable medical equipment if necessary and ordered by physician.

Home help personal care services may be authorized in addition to home health care as long as they do not duplicate services provided by the home health agency.

Example: Mr. Brown receives assistance with bathing from the home health aide on Monday, Wednesday and Friday. The adult services specialist may approve assistance for bathing for the remaining days, if needed.

AREA AGENCIES ON AGING (AAA)

Refer clients 60 years and older who are **not** Medicaid eligible to an Area Agency on Aging (AAA) for personal care/chore services.

For a list of Michigan's sixteen area agencies on aging and the services they provide go to http://www.michigan.gov/miseniors.

MI CHOICE WAIVER

The MI Choice waiver program provides home and community-based services for individuals:

- Aged (65 and over) and disabled persons 18 and over who meet the MA nursing facility level of care.
- Who require at least two MI Choice services on a continual basis, one of which must be supports coordination.
- Meet Medicaid financial eligibility criteria; see BEM 106.

The Michigan Department of Health and Human Services, Home and Community Based Services Section, administers the waiver through contracts with Pre-paid Ambulatory Health Plan (PAHP), commonly referred to as waiver agencies. For a list of the waiver agencies see **Exhibit I in BEM 106.**

Services covered under the waiver include:

- Adult day health.
- Chore services.
- Community living supports.
- Community transition services.
- Counseling.
- Environmental accessibility adaptations.
- Fiscal intermediary.
- Goods and services.
- Non-medical transportation.
- Nursing services.
- Personal emergency response systems.
- Private duty nursing.
- Respite.
- Specialized medical equipment and supplies.
- Supports coordination.
- Training.

MI Choice participants **cannot** receive services from both the **home help program** and the **waiver** as this is a duplication of Medicaid services. The level of care (LOC) code for the MI-Choice waiver is **22.**

HOSPICE

Hospice provides palliative and supportive services to meet physical, psychological, social and spiritual needs of terminally ill patients and their families. The care focuses on pain control,

comfort and emotional support for the dying person and his family. Most of the care is provided in the person's home.

Conditions of eligibility for hospice care paid by Medicaid:

- A doctor **must** certify the person has six months or less to live.
- The person must know about the illness and about how long he or she is expected to live.
- The person must choose to receive hospice services.

Home help personal care services may be authorized to a client living at home in addition to hospice care as long as they do not duplicate services provided by hospice.

Example: Mr. Brown receives assistance with bathing from hospice on Monday, Wednesday and Friday. The adult services specialist may approve assistance for bathing for the remaining days, if needed.

The hospice **must** contact the local office if personal care services are needed. A written plan of care must be requested from hospice services. Review the hospice plan of care to assure services are not duplicated. Determine what services to authorize and provide documentation in the client's service plan.

The level of care (LOC) code for the hospice program is **16**.

HOME HELP FOR FAMILY INDEPENDENCE (FIP) GROUP MEMBERS

If it appears that a member of the FIP group needs home help services, the family independence specialist (FIS) will make a services referral to the adult services unit. Follow referral and case opening procedures. Home help services for FIP group members are provided for the group member who meets home help eligibility requirements.

TRAMATIC BRAIN INJURY (TBI)

Clients with traumatic brain injury in adult community placement (ACP) may qualify for MI Choice services within the residential setting. See ASM 085, Coordination with Other Agencies.

ADOPTION SUBSIDY

Clients with an open adoption subsidy case are eligible to receive home help services if they meet eligibility criteria. A comprehensive assessment must be completed to determine need for services. The use of both home help and adoption subsidy is permitted as the programs are different and not considered a duplication of services.

NURSING FACILITY TRANSITION (NFT)

The Nursing Facility Transition (NFT) program provides Medicaid eligible seniors and adults with disabilities the opportunity to transition from a nursing facility into their own home or community setting of choice. NFT is administered through the Michigan Department of Health and Human Services (MDHHS) who contracts with waiver agents and Centers for Independent Living. Home help services is one option in maintaining independence in the community.

Role of the Transition Agent

The nursing facility transition agent is responsible for transitioning the client to the community. The goal of the transition agent is to have services in place upon discharge. The agent will:

- Contact the adult services unit prior to the resident's discharge from the nursing facility to establish how soon a referral should be made prior to transitioning.
- Coordinate referral time frame and completion of DHS-390, Adult Services Application, and DHS-54A, Medical Needs form, with adult services specialist.
- Invite the adult services specialist to case planning meetings.

- Coordinate home visit assessment date and alternative plans until home help is implemented.
- The transition agent will follow-up with the client for six months after the transition into the community.

Note: The nursing facility transition program **does not** cover personal care services.

Role of the Adult Services Specialist

After contact is made to the adult services unit the specialist will:

- Collaborate with the transition agent on implementing home help services.
- Determine how the DHS-390, Adult Services Application and the DHS-54A, Medical Needs form should be handled.
- Visit the client in the nursing facility prior to transition, if possible (best practice).
- Coordinate home visit for comprehensive assessment on the day of transition or soon after transition (best practice). A face-to-face visit is required in the client's home even if an assessment was completed while the client was in the nursing home.
- Participate in any case management meetings involving the client, if possible (best practice).

Payments for home help services must not begin until the client has transitioned to an independent setting.

Note: All individual home help providers must be enrolled in Champs and screened for a criminal history. Payment to the provider cannot be approved prior to the criminal history screen.

Referrals received from the Nursing Facility Transition Program should be treated as a **priority**, such as, hospice, hospital, or APS referrals. **Do not** deny a referral if the client is residing in a nursing facility at the time of the request for services.

Special Adult Protective Services Home Help Component

Special adult protective services (APS) home help services (HHS) payments may be utilized to support vulnerable adults at risk of harm from abuse, neglect and/or exploitation. These funds are limited and utilized to reduce the individual's risk of harm and increase their safety, **on a temporary basis**, until a permanent resolution is established.

These services may be utilized to support an adult protective services plan for individuals who are also receiving home help services payments. When an adult in need of protective intervention is also receiving home help services payments, the adult protective services payments may not be utilized for services covered through home help.

Process payments for adult protective services/home help locally after the following requirements are met:

- The case is open for adult protective services on ASCAP.
- The provider is enrolled in Bridges with a service type of home help. Individual and agency providers must also register as a vendor with the state of Michigan. Providers must register and update their information online using Contract and Payment Express (C&PE) at www.michigan.gov/CPExpress.
- Documentation supports the need for home help services as a part of the adult protective services plan.
- Payments are entered through the **Payments Module** on **ASCAP**.

There are no financial eligibility requirements to receive these service payments as they are not covered through Medicaid, Title XIX monies. Adult protective services payments must be utilized only when there is no other funding source available or other funding sources have been exhausted.

Note: Home help payments for adults in need of protection cannot exceed $1000 in a twelve month fiscal year. No exceptions can be made to this policy.

PACE (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY)

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables individuals 55 years of age or older, who are certified by their state as needing nursing facility care, to live as independently as possible.

PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize the dignity of, and respect for older adults.
- Enable frail, older adults to live in the community as long as medically and socially feasible, and;
- Preserve and support the older adult's family unit.

The financing model combines payments from Medicare and/or Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

The PACE organization becomes the sole source of service from Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization. **Home help services must not be approved for individuals receiving PACE.**

The level of care for PACE participants is **07.** In addition to PACE, recipients receiving home help will also have a level of care **07**. To identify whether a client is receiving services through PACE, one of the following PACE organizations will be listed as the medical provider:

Center for Senior Independence - Detroit Northwest
7800 W. Outer Drive
Detroit, Michigan 48235

Center for Senior Independence - Rivertown
250 McDougall

Detroit, Michigan 48207

Care Resources
1471 Grace Street, S.E.
Grand Rapids, Michigan 49506

CentraCare
200 West Michigan Avenue #103
Battle Creek, Michigan 49017

CentraCare
445 West Michigan Avenue
Kalamazoo, Michigan 49001

LifeCircles, PACE
560 Seminole Road
Muskegon, Michigan 49444

PACE of Southwest Michigan
2900 Lakeview Avenue
St. Joseph, Michigan 49085

VOANS Senior Community Care
1921 East Miller Road
Lansing, Michigan 48911

Great Lakes PACE
3378 Fashion Square Boulevard
Saginaw, Michigan 48603

Huron Valley PACE
2940 Ellsworth Road
Ypsilanti, Michigan 48197

Genesys PACE of Genesee County
412 E. First Street
Flint, Michigan 48502

See BEM 167 for additional information regarding PACE.

MI HEALTH LINK PROGRAM

See ASM 126, MI Health Link Program, for information regarding the integrated care demonstration project.

LEVEL OF CARE (LOC)

In order to effectively coordinate home help services and avoid duplication of services, the client's level of care (LOC) must be reviewed to determine enrollment in other programs. Under Medicaid, the level of care is used to indicate the type of services the client is receiving.

The adult services specialist must verify the client's level of care status on ASCAP under the Bridges Eligibility screen.

Description of Level of Care Codes

The following are level of care code descriptions:

Level of Care-02 Long Term Care Facility

Clients with a level of care 02 are receiving services in:

- Nursing facility.
- County medical facility.
- Hospital long-term care facility.
- Hospital swing bed.

Client with this level of care status **cannot** receive home help services while admitted in these facilities.

Level of Care-07 Medicaid Health Plan

Clients with a level of care 07 are enrolled in a Medicaid Health Plan. Home help services can be approved for clients with this status code.

Exception: The level of care for PACE recipients is also **07.** See above list of medical providers which will identify if a client is receiving PACE. Home help services **must not** be approved for individuals receiving PACE.

Exception: The level of care for MI Health Link (MHL) recipients is also **07.** Adult services staff will be able to identify MHL recipients if one of the Integrated Care Organizations (ICO) is listed as the Medicaid provider under the level of care module in ASCAP.

Level of care 16- Hospice

Clients with a level of care 16 are receiving hospice services. Home help services may be available to a hospice client living at home, not residing in a hospice residence, nursing facility or adult foster care home.

Hospice services must be utilized prior to home help services. Home help may be approved in addition to hospice care and must not duplicate or replace hospice services. The adult services specialist must contact the hospice coordinator to verify the service and frequency provided by hospice.

Level of Care 22 MI Waiver

Client with a level of care 22 are receiving services from the MI Choice waiver. Participants of the MI Waiver **cannot** receive services from both the waiver and home help services.

Level of Care 32-Institutional Status

Clients with a level of care 32 are involuntarily residing in a detention facility. Medicaid does not reimburse for services provided to individuals being held in a detention facility against their will except for those directly related to an inpatient hospital stay provided in a non-state-owned facility. Clients with this level of care **cannot** receive home help services.

Level of Care 17 - State Psychiatric Facility

Clients with a level of care 17 are residing in a state psychiatric facility. Clients with this level of care **cannot** receive home help services.

For a complete list of level of care codes, refer to the level of care job aid on the adult services home page.

INTRODUCTION

Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare and Medicaid Services (CMS), implemented a new capitated managed care program called MI Health Link. This program integrates, into a single coordinated delivery system, all physical health care, pharmacy, long term supports and services and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid.

The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care and align financial incentives. The program is a demonstration project ending December 31, 2020.

ELIGIBILITY

Individuals who are eligible to participate are those who are age 21 or older, eligible for full benefits under Medicare and Medicaid, and reside in one of the four demonstration regions:

- **Region 1** - All counties in the Upper Peninsula.
- **Region 4** - Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren Counties.
- **Region 7** - Wayne County
- **Region 9** - Macomb County

The following categories are not eligible to participate with the MI Health Link program:

- Individuals under 21 years of age.
- Individuals previously dis-enrolled due to special enrollment from Medicaid managed care as defined in 42 CFR 438.56.
- Individuals not living in one of the four demonstration regions.
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage.
- Individuals without full Medicaid coverage (deductible).

- Individuals with Medicaid who reside in a State psychiatric hospital.
- Individuals with commercial HMO coverage.
- Individuals with elected hospice services.

  Note: The MI Health Link program does not cover hospice services. If MI Health Link enrollees require hospice services, they must dis-enroll from the MI Health Link program and receive the hospice services through original Medicare and Medicaid.

- Individuals found to be not lawfully present (illegal aliens).
- Individuals who are incarcerated.

Individuals enrolled in PACE, MI Choice, MI Care Team and Independence at Home are eligible but must leave their programs before joining MI Health Link.

INTEGRATED CARE ORGANIZATIONS (ICO)

MDHHS and CMS contracts with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services.

The Michigan Pre-paid Inpatient Health Plans (PIHP) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders.

The following is a list of the ICOs providing MI Health Link services in the four regions of the demonstration project:

Region 1 - All counties in the Upper Peninsula (one choice)

Upper Peninsula Health Plan
228 W. Washington Street
Marquette, MI 49855
1-877-349-9324

Region 4 - Southwest Counties (two choices)

Aetna Better Health of Michigan, Inc.
1333 Gratiot
Suite 400
Detroit, MI 48207
1-855-676-5772

Meridian Health Plan
777 Woodward Avenue
Suite 600
Detroit, MI 48226
1-888-437-0606

Region 7 and 9 - Wayne and Macomb Counties (five choices)

Aetna Better Health of Michigan, Inc.
1333 Gratiot
Suite 400
Detroit, MI 48207
1-855-676-5772

AmeriHealth Michigan, Inc.
200 Stevens Drive
Philadelphia, PA 19113-9802
1-888-667-0318

Fidelis SeniorCare, Inc. of Michigan
20 North Martingale Road
Suite 180
Schaumburg, IL 60173
1-313-748-4200

HAP Midwest Health Plan
4700 Schaefer Road
Suite 340
Dearborn, MI 48126
888-645-0706
Molina Healthcare, Inc.

880 W. Long Lake Road
Suite 600
Troy, MI 48098
855-322-4077

COVERED SERVICES

The MI Health Link offers an array of services to dual eligibles enrolled in the program. All health care services covered by Medicare and Medicaid including:

- Dental and vision services.
- Diagnostic testing and lab services.
- Emergency and urgent care.
- Equipment and medical supplies.
- Home health services.
- Hospitalizations and surgeries.
- Medications (without co-payments).
- Nursing home services.
- Physicians and specialists.
- Transportation for medical emergencies and medical appointments.

Services for long term supports and services including:

- Adult day program.
- Chore services.
- Community transition services.
- Equipment to help with activities of daily living.
- Fiscal intermediary services.
- Home delivered meals.
- Home modifications.
- Nursing home care.
- Personal care.
- Personal emergency response system.
- Preventive nursing services.
- Private duty nursing.
- Respite.

Care Coordination Process

An important part of the MI Health Link program is person-centered coordination. The care coordination process will include assessment of the enrollee's health history and current status, development on an Individual Integrated Care and Supports Plan (IICSP) through person-centered planning, creation and maintenance of an Individual Care Bridge Record to promote the storage and sharing of information across providers, collaboration between the enrollee and members of his or her Integrated Care Team, and ongoing monitoring and advocacy.

ENROLLMENT PROCESS

Enrollment in the MI Health Link program occurs in two ways:

1. Voluntary enrollment
2. Passive enrollment.

Voluntary Enrollment

For voluntary enrollment, the eligible individual must call the enrollment broker contracted by the State for Medicaid managed care programs. The individual selects the ICO in which they wish to enroll, using the ICO provider networks and drug formularies to assist in making choices.

Passive Enrollment

Eligible individuals who do not voluntarily enroll in the program receive a notification letter at least 60 days prior to the enrollment effective date informing them they will be passively enrolled. Eligible individuals will have a period of 60 days to cancel their passive enrollment in the program if they choose to do so prior to the enrollment effective date.

Individuals may cancel passive enrollment by calling the entities as indicated in the notification letter. Individuals who do not cancel their enrollment in the program prior to the effective date will be passively enrolled and an ICO will be assigned to them. Prior to the enrollment date, and at any time thereafter, individuals will have the opportunity to select a different ICO than the one assigned, if there is another ICO option in the region.

After enrollment, individuals are issued an ID card that is specific to the MI Health Link program. This ID card is used instead of the traditional Medicare and Medicaid ID cards, and identifies the name of the ICO responsible for coverage along with the MI Health Link logo.

If a client has questions about his or her health care options, refer them to the Michigan Medicare/Medicaid Assistance Program (MMAP) office at 1-800-803-7174.

Note: Clients must call Michigan ENROLLS to enroll, dis-enroll or cancel the passive enrollment of MI Health Link at 1-800-975-7630.

Individuals eligible for MI Health Link may enroll, dis-enroll or cancel the passive enrollment at any time. Disenrollment is effective on the first day of the following month.

HOME HELP

Dual eligible clients enrolled in MI Health Link must receive personal care services through the Integrated Care Organizations (ICOs). Individuals who are enrolled under this program are **not** allowed to receive services from home help or adult community placement and MI Health Link concurrently. This is similar to the MI Choice waiver program or PACE where the client must select **one** program. If the client chooses MI Health Link, the specialist must close the case.

> **Note:** The specialist must send a DHS-1212, Advance Negative Action Notice to the client. A ten day notice is not required as it is the client's choice to end services (see ASM 150).

Individuals in MI Health Link may choose to enroll or dis-enroll on a monthly basis as permitted by Medicare rules. Therefore, it is important to note that an individual who is enrolled and receiving personal care services from an Integrated Care Organization (ICO) in one month may choose to dis-enroll from MI Health Link and reapply for Home Help or adult community placement the following month.

If a home help referral is received from a former client who has dis-enrolled from the MI Health Link plan, these referrals should be treated as a priority in order to limit the disruption of continuity of care.

Home Help Providers

The Integrated Care Organizations (ICOs) are required to make every effort to bring existing home help providers into their network via contracts or other agreements if the enrollee chooses to maintain their current provider. Individuals must meet the requirements for home help providers set by the ICO policy including passing a criminal history screen.

Individuals providing home help services to a client enrolled in the MHL plan must contact the ICO to discuss enrollment as a network provider in order to receive payment for personal care services provided.

Providers with questions regarding the transition from home help to the MI Health Link plan should be referred to the MDHHS Provider Support hotline at 1-800-979-4662.

LEVEL OF CARE (LOC)

In order to effectively coordinate home help services and avoid duplication of services, the client's level of care (LOC) must be reviewed to determine enrollment in other programs. The level of care for the MI Health Link plan is **07**, which is the same LOC for the home help program and adult community placement.

Adult services staff will be able to identify when a client is receiving services from MI Health Link if one of the Integrated Care Organizations is listed as the Medicaid provider under the level of care module in ASCAP. All ICO provider ID numbers begin with **28.**

Level of care (LOC) codes specific to the MI Health Link program are as follows:

Level of Care 03 - Home and Community Based Waiver

Individual meets nursing facility level of care based on the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD), lives in the community, and participates in the MI Health Link HCBS waiver program.

Level of Care 05 - Long Term Care Facility

Resident of any nursing facility or hospital long term care unit (private or county owned) that is not a County Medical Care Facility.

Level of Care 15

This LOC indicates an individual is residing in a County Medical Care Facility.

INTRODUCTION

A service plan must be developed for all independent living services cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment.

The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

Philosophy

Service planning is person-centered and strength-based.

Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service.

Participants in the plan should involve not only the client, but also family, significant others, and the provider, if appropriate.

Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:

- Strengthening families and individuals.
- The role of family in case planning.
- Coordinating with all relevant community-based services.
- Promoting client independence and self-sufficiency.

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment.

Service Plan Development

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.

- The extent to which the client does not perform activities essential to caring for self. The intent of the home help program is to assist individuals to function as independently as possible. It is important to work with the client and the provider, if appropriate, in developing a plan to achieve this goal.

- The kinds and amounts of activities required for the client's maintenance and functioning in their living environment.

- The availability or ability of a **responsible relative** of the client to perform the tasks the client does not perform. A responsible relative is defined as an individual's spouse or a parent of an unmarried child under age 18. Authorize home help **only** for those services or times which the responsible relative is **unavailable** or **unable** to provide; see ASM 120, Adult Services Comprehensive Assessment.

  Example: Client's spouse is unavailable to provide care due to employment. Their work schedule is Monday-Friday, 7:00 a.m. to 6:00 p.m. The client's spouse would be responsible for house cleaning, shopping and laundry (possibly dinner) during those times they are available.

- Home help services may be approved when the client is receiving other home care services **if** the services are not duplicative (same service for the same time period); see ASM 125, Coordination With Other Services.

Good Practices

Service plan development practices will include the use of the following skills:

- **Listen actively** to the client.

- Encourage clients to **explore options** and select the appropriate services and supports.

- Monitor for **congruency** between case assessment and service plan.

- Provide the necessary supports to **assist** clients **in applying for resources**.

- Continually **reassess** case planning.

- Enhance/preserve the client's **quality of life**.

Monitor and document the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS)

INTRODUCTION

The items in this section may apply to both individual and agency providers. For additional policy and procedures regarding home help agency providers see ASM 136, Agency Providers.

PROVIDER SELECTION

The client has the right to choose his or her home help provider(s).The client is the employer and may terminate the provider's employment at any time. Home help services are a benefit to the client and earnings for the provider.

Home help services **cannot** be paid to:

- A responsible relative (spouse caring for a spouse or a parent caring for a minor child).

  Note: Individuals who are separated from their spouse must provide verification that he or she is no longer residing in the same home (responsible relatives must be unable or unavailable in order for the client to be eligible to receive home help). Verification may include their driver's license, rent receipt or utility bill reflecting their separate mailing address. A spouse who is separated from a spouse **cannot** be the individual paid to provide home help.

- A minor (17 and under).

- Fiscal Intermediary (FI).

  Note: Fiscal intermediary services is defined by Community Mental Health (CMH) as services that assist the client in meeting their goals of community participation and integration, independence or productivity, while controlling the client's individual budget and choosing staff who will provide the services and supports identified in the individual plan of service. The fiscal intermediary facilitates the employment of service providers and is **not** the provider of direct hands on care services.

Home help providers who also provide day-care services must **not** provide both services concurrently; see BEM 704, CDC Providers.

Example: Home help services cannot be provided from 8:00 a.m. until 10:00 a.m., if the provider is also providing day-care services during that time frame.

An individual providing home help services cannot simultaneously be a recipient of home help services.

PROVIDER CRITERIA

The determination of provider criteria is the responsibility of the adult services specialist. Determine the provider's ability to meet the following **minimum** criteria during a face-to-face interview with the client **and** the provider:

Age

The provider must be 18 years and older.

Ability

- To follow instructions and home help program procedures.
- To perform the services required.
- To handle emergencies.

Physical Health

The provider's health must be adequate to perform the needed services.

Knowledge

The provider must know when to seek assistance from appropriate sources in the event of an emergency.

Personal Qualities

The provider must be dependable and able to meet job demands.

Criminal History Screen

All individual home help providers must undergo a criminal history screen prior to providing home help services.

Note: Criminal history screens for home help providers are conducted by the MDHHS Provider Enrollment unit and **not** by staff at the local office. Adult services staff ***must only*** utilize LEIN

information in the course of an APS investigation. Use of LEIN in any other adult services program is **prohibited**.

Training

The provider must be willing to participate in available training programs if necessary.

Note: Home help payment may be terminated if the provider fails to meet any of the provider criteria.

PROVIDER INTERVIEW

An initial face-to-face interview must be completed with the home help provider. A face-to-face or phone contact must be made with the provider at the six month review or redetermination to verify services are being furnished. The specialist must document the contact in ASCAP by selecting 'Face-to-Face with Provider' under the contact module.

The provider must present a picture identification (ID) card that includes his/her name and a social security card during the interview.

Note: Picture ID may include driver's license/state ID, passport or employee ID. Expired IDs are acceptable as long as identity can be verified by the adult services specialist.

Explain the following points to the client and the provider during the initial interview:

- Home help services are a benefit to the client and earnings to the provider.
- The provider is employed by the client **not** the State of Michigan.
- As the employer, the client has the right to hire and fire the provider.
- The provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) and undergo a criminal history screen. The screening must be completed and passed before a provider can be paid to provide home help services.

- The provider must keep their contact information up-to-date in CHAMPS; see Provider Change of Address in this item.

- The home help program is funded by Medicaid and payments will not be authorized by the department if the client's Medicaid eligibility is inactive.

- A provider who receives public assistance **must** report all income received as a home help provider to their family independence specialist or eligibility specialist.

- The provider cannot be paid if the client is unavailable; including but not limited to hospitalizations, nursing home or adult foster care (AFC) admissions.

  Note: Home help services cannot be paid the day a client is admitted into the hospital, nursing home or AFC home but can be paid the day of discharge.

- The client and/or provider is responsible for notifying the adult services specialist within **10 business days** of any change; including but not limited to hospitalizations, nursing home or adult foster care admissions.

- The client and/or provider is responsible for notifying the adult services specialist within **10 business days** of a change in provider or discontinuation of services. Payments must **only** be authorized to the individual/agency providing approved services.

  - Home help warrants can **only** be endorsed by the individual(s) listed on the warrant.

  - Home help warrants are issued only for the individual/agency named on the warrant as the authorized provider.

  - If the individual named on the warrant does not provide services or provides services for only a portion of the authorized period, the warrant must be returned.

  Note: Failure to comply with any of the above ***may*** be considered fraudulent or require recoupment.

- Any payment received for home help services **not** provided must be returned to the State of Michigan.

- Accepting payment for services not rendered is fraudulent and could result in criminal charges.

- The provider must submit an electronic services verification (ESV) monthly to confirm home help services were provided.

Exception: Individuals who are unable to submit a service verification electronically must submit a paper service verification (PSV) form monthly.

- Home help warrants are issued as dual party and mailed to the client's address.

Exception: There are circumstances where payment to the provider only is appropriate, for example, client is physically or mentally unable to endorse the warrant. Authorizations to home help agency providers are payable to the provider only.

- **All** earned income must be reported to the IRS; see www.irs.gov.

- No federal, state or city income taxes are withheld from the warrant.

- Social security and Medicare tax (FICA) **are** withheld from individual provider home help warrants.

- Parents who are caring for an adult child do **not** have FICA withheld.

  Note: Parents who wish to have FICA withheld must be assigned in ASCAP as other relative in the Provider Assignment screen.

- **All** individual providers will receive a W-2.

- Agency providers will receive a 1099.

- The client **and** provider **must** sign the MSA-4676, Home Help Services Statement of Employment, before payments are authorized.

  Note: Providers determined to be a business/agency are exempt from signing the MSA-4676.

PROVIDER ENROLLMENT

All providers of home help must enroll in the Community Health Automated Medicaid Processing System (CHAMPS) and be approved prior to authorizing payment. During the enrollment process, individuals will be screened for criminal history. Once a provider is approved, CHAMPS will assign the provider a seven digit identification number. The adult services specialist must allow 24 hours from the completion of enrollment in CHAMPS to interface with ASCAP.

Terms and Conditions

Home help providers are required to agree to a list of terms and conditions during the electronic enrollment process. The terms and conditions **replace** the requirement for the provider to complete and sign the MSA-4678, Medical Assistance Home Help Provider Agreement.

Exception: Providers who are unable to enroll in CHAMPS electronically must complete and sign the MSA-4678.

Manual Enrollment

Individuals who are unable to enroll into CHAMPS electronically must be assisted by the adult services specialist. The specialist will assist in the enrollment process by doing the following:

- Completes the DHS-2351X, Provider Enrollment/Change Request.
- Has the provider complete and sign the MSA-4678, Medical Assistance Home Help Provider Agreement.
- Forwards the DHS-2351X and MSA-4678 to the MDHHS Provider Enrollment Unit via ID mail to:

  MDHHS Provider Enrollment Unit
  P. O. Box 30437
  Lansing, Michigan 48909
  OR
  Scan and email to MSA-HomeHelpProviders@michigan.gov
  OR
  Fax to 517-373-2382

The provider enrollment unit will notify the adult services specialist via email once the provider is enrolled in CHAMPS.

Provider Address Changes in CHAMPS

CHAMPS identifies the following address types:

- ***Location address*** refers to the physical location where the home help provider resides.
- ***Correspondence address*** refers to where the home help provider's mail is delivered. The correspondence address could be the same as the location address or it could be different (for example, a post office post).

  Note: W-2's are mailed to the correspondence address.
- ***Primary pay to address*** refers to the address a single party warrant is mailed to.

The location address and correspondence address can be updated in CHAMPS by the provider. However, the primary pay to address can **only** be updated in CHAMPS by the MDHHS Provider Enrollment (PE) unit. Providers must submit a written request to:

MDHHS Provider Enrollment Unit
P.O. Box 30437
Lansing, MI 48909
OR
Scan and email to MSA-HomeHelpProviders@michigan.gov.
OR
Fax to 517-373-2382

CRIMINAL HISTORY SCREENING

Individuals who wish to provide personal care services through the Medicaid home help program must undergo a criminal history screen during the enrollment process in CHAMPS. The screening must be completed and passed by MDHHS provider enrollment before payment can be authorized.

Individuals with certain excludable convictions may not be approved to provide home help. Excludable convictions fall into two general categories. Mandatory exclusions are those set forth in the Social Security Act (42 USC 1320a-7[a]). Permissive exclusions are

felony convictions identified but not limited to the crimes listed in MSA Bulletin 14-40.

An individual or entity is considered to be convicted of a criminal offense when:

- A judgment of conviction has been entered against the individual or entity by a federal, state or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged.
- A finding of guilt against the individual or entity by a federal, state, or local court.
- A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court.
- An individual or entity that has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

Mandatory Exclusions

Individual providers must be screened for and must disclose the following excludable convictions as required by the state of Michigan. Any person found to meet one of these four categories is **prohibited** from participating as a service provider for the home help program. The four mandatory exclusion categories are listed in MSA Bulletin 14-31 and are as follows:

1. Any criminal convictions related to the delivery of an item or service under Medicare (Title XVIII), Medicaid (Title XIX) or other state health care programs.
2. Any criminal convictions under federal or state law, relating to neglect or abuse of patients in connection with the delivery of a health care item or service.
3. Felony convictions **occurring after August 21, 1996**, relating to an offense, under federal or state law, in connection with the delivery of health care items or services or with respect to any act or omission in a health care program (other than those included in number one above) operated by or financed in whole or in part by any federal, state, or local government agency, of a criminal offense consisting of a felony relating to

fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

4. Felony convictions occurring after August 21, 1996, under federal or state law, related to **unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.**

Permissive Exclusions

Permissive exclusions are felony convictions beyond the four mandatory exclusions. Individual providers are denied enrollment based on permissive exclusions identified in MSA Bulletin 14-40 unless the client signs an Acknowledgement of Provider Selection form stating he or she wishes to retain the provider.

Acknowledgement of Provider Selection

A client may choose to select a provider who has been determined ineligible as a result of a permissive exclusion identified through the criminal history screening process. The client must sign an Acknowledgement of Provider Selection form in order to hire a provider with a permissive exclusion.

The client's signature acknowledges he or she has been informed of the criminal offense (s) and continues to choose the individual to provide services. The effective start date for the selected provider is the date the client signs the acknowledgement form. The specialist **must not** authorize payment prior to the signature date on the acknowledgment form.

Note: If a provider with a permissive exclusion desires to work for multiple clients, an Acknowledgement of Provider Selection form must be signed by **each** client. The approved date of payment is based on the date the client signed the acknowledgement form.

The Acknowledgement of Provider Selection form **cannot** be applied to the federally mandated exclusions.

Procedures

Refer to the Criminal History Screening Process on the adult services home page for processes and procedures.

LEIN

Criminal history screens for home help providers are conducted during the CHAMPS enrollment process and **not** by staff at the local office. Adult services staff ***must only*** utilize LEIN information in the course of an APS investigation. Use of LEIN in any other adult services program is **prohibited**.

Any inappropriate access, use or disclosure of LEIN information will result in disciplinary action. For information regarding penalties for improper use and release of LEIN information, see ASM 264.

HOME HELP STATEMENT OF EMPLOYMENT (MSA-4676)

The purpose of the MSA-4676, Home Help Services Statement of Employment, is to serve as an agreement between the client and provider which summarizes the general requirements of employment. The form is completed by the adult services specialist as part of the provider interview process.

An employment statement must be signed by **each** provider who renders service to a client.

The statement of employment does the following:

- Confirms an understanding of the personal care services provided, how often services are provided, and wages to be paid.
- Requires positive identification of the provider by means of a picture ID and social security card.
- Documents an understanding by both parties that the client, not the State of Michigan, is the employer of the provider.
- Stipulates that the client must report any changes to the adult services specialist within 10 business days.
- Requires the provider to repay the State of Michigan for services he or she did not provide.
- Informs a provider receiving public assistance that this employment must be reported to the Michigan Department of Health and Human Services.

- Requires the client and provider to sign the MSA-4676 statement indicating their understanding of the terms of the agreement.

Distribution of Employment Statement

The adult services specialist will make **two copies** of the completed and signed form and distribute as follows:

- Give one copy to the client.
- Give one copy to the provider.
- Place the **original** form in the client's case record.

ELECTRONIC SERVICES VERIFICATION (ESV)

Individual home help providers are required to submit an electronic services verification (ESV) through the Community Health Automated Medicaid Processing System (CHAMPS) each month. The ESV lists the activities of daily living (ADL) and instrumental activities of daily living (IADL) approved by the specialist.

The adult services specialist accesses CHAMPS to view the submission of an electronic services verifications.

Individual home help providers with questions on how to submit an ESV should be referred to the MDHHS Home Help website at www.michigan.gov/homehelp or call the Provider Support hotline at 1-800-979-4662.

The electronic services verification (ESV) replaces the DHS-721, Personal Care Services Provider Log.

PAPER SERVICES VERIFICATION (PSV)

A paper service verification (PSV) form is available as an **exception** for individual providers who are unable to submit an electronic services verification. Providers eligible for this exception must meet the following criteria:

- The individual providing care does **not** have access to a computer.

- The individual providing care does **not** have access to the internet.

- Internet access is unavailable within 15 minutes of where the client or provider resides and the provider has a valid reason, such as lack of transportation or unable to leave the client alone.

- Provider lives in a rural area where internet is scarce or non-existent.

The adult services specialist can generate the paper services verification (PSV) form through CHAMPS, along with a cover sheet and instructions for completing the PSV. Providers are required to return the form monthly to the following mailing address located on the cover letter:

MDHHS Adult Home Help
P.O. Box 26007
Lansing, Michigan 48909
OR
Fax to 517-763-0111

Note: Individual home help providers must be instructed not to submit PSVs for future months as these will not be accepted.

The PSV will be scanned and stored in CHAMPS and the specialist has the ability to view the PSV for accuracy.

The paper services verification form generated in CHAMPS replaces the DHS-721, Personal Care Services Provider Log.

SERVICE VERIFICATIONS TIED PAYMENTS

Individual home help providers must submit an Electronic Services Verification (ESV) or a Paper Services Verification (PSV) each month in order to receive payment. An ESV or PSV must be submitted starting the first day of the following month after the service period before a warrant is generated.

Note: A payment authorization must be on ASCAP in order for an ESV to be displayed in CHAMPS or for a PSV to be generated from CHAMPS.

MEDICAL ASSISTANCE HOME HELP PROVIDER AGREEMENT (MSA-4678)

Federal regulations require that all providers of Medicaid covered services complete and sign a provider agreement. This agreement states providers will abide by Medicaid policies in providing services to program clients and in receiving payment from the program.

Providers who electronically enroll in CHAMPS meet this requirement by agreeing to a list of terms and conditions. Providers who are unable to enroll electronically **must** complete and sign the MSA-4678.

The specialist must forward the completed and signed agreement to the Provider Enrollment unit. Refer to the Manual Enrollment section previously mentioned in this item.

LOCAL OFFICE INDIVIDUAL HOME HELP PROVIDER HOURLY RATE

Each local MDHHS office has an established individual home help provider rate. Specialists must **not** authorize above or below the established county rate. For the list of individual and agency hourly rates, see ASM 138, County Rates.

PROVIDER INCOME VERIFICATION

Requests received by the local office for verification of provider income or employment should be forwarded to MDHHS Provider Support hotline at 1-800-979-4662.

AGENCY DEFINITION AND CRITERIA

A home help services provider is eligible to be approved as an agency when either of the following criteria are met:

- A Medicaid enrolled home health agency.
- Has a Federal Tax Identification number, also known as Employer Identification Number (EIN), **AND** employs or (sub) contracts with two or more persons, not including the owner, to provide home help services.

When an agency has met the above requirements, it will fall into one of two categories. It will be either an agency that employs its service providers or an agency that subcontracts with its service providers.

Agencies That Employ Service Providers

An agency that directly employs service providers must document that Federal Insurance Compensation Act (FICA) taxes and State Unemployment Insurance (SUI) are paid for all service providers.

Documentation

FICA is paid on a quarterly basis. The agency's current IRS-941, Employer's Quarterly Federal Tax Return, will serve to document the agency has paid FICA for its employees.

State unemployment insurance is also paid on a quarterly basis and is documented by the agency's current UIA-1020, Employer's Quarterly Tax Report.

There are agencies that employ their services providers that qualify as a nonprofit organization under Section 501 (c)(3) of the Internal Revenue Code. These agencies may choose to pay state unemployment insurance on a quarterly basis or they may choose to pay as a reimbursing employer.

If the agency chooses to pay as a reimbursing employer, the state is paid only for claims actually paid out to former employees. In these cases, the agency's current UIA 1020-R, Reimbursing Employer's Quarterly Payroll Report, will serve as documentation.

Agencies that Subcontract with Service Providers

Agencies that subcontract with service providers are not required to pay FICA or SUI.

Documentation

Copies of the subcontractor agreements in addition to Internal Revenue Service (IRS) 1099 forms will serve as documentation.

The 1099 is an IRS form that states how much was paid to a subcontractor for the year. It is a record of income paid by the agency to the subcontractor. The agency is responsible for preparing and sending the information to the subcontractor and to the IRS. Agencies are required to submit this information for every person that is not an employee.

Agencies that subcontract may also present the response letter to an IRS SS-8 form request. The IRS SS-8 is a request that an agency can make to the IRS to determine an employee's work status for the purposes of Federal Employment Taxes and Income Tax Withholding. It states whether a worker is an employee or a subcontractor.

Verification of Agency Status

The adult services specialist should instruct agencies to submit the required documentation for agency status approval to:

Michigan Department of Community Health
Long Term Care Services Policy Section
Capital Commons Building, 6th Floor
400 S. Pine Street
P.O. Box 30479
Lansing, Michigan 48909-7979
OR
Fax to 517-335-7959

Agencies will receive a determination letter from MDCH stating one of the following:

- The agency has met the criteria and is approved (agencies are often given provisional approval status).

- The agency has not met the criteria and is denied.
- The agency must submit additional information in order to meet the requirements.

MDCH will randomly select agencies and request documentation to review agency status. An agency must notify the adult services specialist within **10 business days** of any changes that may affect meeting the agency requirement.

Agency Approval List

A list of approved agencies is maintained on the Adult Services Home Page. If an agency is on the Home Help Agency List, their status as an approved agency extends to all counties.

Agency Rates for Home Help

Agency rates for reimbursement of home help services are predicated on the following rules:

1. The maximum agency rate for any county is 200 percent of the lowest county individual rate in the state at the time of policy implementation. Any county's agency rate that is currently above that amount will be frozen unless a county does not currently have an agency rate. In this circumstance, the agency rate for the county will be established at an amount equal to 170 percent of the county's individual provider rate.

   Effective August 1, 2008, county agency rates were increased by five percent (or by a lesser amount if the lesser amount achieves the target rate of 170 percent of the county's individual provider rate) unless the current agency rate is equal to or greater than 170 percent of the county's individual provider rate. Any agency rates equal to or greater than 170 percent of the county's new individual provider rate will be frozen until such time that the agency rate is equal to or less than 170 percent of the county's individual provider rate.

2. The minimum agency rate for any county is 170 percent of the lowest county individual provider rate in the state.

3. All agency rates are rounded to the nearest quarter (twenty five cents).

4. Any agency rates that do not conform to the policy outlined above, but were approved for an individual client, will remain in effect for that client until that respective agency-client relationship is terminated, or until the above stated policy would result in a higher rate.

There will be no exceptions granted for deviation from the respective rates resulting from implementation of this policy.

The agency rates resulting from the establishment of this policy are not applicable to individual home help providers.

An agency can only receive the established agency rate if they have been approved by MDCH. If an agency does not meet the criteria:

- Reduce the hourly rate to the individual rate. Do not terminate ongoing authorizations.
- Send appropriate notification to the client.

Note: Businesses not listed on the MDCH approved agency list must be paid at the individual county rate.

See ASM 138 for the county rate table.

Agency Registration

Payments made for the provision of personal care services to Medicaid recipients qualify as income for the provider and must be reported to the Internal Revenue Service (IRS) by the Michigan Department of Community Health.

All agency home help providers must register with the state of Michigan by submitting a W-9, Request for Taxpayer Identification Number and Certification. MDCH will use the information collected from the W-9 to produce a 1099 that will detail payments made by MDCH during the tax year.

Agencies who have not submitted a W-9 will not receive payment.

Registration Procedures

Home help agency providers must complete a W-9 and submit it to the state of Michigan by one of the following methods:

- Mail:

  State of Michigan
  Payee Registration
  P.O. Box 30026
  Lansing, Michigan 48909

- Fax form to Vendor Registration at 517-373-0297

- Online registration at http://www.mi.gov/cpexpress

Agency providers with additional questions regarding vendor registration should be referred to:

- Payee Registration Helpline at 517-373-4111 (Lansing area) or 888-734-9749.

- Payee Registration email at dmb-vendor@michigan.gov.

Agency providers must submit a new W-9 to Vendor Registration for a change of address as well as contact the local DHS office to update information in Bridges.

Agency Provider Enrollment

Agency providers must first be enrolled in Bridges prior to authorizing payment; see ASM 135, Home Help Providers.

Agency Billing

Agency/business providers have the option of submitting monthly invoices in lieu of the DHS-721, Provider Log. Each invoice must specify the following:

- The service(s) provided.
- The date(s) of service.

Hours billed that exceed the approved cost of care amount must receive prior approval by the adult services worker in order to receive payment.

Invoices must be received within 365 days of the service date. Failure to submit an invoice within 365 days of the service date will result in non-payment.

Payment authorizations up to 13 months are allowed if hours remain consistent.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS)

DEFINITION

Service animals are defined by the Americans with Disabilities Act (ADA) as dogs that are individually trained to do work or perform tasks for people with disabilities. Service dogs are working animals and not pets. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

Note: Under the ADA titles II and III, as revised on March 15, 2011, special provisions allow for the use of miniature horses as a service animal.

Examples of tasks performed by a service animal may include but are not limited to the following:

- Guiding individuals who are blind,
- Alerting individuals who are deaf.
- Pulling a wheelchair.
- Alerting and protecting individuals with a seizure disorder.
- Reminding individuals with mental illness to take prescribed medications.
- Calming individuals with Post Traumatic Stress Disorder (PTSD) during an anxiety attack.

The benefit for maintenance costs of a service animal may be authorized if **all** of the following conditions are met:

- The client is receiving home help services.

- The client is certified as disabled due to a specific condition such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury.

- The service animal is trained to meet the specific needs of the client relative to their disability.

  Note: The service animal does **not** have to be professionally trained and proof of training must **not** be requested.

- The tasks performed by the service animal are for the client.

The service plan must document that the service animal will be used primarily to meet specific client personal care needs. The adult services specialist may ask what tasks the service animal performs for the client but cannot request a demonstration of the tasks.

The maximum payment level for the maintenance of a service animal is $20 a month.

Note: This is a benefit to the client and not earned income.

There is no enrollment process for service animals. Authorizations are submitted through ASCAP payment module with service code 0501 and paid to the client only.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS)

INDIVIDUAL AND AGENCY COUNTY RATES

The following table lists the individual and agency provider rates for each county effective 01/01/2016. Historical individual county rates are located in ASCAP on the provider assignment screen.

County Code	County Name	Individual Provider Rate	Agency Provider Rate
1	Alcona	$8.50	$14.50
2	Alger	$8.50	$14.25
3	Allegan	$8.50	$13.50
4	Alpena	$8.50	$13.50
5	Antrim	$8.50	$14.75
6	Arenac	$8.50	$13.50
7	Baraga	$8.50	$15.00
8	Barry	$8.50	$14.50
9	Bay	$8.50	$13.50
10	Benzie	$11.00	$14.25
11	Berrien	$8.50	$13.50
12	Branch	$8.50	$14.50
13	Calhoun	$8.50	$14.50
14	Cass	$8.50	$14.50
15	Charlevoix	$8.50	$13.50

County Code	County Name	Individual Provider Rate	Agency Provider Rate
16	Cheboygan	$8.50	$14.50
17	Chippewa	$9.00	$14.50
18	Clare	$8.50	$13.50
19	Clinton	$8.50	$14.50
20	Crawford	$8.50	$15.00
21	Delta	$8.50	$13.50
22	Dickinson	$8.50	$14.50
23	Eaton	$8.50	$14.50
24	Emmet	$8.50	$13.50
25	Genesee	$8.50	$13.50
26	Gladwin	$8.50	$13.50
27	Gogebic	$8.50	$15.00
28	Grand Traverse	$11.00	$15.00
29	Gratiot	$8.50	$14.50
30	Hillsdale	$8.50	$14.50
31	Houghton	$8.50	$15.00
32	Huron	$8.50	$13.50
33	Ingham	$8.50	$13.75

County Code	County Name	Individual Provider Rate	Agency Provider Rate
34	Ionia	$8.50	$13.50
35	Iosco	$8.50	$14.50
36	Iron	$8.50	$14.50
37	Isabella	$8.50	$13.50
38	Jackson	$8.50	$14.50
39	Kalamazoo	$8.50	$14.50
40	Kalkaska	$8.50	$14.75
41	Kent	$8.50	$15.50
42	Keweenaw	$8.50	$15.00
43	Lake	$8.50	$13.50
44	Lapeer	$8.50	$14.00
45	Leelanau	$11.00	$15.00
46	Lenawee	$9.50	$14.25
47	Livingston	$9.00	$13.50
48	Luce	$9.00	14.50
49	Mackinac	$8.50	$14.50
50	Macomb	$8.50	$14.25
51	Manistee	$11.00	$14.25

County Code	County Name	Individual Provider Rate	Agency Provider Rate
52	Marquette	$8.50	$14.25
53	Mason	$8.50	$15.00
54	Mecosta	$8.50	$13.50
55	Menominee	$8.50	$13.50
56	Midland	$8.50	$13.50
57	Missaukee	$8.50	$13.50
58	Monroe	$8.50	$14.50
59	Montcalm	$8.50	$13.50
60	Montmorency	$8.50	$14.00
61	Muskegon	$8.50	$14.50
62	Newago	$8.50	$13.50
63	Oakland	$8.50	$13.50
64	Oceana	$8.50	$15.00
65	Ogemaw	$8.50	$14.50
66	Ontonagon	$8.50	$15.00
67	Osceola	$8.50	$13.50
68	Oscoda	$8.50	$14.00
69	Otsego	$8.50	$15.00

County Code	County Name	Individual Provider Rate	Agency Provider Rate
70	Ottawa	$8.75	$13.50
71	Presque Isle	$8.50	$13.50
72	Roscommon	$8.50	$14.50
73	Saginaw	$8.50	$13.50
74	St. Clair	$8.50	$14.50
75	St. Joseph	$8.50	$14.50
76	Sanilac	$8.50	$14.00
77	Schoolcraft	$8.50	$14.25
78	Shiawassee	$9.00	$13.50
79	Tuscola	$8.50	$13.50
80	Van Buren	$8.50	$14.50
81	Washtenaw	$8.50	$14.50
82	Wayne	$8.50	$13.50
83	Wexford	$8.50	$13.50

ADULT SERVICES AUTHORIZED PAYMENTS (ASAP)

The Adult Services Authorized Payments (ASAP) is the Michigan Department of Health and Human Services payment system that processes adult services authorizations. The adult services specialist enters the payment authorizations using the **Payments** module of the **ASCAP** system.

Payment Authorizations

No payment can be authorized unless the individual provider has been enrolled and screened for criminal history in the Community Health Automated Medicaid Processing System (CHAMPS).

Agency providers must also be enrolled in CHAMPS. In addition to enrolling in CHAMPS, a home help agency provider must be registered as a vendor with the State of Michigan by registering and updating their information online using Contract & Payment express (C&PE) at www.michigan.gov/CPExpress.

If an agency provider is not registered with the State of Michigan, payments will not process.

Note: The adult services home page provides a link to the provider enrollment instructions located on the Office of Workforce & Training Development. For additional questions regarding provider enrollment in CHAMPS, refer providers to Provider Support at 800-979-4662.

Home help services payments to providers must be:

- Authorized for a specific period of time and payment amount. The task is determined by the comprehensive assessment in ASCAP and will automatically include tasks that are ranked a level three or higher.

  Note: The adult services specialist can authorize an ongoing home help payment for up to six months, not to exceed the next review.

- Authorized **only** to the person or agency actually providing the hands-on services.

Note: An entity acting in the capacity of the client's fiscal intermediary is not considered the provider of home help and **must not** be enrolled as a home help provider; see ASM 135, Home Help Providers.

- Made payable jointly to the client and the provider.

Exception: Authorizations to home help agency providers are payable to the provider only. In addition, there are circumstances where authorizations payable only to the individual provider are appropriate, for example, client is physically or mentally unable to endorse the warrant. All single party authorizations must be approved by the adult services supervisor.

- Prorate the authorization if the MA eligibility period is less than the full month.

Example: A client meets his/her MA deductible on the third of every month. ASCAP will process prorated month (s) automatically. To prorate manually, divide the monthly care cost by the number of days in the month. Multiple the daily rate by the number of eligible days. Refer to the ASCAP User Guide for additional instructions on steps for prorating in ASCAP.

- Do **not** authorize payments to a **responsible relative**. A responsible relative is defined as a spouse caring for a spouse or a parent caring for a minor child.

Any payment authorization that does **not** meet the above criteria must have the reason fully documented in the **Payments** module, exception rationale box, in **ASCAP**. The supervisor will approve or deny the authorization and provide comments in the rationale box as needed.

MAXIMUM PAYMENT LEVELS

Home help payments **cannot** exceed established maximum levels. **All** payments for the client are included within the maximum level, even if the client has more than one provider. The service code for home help services is **0301**.

Home Help

The adult services specialist is allowed to approve a maximum of $799.99 a month.

Expanded Home Help

Payment levels of $800 - $1599.99 a month must be approved by the supervisor.

Payment levels of $1600 a month and over require prior approval from the MDHHS Long Term Care Policy Section. The specialist **must** receive a copy of the Policy Decision (DCH-1785) from the Long Term Care Policy Section before submitting the authorization.

Home Help Services for Adults in Need of Protection

The special adult protective services (APS) home help services component may be authorized to support the adult protective service plan of a vulnerable adult who is at risk of harm, abuse, neglect or exploitation; see ASM 125, Coordination with Other Services.

The maximum payment level is $1000 within a 12 month fiscal year. These authorizations are payable to the provider only and FICA is not withheld. The service code for adult protective services is **0302**.

Service Animal

The payment for service animals is fixed at $20 a month. These authorizations have a service code of 0501 and payable to the client.

Payments on Closed Cases

Authorizations on a closed case for a time period when the case was open can be made with supervisor approval as long as the provider was assigned to the case.

Note: If the provider was not assigned prior to the case closure, contact the Adult Services Program Office for assistance via the policy mailbox at: MDHHS-Adult-Services-Policy@michigan.gov.

Adult Services Program Office Payment Exceptions

The following payment authorizations will be forwarded via ASCAP to the Adult Services Program Office for processing:

- Authorization period is more than six months prior to the current date.
  - Payments within six months must be approved locally and cannot be approved as a program office exception.
  - Future authorizations **must** be approved locally and cannot be approved as a program office exception.
- Retroactive adjustments more than six months. Payments within six months **must** be approved locally.
- Authorizations that occur during the same time period as another adult services program (for example, adult protective services and home help services). The authorization submitted to program office must **only** be for the time period the programs overlap.
- Cases where an administrative error occurred.

Adequate justification must be entered in the rational box in ASCAP for the authorization to be approved.

Payment authorizations approved by the Adult Services Program Office will indicate the program service code proceeded by the number **9**.

INTRODUCTION

The Federal Insurance Contribution Act (FICA) tax is an employment tax imposed by the federal government on both employees and employers to fund social security and Medicare. In the home help program, clients are the employers and providers are the employees.

AUTHORIZATION FOR WITHHOLDING OF FICA TAX IN HOME HELP PAYMENTS (DHS-4771)

The DHS-4771, Authorization for Withholding of FICA Tax in Home Help Payments, allows the state of Michigan to act as the client's filing agent. The state of Michigan will withhold FICA taxes from the wages paid, on the client's behalf, to individual home help services providers.

The Michigan Department of Health and Human Services (MDHHS) will pay the amount of FICA tax the client is responsible for and withhold the provider's portion from the monthly home help payment. The combined amounts will be sent to the Internal Revenue Service.

MDHHS, acting as the client's agent, will file an IRS-941, Employer's Quarterly Federal Tax Return, for the client and issue a W-2 for the individual provider at the end of the year. This enables the provider to obtain work credits for Social Security and Medicare benefits.

The **client's** signature and date is required on the DHS-4771. It is completed as part of the initial comprehensive assessment process.

The DHS-4771 is completed **once**, for all new home help cases. The signed and dated form must be retained in the client's case record in the **Do Not Destroy** packet.

Exclusions

FICA is not withheld from home help payments when the provider is one of the following:

- Parent (including adoptive, foster, stepparent).

  Note: If a parent provider requests FICA to be withheld, change the provider assignment in ASCAP to other relative and provide explanation in narrative.

- Children 18 through 20 years old providing home help to a parent.

- Agency/business.

Note: The state of Michigan does not pay the FICA employer portion on the above exclusions. If the client has selected the Medicaid Personal Care Option, the state is **not** responsible for paying FICA tax on the Medicaid deductible paid by the client to the provider each month.

FICA Rebates

FICA rebates are issued to **all** individual providers who earn **less** than the gross limit set by the federal government; see www.irs.gov/pub/irs-pdf/p15.pdf.

The MDHHS Medicaid Payments unit (MPU) issues FICA rebates at the end of the calendar year. The FICA rebate warrant is issued to the provider only.

The adult services specialist will be able to identify FICA rebate warrants in ASCAP by the service period and service code. The service period will reflect the entire year. ASCAP will display 'FICA' for the service code.

Note: If a FICA rebate warrant is returned to Treasury as undeliverable, ASAP will generate a DCH-2362A for the warrant to be rewritten or canceled.

FICA Reimbursement

If a provider is coded incorrectly and FICA is withheld in error, the adult services specialist must send an email to the MDHHS Medicaid Payments unit mailbox at:MDHHS-Medicaid-Payments-Unit@michigan.gov

The email must include:

- Provider ID number.

- Client recipient ID number.
- Summary describing the error and time period
- Amount of FICA withheld in error.
- Warrant number (s) where the error occurred.

MPU will issue a warrant reimbursing all FICA at the end of the calendar year.

INTRODUCTION

In the home help program, payments made to individual providers are considered earned income and must be reported to the Internal Revenue Service (IRS). The Michigan Department of Health and Human Services (MDHHS), on behalf of the client, issues a W-2 for all individual providers. W-2s are based on wages **issued** in a calendar year. Agency providers are issued a 1099.

NON-RECEIPT OF W-2

If an individual home help provider reports non-receipt of their W-2, refer to the Provider Support hotline at 1-800-979-4662.

W-2 CORRECTIONS

W-2 corrections are required when an individual home help provider reports inaccurate earnings on their W-2 or when earnings were attached to an incorrect social security number.

Inaccurate Earnings

Complete the following steps when a provider reports inaccurate earnings on their W-2:

1. Verify the provider's period of employment with both the client and the provider.

2. Determine the total amount of gross wages that were **issued** in the calendar year.

- Exclude warrants that were returned to Treasury and canceled. Outstanding warrants from the previous calendar year must be canceled or rewritten so earnings are determined accurately.

- Exclude overpayments recouped by the MDHHS Medicaid Collections unit (MCU).

- If there is a dispute over total earnings, the adult services specialist must order copies of the warrant(s) from Treasury to verify signatures.

- If an overpayment is determined, follow recoupment procedures noted in ASM 165, Overpayment and Recoupment Process.

- If fraud is determined, make a referral to the Office of Inspector General (OIG).

1. Request a W-2 correction to MDHHS Provider Support via email at ProviderSupport@michigan.gov. Insert Home Help W-2 Correction in the subject line of the email.

2. Furnish Provider Support with the following:

   - Provider name and social security number.
   - Provider's current address.
   - Client's name and recipient ID number.
   - Client's current address.
   - A summary describing the error, the time period when the error occurred and the correct gross wages earned.

Incorrect Social Security Number

Complete the following steps when it is discovered a provider's earnings were attached to an incorrect social security number:

1. Determine the time period earnings were attached to the incorrect social security number.

2. Determine the total amount of gross wages that were issued in the calendar year (s).

   - Exclude warrants returned to Treasury and canceled. Outstanding warrants from the previous tax year in issue status must be canceled or rewritten so earnings are determined accurately.

   - Exclude overpayments recouped by MDHHS Medicaid Collection unit (MCU).

3. Request a W-2 correction to MDHHS Provider Support via email at ProviderSupport@michigan.gov. Insert 'Home Help W-2 Correction' in the subject line of the email.

4. Furnish MDHHS Provider Support with the following:

   - Correct provider name and social security number.

   - Correct provider address.

   - Incorrect social security number and if available, provider name.

- Incorrect provider address, if available.
- Client's name and recipient ID number.
- Client's current address.
- A summary describing the error, the time period when the error occurred and the correct gross wages earned.

NON-RECEIPT OF 1099 AND 1099 CORRECTIONS

Payments made to agency providers for the provision of home help services and Adult Foster Care/Home for the Aged providers for the provision of personal care services qualify as income that must be reported to the IRS. A 1099 is issued to agencies and AFC/HA providers when earnings are above $600 in a calendar year.

Providers (individual or business) who received payment for providing adult protective services will also receive a 1099.

If an agency provider reports non-receipt of a 1099 or requires a 1099 correction, refer to the Provider Support hotline number at 1-800-979-4662.

INTRODUCTION

Individuals who submit an application (DHS-390) for home help services or adult community placement must be given written notification of approval or denial for services. A written notice must be sent within the 45 day standard of promptness.

Clients with active service cases must be provided written notice of any change in their services (increase, reduction, suspension or termination).

Written Notification of Disposition

All notifications are documented under ASCAP contacts when they are generated. This documentation acts as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice.
- DHS-1212A, Adequate Negative Action Notice.
- DHS-1212, Advance Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

The adult services specialist **must sign** the bottom of the second page of all notices (DHS-1210, DHS-1212A, DHS-1212) before they are mailed to the client.

Services Approval Notice (DHS-1210)

Notification Services Have Been Approved

If independent living services (non-payment services) or adult community placement services are approved, the DHS-1210, Services Approval Notice, is sent indicating what services have been authorized.

If home help services will be authorized, note the amount and the payment effective date. Print and attach a copy of the Time and Task worksheet. The DHS-1210 is completed and generated through the Adult Service Comprehensive Assessment Program (ASCAP).

Notification Services Have Been Increased

The DHS-1210 must also be used when there is an increase in the amount of home help services on an open case. Appropriate notations must be entered in the comment section. A copy of the Time and Task worksheet must be printed and sent with the notice.

Adequate Negative Action Notice (DHS-1212A)

The DHS-1212A, Adequate Negative Action Notice, is used and generated on ASCAP when home help services and adult community placement services cases have been denied. Appropriate notations **must** be entered in the comment section explaining the reason for the denial.

Adequate Negative Action Notices **do not** require a 10 business day notice to the client.

Advance Negative Action Notice (DHS-1212)

The DHS-1212, Advance Negative Action Notice, is used and generated on ASCAP when there is a reduction, suspension or termination of services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

- Reduced - decrease in payment.
- Suspended - payments stopped but case remains open.
- Terminated - case closure.

Administrative Hearings

The client may appeal any negative action by requesting an administrative hearing. A DCH-0092, Request for Hearing form, is generated whenever a negative action notice is printed from ASCAP and must be mailed to the client with the negative action notice.

Note: Home help providers **cannot** appeal a negative action given to the client. Only the client can request an administrative hearing.

Hearing procedures are explained in Bridges Administrative Manual (BAM 600, Hearings).

Negative Actions Requiring Ten Day Notice

The effective date of the negative action is ten business days **after** the date the notice is mailed to the client. The effective date must be entered on the negative action notice.

If the client does not request an administrative hearing before the effective date, the adult services specialist must proceed with the proposed action.

If the client requests an administrative hearing before the effective date of the negative action, and the specialist is made aware of the hearing request, continue payments until a hearing decision has been made. If the specialist is made aware of the hearing request **after** payments have ended, payments must be reinstated pending the outcome of the hearing. Offer the client the option of discontinuing payment pending the hearing decision.

Note: When payments are continued pending the outcome of a hearing, the client must repay any overpayments if the department's negative action is upheld. Initiate recoupment procedures by sending the client a Recoupment Letter.

Negative Actions Not Requiring Ten Day Notice

The following situations **do not** require the ten business day notice on negative actions:

- The department has factual confirmation of the death of the client (negative action notice must be mailed to the guardian or individual acting on the client's behalf) or death of the service provider.

  Note: Cases should remain open until all appropriate payments have been issued.

- The department receives a verbal or written statement from the client, stating they no longer want or require services, or that they want services reduced.

  Note: This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The department receives a verbal or written statement from the client that contains information requiring a negative action. The

statement must acknowledge the client is aware the negative action is required **and** they understand the action will occur.

Example: A home help services client informs the specialist that they are engaged and will be married on a specific date. They also acknowledge that their new spouse will be responsible for meeting their personal care needs and they will no longer qualify for home help services.

Note: This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The client has been admitted to an institution or setting (for example, hospital, nursing home) where the client no longer qualifies for federal financial participation under the Medicaid State Plan for personal care services in the community.

  Note: When a client is admitted to a hospital or nursing home, the facility is reimbursed for the client's care on the day the client is admitted, but not for the day of discharge. The home help provider cannot be reimbursed for the date the client is admitted to the facility but may be paid for the day of discharge.

- The client cannot be located and the department mail directed to the client's last known address has been returned by the post office indicating the forwarding address is unknown.

  Note: In this circumstance, a services payment must be made available if the client is located during the payment period covered by the returned warrant.

- The client has been accepted for services in a new jurisdiction and that fact has been established by the jurisdiction previously providing services.

- The time frame for a services payment, granted for a specific time period, has elapsed. The client was informed, in writing, at the time payments were initiated, that services would automatically terminate at the end of the specified period.

Example: The DHS-1210 clearly states a begin and end date for the services payments.

LEGAL BASE

Administrative Rule 400.901 and 902 (Hearings and Appeals)

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

CASE REVIEWS

Independent living services (home help) cases must be reviewed every six months. A face-to-face contact is required with the client, in the home.

A face-to-face or phone contact must be made with the provider at each review to verify services are being furnished.

Note: If contact is made by phone, the provider must offer identifying information such as date of birth and the last four digits of their social security number. A face-to-face interview in the client's home or local Michigan Department of Health and Human Services (MDHHS) office must take place at the next review.

Review requirementsRequirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- Verification of the client's Medicaid eligibility, when home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan, if applicable.
- Review of client satisfaction with the delivery of planned services.
- Reevaluation of the level of care to assure there are no duplication of services.

Documentation

Case documentation for **all** reviews must include:

- An update of the **Disposition** module in ASCAP.
- A review of **all** ASCAP modules with information updated as needed.
- A brief statement of the nature of the contact and who was present in the **Contact Details** module of ASCAP. A face-to-face contact entry with the client generates a case management billing.
- Documented contact with the home help provider.

- Expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
- A record summary of progress in service plan.
- Document in the general narrative if a DHS-54, Medical Needs form is or is not needed

INTRODUCTION

BEM 220 states that residency continues for an individual who is temporarily absent from Michigan or intends to return to Michigan when the purpose of the absence has been accomplished.

Example: Individuals who spend the winter months in a warmer climate and return to their home in the spring. They remain MI residents during the winter months.

Home Help

Active home help clients can remain eligible for home help payments in a temporary residence outside of the state, if there is evidence of intent to return to Michigan. Medicaid remains active during the temporary absence.

Evidence of intent may be contract or rent payments, property taxes or utility services paid by the client or their legally responsible party.

Example: Parents caring for a disabled adult child while spending the winter months in Florida and take their child with them can be paid as home help providers for their adult child.

Authorization of Services

Payment can be authorized only for those services required by the client in any living arrangement (permanent or temporary) and **only** to providers authorized to provide home help services **prior** to the client's temporary absence.

Authorizations **cannot** extend beyond the six month review date as the specialist is unable to meet the face-to-face contact requirement. Increases in care cost **cannot** be approved without a face-to-face assessment of the client.

Documentation

The adult services specialist must confirm and document the following:

- The time frame of the client's absence from the state.
- The client will be traveling with the provider.

- The need for continuation of care during the temporary absence.

LEGAL BASE

42 CFR 435.403
Section 11005 of P.L. 99-570
Social Welfare Act, Sections 1902(a)(48), 1902(b)(2)
MCL 400.32

JOINT POLICY DEVELOPMENT

The Adult Service Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

GENERAL INFORMATION

Adult services warrants are processed through the Michigan Department of Health and Human Services (MDHHS) Adult Services Authorized Payments (ASAP) system and are rewritten by the MDHHS Medicaid Payments Unit (MPU).

The adult services specialist is responsible for determining the disposition of all adult services program warrants returned to the Department of Treasury. The DCH-2362A, Adult Services Warrant Rewrite/Disposition Request, is the form used when determining if a warrant needs to be rewritten or canceled.

DCH-2362A

The DCH-2362A is generated electronically by ASAP or provided by the MDHHS Medicaid Payments unit when a warrant is canceled, stopped or returned to Treasury as undelivered.

When a warrant includes multiple clients (agencies or adult foster care providers) and multiple adult services specialists are involved with one rewrite request, the request is to be coordinated by the Medicaid Payments Unit.

WARRANT REWRITE ACTIONS

The **original** warrant may be rewritten **once**. All information pertaining to the client must be accurate in ASCAP. The provider information must be up-to-date in the Community Health Automated Medicaid Processing System (CHAMPS). The specialist must verify the following before processing the DCH-2362A:

- Dual-party warrants:
  - Client address information must be updated on the Basic Client screen in ASCAP.
- Single-party warrants:
  - Changes to the provider's primary pay to address must be updated in CHAMPS before a warrant can be rewritten. The primary pay to address is the location the warrant is mailed if single party.

- The primary pay to address for providers can only be updated in CHAMPS by the MDHHS Provider Enrollment (PE) Unit. Providers must submit a written request to:

  MDHHS Provider Enrollment Unit
  P. O. Box 30437
  Lansing, MI 48909

- The adult services specialist has the ability to view provider contact information in ASCAP.

- Agency or business providers:
  - The provider information in CHAMPS and Vendor Registration (MAIN) must match.
  - When there is a change in address, agencies **must** update their information online with Vendor Registration using Contract and Payment Express (C&PE) at www.michigan.gov/CPExpress.
  - Send a written request to the MDHHS Provider Enrollment unit to update the primary pay to address in CHAMPS.

Acceptable Actions

The following are acceptable actions for a warrant rewrite:

- A warrant can be replaced for the period covered in the original warrant once the warrant has been canceled or voided by Treasury.
- A warrant can be rewritten for the same amount or a lesser amount than the original warrant.
- A dual-party warrant can be rewritten to a provider only.

Unacceptable Actions

The following actions are **not** acceptable for a warrant rewrite:

- Warrants cannot be rewritten to a provider other than the provider identified in the original warrant.

Note: To issue a warrant to a different provider, the original warrant must be canceled and a new authorization must be entered on the ASCAP payment screen for the new provider.

- Warrants cannot be rewritten for an amount higher than the amount of the original warrant.

  Note: Increases in warrant amounts are processed as retroactive payment adjustments on ASCAP.

- Warrants cannot be rewritten if pulled by Treasury; see ASM 161 for Treasury status codes.

Adult services specialists are not to accept returned warrants. Warrants must be returned to the Department of Treasury at the following address:

Department of Treasury
Office of Financial Services
P. O. Box 30788
Lansing, Michigan 48909

PAYMENT HISTORY

A history of adult services warrants can be viewed in ASCAP by clicking the Authorization History ICON and selecting the DCH Payroll function button. The Adult Services Authorized Payment system (ASAP) maintains a payment history dating back to April 2006.

WARRANTS RECEIVED BY THE LOCAL OFFICE

Adult services program warrants received by the local office must be voided per the accounting procedural manual and returned to the Department of Treasury at the following address:

Department of Treasury
Office of Financial Services
P. O. Box 30788
Lansing, Michigan 48909

WARRANTS RETURNED TO THE DEPARTMENT OF TREASURY

When a warrant is returned to Treasury by the local MDHHS office, client/payee, or U.S. Post Office, the status is updated to undeliverable.

Actions

The following outlines the action steps that must be taken by various parties in the process of rewriting warrants returned to Treasury.

- Adult Services Authorized Payment System (ASAP)Generates and forwards an electronic version of the DCH-2362A, Adult Services Warrant Rewrite/Disposition Request, to the MDHHS local office designee (LOD) via email.

MDHHS Local Office Designee (LOD)

- Receives email notice that warrant has been returned to Treasury.
- Prints the attached DCH-2362A received from ASAP (items 1-13 are pre-filled).
- Forwards the original DCH-2362A to the adult services specialist.

Adult Services Specialist

- Determines if the warrant needs to be rewritten or canceled and completes appropriate item(s) on the DCH-2362A within **ten business days**.
- Before completing the DCH-2362A, verifies the client's address is correct on the **Basic Client** screen in **ASCAP** for dual party warrants. If the warrant will be rewritten to a single payee, verifies the provider's address is correct in CHAMPS.
- Completes the DCH-2362A and obtains supervisor signature (see instructions for completion of the DCH-2362A at the end of this item).

MDHHS Local Office Designee (LOD)

- Retains a copy of the DCH-2362A in accounting files.
- Scans and email the DCH-2362A to the MDHHS Medicaid Payments mailbox at MDHHS-Medicaid-Payments-Unit@michigan.gov or sends via FAX to 517-763-0160 (scanning is the preferred method).

MDHHS Medicaid Payments Unit

- Receives the DCH-2362A from the MDHHS local office designee and processes the rewrite or cancellation.

Note: Warrants rewritten by the MDHHS Medicaid Payments Unit (MPU) will be generated the week after MPU has completed processing the rewrite.

LOST, DESTROYED, NOT RECEIVED AND STOLEN WARRANTS

Warrants reported lost, destroyed, not received or stolen may be replaced/rewritten **after recovery** is made on the original warrant.

Recovery means the value of the warrant has been credited back to the account it was written from or if a forged warrant has cleared Treasury, the party which cashed the forged warrant has reimbursed the state.

Lost/Not Received Warrants

Action

Payee

- Reports to the adult services specialist that a warrant was lost or not received.

Adult Services Specialist

- If a warrant was not received, the adult services specialist must review ASAP Payment History to see if the warrant was issued.

- If the warrant was not issued, determine the reason why and correct the problem. Suggested methods for identifying reasons why a warrant was not received include:
  - Verify the payment authorization was entered on ASCAP.
  - Verify client's Medicaid eligibility status on the Bridges Eligibility screen in ASCAP. If Medicaid is not active for the time period in question, a warrant will not be generated.
  - For AFC/HA payments, verify the status of the claim by selecting the ASAP Claims tab under the DCH Payroll button in ASCAP.
  - Verify provider eligibility status was not end dated in CHAMPS. (Provider deceased or provider status end dated in error).
- If the warrant disposition shows an issue status, instruct the client/provider to follow up with the post office to verify delivery.
  - If delivery **cannot** be verified, consider the warrant not received.
  - If the delivery is verified, but client/provider claims non-receipt, consider the warrant **lost** or **stolen**.
    - If the warrant was issued and the disposition code indicates the warrant was returned to Treasury as undelivered, **do not** complete the 1778. ASAP will generate a DCH-2362A for the warrant to be rewritten or canceled.
    - If the warrant indicates that it was pulled by Treasury **do not** proceed with stop/rewrite; see ASM 161 for Treasury status codes.
- **Waits 5-7 mail delivery days** from warrant date prior to pursuing the completion of the 1778 by the client/payee.
- The 1778 must be completed by the payee (s) **listed on the warrant**. For dual party warrants, if one of the parties is unable to sign, (client deceased or moved out of state) provide explanation on the 1778 in box 29.

- Records his/her name and email address on the bottom of the 1778 in the event the MDHHS Medicaid Payments unit needs to contact the adult services specialist.

  Note: Treasury only requires one copy of the 1778 to be signed; sealed and notarized by a notary public (it is acceptable to make additional photo copies).

- If the warrant was lost, instructs the payee (s) that if the warrant is found **after** the 1778 is processed, the warrant **must not** be cashed. The warrant must be voided and returned to Treasury.

  Note: Prior to voiding the warrant and returning it to Treasury, the adult services specialist should contact the Medicaid Payments Unit to see if the 'stop payment' can be lifted. If the stop payment is lifted, the warrant may be cashed. If the stop payment cannot be lifted, the warrant must be voided and returned to Treasury so it can be rewritten.

- **Disregard the distribution instructions on the bottom of the 1778 and use the following**:

  - Retain a copy in the case record.
  - Give a copy to the client/payee.
  - Forward a copy to the MDHHS local office designee.

MDHHS Local Office Designee (LOD)

- Scans and emails the 1778 to the MDHHS Medicaid Payments unit at MDHHS-Medicaid-Payments-Unit@michigan.gov or sends via FAX to 517-763-0163 (scanning is the preferred method).

MDHHS Medicaid Payments Unit

- Receives the 1778 and initiates the stop payment on Adult Services Authorized Payment (ASAP) system.

  Note: The warrant cannot be rewritten until ASAP indicates it has been canceled.

- ASAP will generate an electronic version of the DCH-2362A to the MDHHS local office designee.

MDHHS Local Office Designee (LOD)

- Forwards the DCH-2362A to the adult services specialist.

Adult Services Specialist

- Completes appropriate item(s) on the DCH-2362A and returns to the MDHHS local office designee **within 10 business days.**

MDHHS Local Office Designee (LOD)

- Scans and emails the DCH-2362A to the MDHHS Medicaid Payments unit at MDHHS-Medicaid-Payments-Unit@michigan.gov.

Stolen/Forged

If a warrant was issued and the disposition status shows **paid**, the warrant has been cashed. If the payee claims they did not receive or cash the warrant, they must complete the 1354, Affidavit Claiming a Forged Endorsement on a State Treasurer's Warrant.

If the warrant was stolen, the payee must file a police report (verification required by furnishing the report number or copy of report).

Note: Lost warrants do not require a police report.

Action

Adult Services Specialist

- Reviews warrant information under the DCH Payroll function in ASCAP, to ensure the warrant has not been pulled by Treasury (see ASM 161 for Treasury codes).
- Requests a copy of the warrant using Treasury form 1363, Request for Copy of Original Warrant, from MDHHS Medicaid Payments unit or directly from Treasury.
- When the copy of the warrant is received, schedules an appointment with the payee (s) in the local office to view the endorsements on back of the warrant.
- If the payee(s) claims forgery, the 1354 is signed in the presence of a notary public.

Note: All six pages of the 1354 **must** be completed, signed and sealed by a notary public. (Treasury requires four original copies).

- If a client or provider refuses to sign the affidavit on a dual party warrant, the warrant cannot be rewritten. This now becomes a civil matter and possible fraud referral to OIG.
- If one of the payees of a dual party warrant endorses the warrant it will not be rewritten.
- If the client or payee admits endorsing the warrant, obtain a signed statement to that effect. No further action is required.
- Retains a copy of the signed 1354 and copy of the cashed warrant in the case record, and gives a copy of the affidavit to the client/provider.
- Forwards the remaining **four** original copies of the 1354 and copy of warrant to the local office designee.

MDHHS Local Office Designee (LOD)

- Logs receipt of the 1354 and copy of cashed warrant according to accounting procedures.
- Forwards the **four original copies** of the 1354 to MDHHS Medicaid Payments Unit via ID mail to:

  MDHHS Bureau of Finance
  Expenditure Review/Medicaid Payments Unit
  Grand Tower Building
  235 S Grand Avenue, Suite 1005
  Lansing, MI 48933

MDHHS Medicaid Payments Unit

- Reviews the 1354 for accuracy.

  Note: If the affidavit is inaccurate or incomplete it will not be processed. MDHHS Medicaid Payments unit will notify the adult services specialist assigned to the case.

- If the monies are recovered, MDHHS Medicaid Payments unit will send an electronic version of the DCH-2362A to the MDHHS local office designee.

Note: If the warrant **cannot** be rewritten, the MDHHS Medicaid Payments unit will notify the adult services specialist in writing via email.

MDHHS Local Office Designee (LOD)

- Forwards a copy of the DCH-2362A to the adult services specialist for completion.

Adult Service Specialist

- Completes the DCH-2362A and returns to the MDHHS local office designee **within ten business days**.
- If the warrant cannot be rewritten, the adult services specialist notifies the client/provider.

  Note: If the client and/or provider disagree with the decision not to issue a replacement warrant, the client may request an administrative hearing. The provider must send a letter to the Administrative Tribunal.

There is a statute of limitation on forgery claims, therefore, these claims are time sensitive. Financial institutions do not have to honor a forgery claim if it is three years past the date of the warrant.

Forgery resolutions could take up to a year.

Mutilated/ Destroyed Warrants

If the remains of a mutilated warrant identifies the warrant number, the warrant must be returned to Treasury. The completion of the 1778, Affidavit Claiming Lost, Destroyed, Not Received, or Stolen State Treasurer's Warrant is not necessary. Once the warrant is returned to Treasury and cancelled, ASAP will generate a DCH-2362A and forward to the local office designee.

If the remains of the mutilated warrant does not identify the warrant number, a 1778 must be completed. Follow the procedures for the completion of the 1778 listed under the Lost/Not Received Warrant section in this manual item. warrants canceled by treasury, over 180 days old

After 180 days, uncashed warrants are automatically canceled by Treasury. These warrants will display a disposition reason of **can-**

celed over 180 days old. The Adult Services Authorized Payment system (ASAP) will generate a DCH-2362A and forward it via email to the MDHHS local office designee. The DCH-2362A is forwarded to the adult services specialist for processing. The specialist must follow the instructions for rewriting a warrant previously noted in this item.

WARRANTS NOT ISSUED BECAUSE OF INVALID PROVIDER TAX ID NUMBER

Invalid provider tax identification numbers for home help agency providers or adult foster care/homes for the aged providers will result in adult services warrants not being issued. Provider tax numbers include social security and federal tax identification numbers.

Provider Tax ID Numbers

Adult Foster Care/Homes for the Aged Providers

Licensed providers such as adult foster care and homes for the aged must use the same social security or federal tax identification number, associated with their license, on both Bridges and Vendor Registration. The Bureau Information Tracking System (BITS) sends the licensee information to Bridges. The same tax ID number used in BITS must be used in Bridges. Vendor Registration will use the tax number supplied by the provider when the vendor registers with the State of Michigan through Contract and Payment Express (C&PE). If the tax ID numbers on BITS and Bridges do not match, payments **will not be processed**.

Home Help Agency Providers

Home help providers that are agencies/businesses will enter their federal tax id number in CHAMPS during the provider enrollment process.

Vendor Registration will use the tax ID number supplied by the provider. Agencies must update their information online with Vendor Registration by using Contract & Payment Express (C&PE) at www.michigan.gov/CPExpress.

Determining Validity of Provider Tax ID Numbers

Payments with invalid provider tax ID numbers for adult foster care, homes for the aged or home help agency providers will not be issued.

These providers will be identified on the Department Auto Financial Report (DAFR). The DAFR is an error report produced by the ASAP system and used by central office.

Correcting Invalid Provider Tax ID Numbers

Providers with an invalid tax number must be contacted to determine the correct tax number.

Adult foster care, homes for the aged and home help agency/business providers must update their information online with Vendor Registration by using Contracts and Payment Express at www.michigan.gov/CPExpress.

All Adult Services Providers

Social security or federal tax ID numbers can only be changed in CHAMPS by the Provider Enrollment unit.

Note: A W-2 correction will be required at the end of the tax year for individual providers with an incorrect social security number in CHAMPS; see ASM 146, W-2 and 1099.

AFC/HA Providers

Corrections to the tax ID number associated with a licensed AFC/HA should be brought to the attention of the Bureau of Community and Health Systems (BCHS). Refer AFC/HA providers to the BCHS Hotline at 866-685-0006.

Providers must correct their tax ID number online with Vendor Registration through Contract and Payments Express at www.mi.gov/cpexpress.

Note: Warrants not issued due to an invalid tax ID number are suspended and do **not** require a warrant rewrite. Once the tax ID number is corrected, warrants will be processed.

GARNISHMENT

A writ of garnishment is how some creditors recover unpaid debt. Wage garnishment in Michigan comes after a court-ordered judgement.

Single party warrants are considered earnings to the provider and **are** subject to garnishment. Dual party warrants **are not** subject to garnishment as these payments are a benefit to the client.

Forward new requests for garnishment, received at the local DHHS office, to:

Michigan Department of Health and Human Services
Bureau of Legal Affairs
333 S. Grand Ave, 5th Floor
Lansing, Michigan 48933

TREASURY OFFSET

The Department of Treasury can pull a warrant to offset a debt owed to the state by the provider; see ASM 161, Warrant Treasury Codes and Disposition Status.

If the provider disputes this action, the specialist should refer them to:

Department of Treasury
Collections Offset unit, 3rd Party
517-636-5333

Note: When single party warrants are pulled by Treasury, they **cannot** be rewritten.

COMPLETION OF THE DCH-2362A

The DCH-2362A, Adult Services Warrant Rewrite/Disposition Request, is generated by the Adult Services Authorized Payment (ASAP) system and is used to rewrite all adult services warrants. The MDHHS Medicaid Payments unit sends the form electronically via email to the MDHHS local office designee to be forwarded and completed by the adult services specialist.

Instructions

Items 1-13

These fields are prefilled by the ASAP system. The client recipient ID number is used in lieu of the case number.

Item 14

Select the appropriate action code. Select only **one**.

Action Code 01 - Rewrite Warrant

- Use this code if the warrant must be rewritten for the same or lesser amount.

  Note: For home help, the warrant amount is the cost of care authorized before FICA or client pay (deductible) is deducted (gross amount).

- Use this code if the warrant must be rewritten from a dual party to a single party payee.

Action Code 02 - Cancel Warrant

- Select this code if the warrant needs to be permanently canceled.

  Note: If a warrant is canceled in error, revise the DCH-2362A and resubmit to MDHHS Medicaid Payments unit via email at MDHHS-Medicaid-Payments-Unit@michigan.gov.

- Select this code if a warrant needs to be issued to a different provider. An authorization for the alternate provider must be approved on ASCAP.

Action Code 03 - Leave Status as Undeliverable

Not applicable. Do not select this option.

Item 15A

Rewrite Code - Select only one rewrite code from the list. Complete if item 14, Action Code 01 is selected.

Item 15B

Reason/Disposition Code - Select one or more of the appropriate codes. Complete if item 14, Action Code 01 is selected.

- Outdated or Voided Warrant - Select if the warrant was canceled by Treasury after 180 days.
- Change in Amount - Select if the warrant needs to be rewritten for a lesser amount.
- Correction in Payee Name - Not applicable
- Mutilated Warrant - Not applicable
- Send Rewrite to Local Office - If applicable
- Pay Client Only - Used only for service animal warrants.
- Pay Provider Only - Select this option if the warrant must be rewritten to the provider only.
- Pay Third Party Only - Not applicable for adult services programs.
- Change of Address - Complete items 17-23 on form. Provider information must be current in CHAMPS and/or client information must be updated on ASCAP before completing the rewrite.
- Delete Third Party - Not applicable.

Item 16A

Rewrite Warrant - Select this box if the warrant is to be rewritten. Complete if item 14, Action Code 01 is selected. Complete 17-24.

Item 16B

Cancel Warrant - Select this box if the warrant needs to be canceled. Provide a reason for canceling the warrant. Complete if item 14, Action Code 02 is selected; proceed to item 25, specialist signature.

Items 17-18

First/Second Payee Name - Complete if item 14, Action Code 01 and 16A are selected. The first payee represents the provider. The second payee represents the client.

Note: A warrant cannot be rewritten to a different provider.

Items 19-23

Address - Complete if item 14, Action Code 01 and 16A are selected. Enter entire address where rewritten warrant should be mailed, including apartment or mobile home lot number, if applicable. When a post office box is used, it must be entered on line 20. Enter only **one** mailing address.

Item 24

New Warrant Amount - Enter the **gross** amount of the original warrant. If the new warrant amount is for a lesser amount, enter the **gross** amount calculated before FICA or client co-pay is deducted.

Note: Increase in payment for home help warrants are processed through ASCAP by modifying the original authorizations.

Item 25

Worker's Signature and Date - This item is prefilled by the MDHHS adult services authorized payment (ASAP) system. In addition, the specialist must enter a legible signature and date.

Item 26

Supervisor's Signature and Date - This item is pre-filled by the MDHHS adult services authorized payment (ASAP) system. The supervisor approving the action must enter a legible signature and date.

WARRANT TREASURY CODES AND DISPOSITIONS

The following tables outline the various codes utilized by the Department of Treasury to identify the warrant status and disposition.

Status Codes

Treasury status is located in ASCAP under the DCH Payroll function listed as 'Treas'

Treasury Code	Description
S=STAR Offset	State Treasurer Accounts Receivable - Collection Division Offset
G=GAL Offset	Garnishment and Levy - Collection Division, Third Party Withholding Unit offset action. ***Dual party warrants are not subject to garnishment.**
B=Both	STAR and GAL Offsets occurring
W=Written	No offset is occurring and warrant is printed for mailing.

Disposition Codes

Disposition status is located in ASCAP under the DCH Payroll function listed as 'Dispo Status'.

Disposition Codes	Description
Issued	Warrant was mailed.
Paid	Warrant was cashed.
Canceled	Warrant was returned to Treasury and canceled.
Undelivered	Warrant returned to Treasury as undelivered,
Stopped	Warrant no longer valid-**must not** be cashed.
Submitted mm/dd/yyyy	Warrant was processed and will be issued the week of the submitted date. Warrant number and warrant date are blank.
DAFRDEL	Warrant never paid. Contact Office of Adult Services.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

GENERAL POLICY

The department is responsible for determining accurate payment for services. When payments are made in an amount greater than allowed under department policy, an overpayment occurs. When an overpayment is discovered, corrective actions must be taken to prevent further overpayment and to recoup the overpayment amount.

OVERPAYMENT TYPES

The overpayment type identifies the cause of an overpayment:

- Client errors.
- Provider errors.
- Administrative or departmental errors.
- Department upheld at an administrative hearing.

Appropriate action must be taken when any of these causes occur.

Client Errors

A client error occurs when the client receives more benefits than they were entitled to because the client provided incorrect or incomplete information to the department.

A client error also exists when the client's timely request for a hearing results in deletion of a negative action issued by the department and one of the following occurs:

- The hearing request is later withdrawn.
- The Michigan Administrative Hearing Services (MAHS) denies the hearing request.
- The client or authorized representative fails to appear for the hearing and MAHS gives the department written instructions to proceed with the negative action.
- The hearing decision upholds the department's actions.

Client error can be deemed as intentional or unintentional. If the client error is determined to be intentional, refer to ASM 166, Fraud -Intentional Program Violation.

Unintentional Client Overpayment

Unintentional client overpayments occur when either:

- The client is unable to understand and/or perform their reporting responsibilities to the department due to physical or mental impairment.

Example: The client was unable to fulfill his or her reporting responsibilities due to a hospitalization. However, the specialist must identify if this scenario falls within the scope of provider error.

- The client has a justifiable explanation for not giving correct or full information.

All instances of unintentional client error must be recouped. **No fraud referral is necessary**.

Provider Errors

Service providers are responsible for correct billing procedures. Providers must only bill for hours and services delivered to the client that have been approved by the adult services specialist. Providers are responsible for refunding overpayments resulting from an inaccurate submission of hours. Failure to bill correctly or refund an overpayment is a provider error.

Example: Client was hospitalized for several days and the provider failed to report changes in service hours resulting in an overpayment.

Provider error can be deemed as intentional or unintentional. If the provider error is determined to be intentional; see ASM 166, Fraud - Intentional Program Violation.

All instances of unintentional provider error must be recouped. **No fraud referral is necessary.**

Administrative Errors

An administrative error is caused by incorrect actions by the department.

Computer or Mechanical Process Errors

A computer or mechanical process may fail to generate the correct payment amount to the client and/or provider resulting in an overpayment. The specialist must initiate recoupment of the overpayment from the provider or client, depending on who was overpaid (dual-party warrant or single-party warrant).

Specialist Errors

An adult services specialist error may lead to an authorization for more services than the client is entitled to receive. The provider delivers, in good faith, the services for which the client was not entitled to, based on the specialist's error. When this occurs, no recoupment is necessary.

Note: If overpayment occurs and services were **not** provided, recoupment must occur.

Administrative Hearing Overpayments

When a client makes a timely request (90 days) for an administrative hearing regarding a negative action, the proposed negative action is delayed pending the outcome of the hearing.

Overpayments result when one of the following occurs:

- The hearing request is withdrawn.
- The client fails to appear for the hearing.
- The Department's negative action is upheld.

When any of the above takes place, the specialist must begin the recoupment process for any overpayments that occurred after the effective date of the negative action.

PREVENTION OF OVERPAYMENTS

During the initial assessment and subsequent case reviews , the adult services specialist must inform the client and provider of their reporting responsibilities and act on the information reported back to the department prior to an overpayment occurring. The client and/or provider should be reminded of the following:

- Home help recipients are required to give complete and accurate information about their circumstances.
- Recipients and providers of home help are required to notify the adult services specialist within **10 business days** of any changes including but not limited to hospitalization, nursing home or adult foster care/home for the aged admissions.
- The recipient and/or provider agree to repay or return any payments issued in error to the State of Michigan for home help services not rendered.
- A timely hearing request can suspend a proposed reduction in the approved cost of care. However, the client must repay the overpayment amount if either:
  - The hearing request is later withdrawn.
  - The Michigan Administrative Hearings System (MAHS) denies the hearing request.
  - The client or authorized representative for the hearing fails to appear for the hearing and MAHS give the department written instructions to proceed with the negative action.
  - The hearing decision upholds the department's actions.

Terms and Conditions

All home help providers agree to a series of terms and conditions upon enrollment in the Community Health Automated Medicaid Processing System (CHAMPS). Individual home help providers agree to terms and conditions monthly when submitting their electronic services verification (ESV) in CHAMPS.

Individual home help providers who submit monthly paper services verifications (PSV) receive a cover letter with a list of terms and conditions. By signing the PSV, the provider understands and agrees to the terms and conditions.

RECOUPMENT METHODS FOR ADULT SERVICES PROGRAMS

The MDHHS Medicaid Collections Unit (MCU) is responsible for recoupment of overpayments for the adult services programs. The

adult services specialist is responsible for notifying the client or provider in writing of the overpayment.

The adult services specialist **must not** attempt to collect overpayments by withholding a percentage of the overpayment amount from future authorizations or reducing the full amount from a subsequent month.

Recoupment Letter for Home Help (DHS-566)

When an overpayment occurs in the home help program, the adult services specialist **must** complete the DHS-566, Recoupment Letter for Home Help, located under the forms module in ASCAP.

ASCAP will solicit all necessary information to complete this letter. The specialist must supply the following:

- Determine if the recoupment is solicited from the client or provider.
- The reason for recoupment.
- Warrant details and service period.
- The **exact time period** in which the overpayment occurred.
- The amount of the overpayment.

  Note: The overpayment amount is the net amount (after the FICA deduction), not the cost of care (gross) amount.

Additional Instructions When Completing DHS-566

Consider the following points when completing the DHS-566:

- If the overpayment occurred over multiple months, the DHS-566 will reflect the entire amount to be recouped.

  Note: A separate DHS-566 is **not** required to reflect an overpayment for multiple months for the same client.

- Two party warrants issued in the home help program are viewed as client payments. Any overpayment involving a two party warrant must be treated as a client overpayment.

Exception: If the client was deceased or hospitalized and did not endorse the warrant, recoupment must be from the provider.

- Overpayments must be recouped from the provider for single party warrants.
- **When there is a fraud referral, do not send a DHS-566 to the client/provider** (refer to ASM 166, Fraud - Intentional Program Violation).
- Warrants that have **not** been cashed are **not** considered overpayments. These warrants must be returned to Treasury and canceled.

Distribution of the DHS-566

Upon completion, a copy of the DHS-566 is electronically forwarded to the MDHHS Medicaid Collections unit mailbox at MDHHS-Medicaid-Collections-Unit@michigan.gov.

The specialist sends two copies to the client/provider. The client/provider keeps a copy for their records and sends the other copy to MDHHS Medicaid Collections unit along with a check or money order for the overpayment amount.

An electronic version of the DHS-566 is stored in ASCAP under the contacts module.

Recoupment Letter for ACP/HA (DHS-567)

Follow the same procedures as the DHS-566. The recoupment letter for the adult community placement program is always sent to the adult foster care or homes for aged provider.

Recoupment for APS Payments

The adult services specialist must utilize the DHS-566 when recouping an overpayment for Adult Protective Services. The specialist must access the DHS-566 from the online Forms Library and complete it manually crossing out home help and inputting APS.

Follow the instructions for completing the form mentioned previously in this item.

Overpayments Returned to the Local County MDHHS Office

Overpayments returned to the local county MDHHS office must be forwarded to the MDHHS Medicaid Collections unit in accordance to ACM 430, Cash Handling-General Policy.

Example: A provider serving multiple clients cashes a warrant after discovering the warrant included funds for a client they no longer serve. The provider writes a personal check in the amount of the overpayment and returns it to the local county MDHHS office.

The adult services specialist must complete a DHS-566 and forward to the Medicaid Collections unit. A copy of the 566 does **not** have to be mailed to the client/provider since the overpayment was returned.

Overpayments Returned to the MDHHS Medicaid Collections Unit

There are occasions when a client or provider will return an overpayment directly to the Medicaid Collections unit (MCU) prior to notifying the adult services specialist of the error. In these instances, MCU will require the adult services specialist to complete a recoupment letter for the overpayment amount returned to the state.

Repay Agreements

All repay agreements for home help and adult community placement overpayments are established by the Medicaid Collections Unit.

Withdrawal of Recoupment

If a recoupment is rescinded by the adult services specialist, the Medicaid Collections Unit **must** be notified in writing via email that the recoupment has been canceled.

The specialist must provide the following information when requesting a recoupment be rescinded:

- Client name.
- Client recipient ID number.
- Provider name.
- Provider ID number.
- Amount of recoupment.
- Reason for rescinding the recoupment.

Verification of Recoupment

Upon receipt of the DHS-566, the Medicaid Collections Unit will create a receivable account so funds are properly tracked and credited.

If the adult services specialist needs to verify an overpayment has been recouped, contact the Medicaid Collections unit via their email box at MDHHS-Medicaid-Collections-Unit@michigan.gov.

LEGAL REQUIREMENTS

Social Welfare Act, 1939 PA 280, as amended, MCL 400.14(1) (p).

OVERVIEW

Intentional Program Violation (IPV) occurs when the client, provider and /or client's authorized representative intentionally make a false or misleading statement, hides or misrepresents/withholds facts to receive or to continue receiving benefits. IPV is considered fraud and must be reported to the Office of Inspector General.

Client Suspected of Intentional Program Violation (IPV)

Suspected intentional program violation (IPV) means an overpayment exists when all three of the following conditions occur:

- The client (or legally responsible party) **intentionally** failed to report information or gave incomplete or inaccurate information needed to make a correct benefit determination.
- The client was clearly instructed regarding his or her reporting responsibilities to the Department.

  Note: A signed DHS-390, Adult Services Application instructs the client of their reporting responsibilities. The specialist must reiterate the client's responsibility to report any changes **within 10 business days** during the client case reviews.
- The client has no apparent physical or mental impairment that limits his or her understanding or ability to fulfill their reporting responsibilities.

Intentional program violation (IPV) is suspected when there is credible evidence that the client has **intentionally** withheld or misrepresented information for the **purpose** of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility. In such cases where these conditions exist, make a fraud referral to the Office of Inspector General (OIG).

Example: The client (or legally responsible party) intentionally reports inaccurate or incomplete information to conduct an accurate comprehensive assessment of need for home help.

No recoupment action is taken on cases that are referred to OIG for investigation, while the investigation is being conducted.

Providers Suspected of Intentional Program Violation (IPV)

A suspected provider intentional program violation (IPV) is an overpayment caused by a provider's intentional false billings or intentional inaccurate statements. Examples of provider overpayment that may be an IPV are:

- Failing to bill correctly (intentionally submitting an incorrect invoice).
- Receiving payment for hours when the client was unavailable; such as but not limited to hospitalizations, nursing home or AFC stays.
- Receiving payment for hours when the provider was unavailable and/or did not provide the care.

Example: Provider receives and cashes a single party warrant for a time period he or she is unavailable and did **not** provide care.

Intentional program violation is suspected when there is credible evidence that the provider has intentionally withheld or misrepresented information for the purpose of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility.

No recoupment action is taken on cases that are referred to OIG for investigation, while the investigation is being conducted.

OIG REFERRAL CRITERIA

When an adult services specialist believes fraud has occurred within the home help program, the specialist must make a referral to the Office of Inspector General (OIG). Prudent judgement should be used in evaluating an overpayment for suspected IPV.

Consider the following questions when reviewing the case for fraud:

- Does the case record indicate department staff advised the client of his or her rights and responsibilities?

Note: The DHS-390 instructs clients of their rights and responsibilities; however the specialist must remind the client and provider of his or her reporting responsibilities at each case review.

- Does the case narrative reflect the client's acknowledgement of these rights and responsibilities?
- Did the client or provider neglect to report timely when required to do so after being informed of their responsibility to report?
- Did the client or provider make false or misleading statements?
- Does the client or provider error meet suspected IPV criteria?

Home Help Fraud/IPV Scenarios

The following scenarios are provided as guidance for when a home help fraud referral should be made to the Office of Inspector General:

- Client alters or forges the DHS-54A, Medical Needs form in order to become eligible for services.
- Client forges the provider's signature on a dual-party warrant and services were **not** provided.

  Note: If the client forges the provider's signature on a dual-party warrant and services **were** provided, this becomes a civil matter and should **not** be referred to OIG.

- Client/provider has an arrangement to split the warrant and services were **not** provided.
- Provider reports earnings indicated on his/her W-2 are inaccurate and the specialist discovers services were not provided..

Example: Provider asserts he or she ended services on a specific date but the warrants continued to be cashed under their name.

- Client fails to disclose changes that would affect their eligibility or cost of care and was clearly instructed regarding their reporting responsibilities.

Example: Client gets married and the spouse is able and available to provide care.

Example: Client's health improves and they fail to report the change in care needs.

Example: Client fails to disclose others living in the home which would affect their proration for instrumental activities of daily living (IADL).

- The provider cashes the warrant when the client was unavailable.

Example: Client was admitted into a nursing facility and the provider continued to cash the warrant(s).

- The provider continues to receive and cash warrants after the client's death.

If the specialist questions the appropriateness of a referral, it should be forwarded to OIG who will determine whether to investigate.

Making a Referral to OIG

Refer all suspected cases of fraud/IPV in the home help program to OIG using the DHS-1131, Medicaid Services Fraud Intake Form. This form must be used in lieu of the DHS-834, Fraud Investigation Request. Complete the DHS-1131 and provide copies of all supporting documentation that would assist in the investigation.

Scan and send the DHS-1131 and supporting documentation to the OIG Fraud Complaint mailbox at:

DHS-OIG-FraudComplaints@michigan.gov

The adult services specialist will be notified if a referral is denied for investigation.

No recoupment action is taken on cases that are referred to OIG for investigation, while the investigation is being conducted.

Threshold

Provider fraud has **no** threshold and should be reported to OIG. A provider IPV overpayment of $500 or greater is a felony.

Client suspected IPV has a threshold of $500. A referral to OIG must be made if the total overpayment is **less** than $500, **and** one of the following conditions exists**:**

- The client has a previous IPV, **or**
- The client has had at least two client errors previously, **or**
- The alleged fraud is committed by a state government employee.

If the overpayment is less than $500 and doesn't meet the conditions above, refer to ASM 165, Overpayment and Recoupment Process.

OIG RESPONSIBILITIES

The MDHHS Office of Inspector General is the sole contact point for all fraud referrals pertaining to home help and the investigation will be assigned based on the investigation type (client or provider).

Referrals are made to the Attorney General Medicaid Healthcare Fraud Division for prosecution when there is credible evidence of fraud that exceeds $4000.

Action Taken by OIG

Within 12 months OIG will:

- Refer suspected IPV cases that meet criteria for prosecution to the prosecuting attorney or AG's office.
- Refer suspected IPV cases that meet criteria for IPV administrative hearings to the Michigan Administrative Hearings System (MAHS).
- Return all non-IPV client cases to the adult services specialist to initiate recoupment.
- Pursue recoupment for non-IPV provider cases. A Recoupment Letter is sent to the provider with a copy to MDHHS Medicaid Collections Unit and the adult services specialist. **No further action is required by the adult services specialist.**

  Note: OIG will not send a copy of the recoupment letter to the local county MDHHS office if the case is closed.

IPV Hearings

OIG shall request an IPV hearing when there is no signed DHS-4350, Intentional Program Violation Repayment Agreement obtained and correspondence to the client is returned as undeliverable, or a new address is located.

The department may request a hearing to:

- Establish an intentional program violation against the client.
- Establish a collectable debt (client debt).

HOME HELP PROVIDER SUSPENSION

Pursuant to federal law, codified at 42 CFR 455.23, a state Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual provider or entity, unless there is good cause not to suspend.

The MDHHS OIG will notify the adult services program office when a credible allegation of fraud is evident against a home help provider. The AS Program Office will contact the local MDHHS office and instruct the specialist to suspend the payment authorization(s). The MDHHS Provider Enrollment unit will be notified to end date/suspend the provider eligibility in CHAMPS. OIG will inform the local office and the program office if the provider suspension is lifted.

RECOUPMENT

No recoupment action should be taken on cases that are referred to OIG for investigation until notified.

OIG will notify the referring adult services specialist of non-IPV substantiated cases of client fraud. The specialist will be responsible for initiating the recoupment.

OIG will initiate recoupment on provider fraud cases investigated but denied for prosecution. OIG will send the provider a recoupment letter and forward a copy to the MDHHS Medicaid Collection unit for recoupment. **No further action is needed by the adult services specialist.**

FRONT END ELIGIBIITY (FEE)

The Office of Inspector General established the Front End Eligibility (FEE) program in response to the need for fraud prevention. The goal of the FEE program is to obtain and maintain a partnership between the MDHHS local office staff early in the eligibility determination process in order to reduce errors.

FEE Referral

The adult services specialist may request a pre-eligibility investigation by the OIG regulation agent when it is believed the client is intentionally misrepresenting the need for home help. Referrals for FEE are also accepted for open cases when it is believed a client is misrepresenting the need for continued care.

Examples of an appropriate FEE referral for home help would be the following:

- A home help case is denied due to a spouse (responsible relative who is **able** and **available**) in the home and client later reapplies claiming the spouse has moved out of the home.
- The specialist suspects the client and provider of home help are married to one another and they are not disclosing their marital status.
- The client indicates he or she lives alone either verbally or on the DHS-390, Adult Services Application but Bridges shows others living in the home.
- Client's medical condition improves and fewer services are needed but the client/provider fails to report.

Components of a Quality FEE Referral

The following are components of a quality FEE referral:

- The case should be active or pending for benefits.
- Ensure that policy supports why the client may not be eligible.
- Provide accurate case demographics.
- Attach all supporting documentation.

To make a FEE referral, select the hyper link which states Front End Eligibility (FEE) Referral Form on the MDHHS-Net under Hot Topics.

OIG regulation agents must complete the investigation within ten business days and respond to staff with their findings. Investigations are completed prior to opening the case or recertifying the applicant for benefits.

CASE CLOSURE PROCEDURES

There are specific actions that must occur when closing an adult services case.

Note: Adult services specialists may chose to suspend payments, and delay case closure, if it appears the situation may be temporary.

Termination of Home Help Payments

Home help services payments may be terminated and closing procedures initiated, in any of the following circumstances:

- The client fails to meet any of the eligibility requirements.
  - Medicaid eligible.
  - Medical professional does not certify a need for services on the DHS-54A, Medical Needs form.
  - Assessment determines client no longer requires home help services.
- The client no longer wishes to receive home help services.
- The client is receiving services from another program and this would result in a duplication of services.

Suspension of Home Help Payments

The adult services specialist may choose to suspend payments, rather than terminate payments and initiate closing procedures, in the following circumstances:

- Client's Medicaid has ended and it appears to be temporary.
- Client's provider fails to meet qualification criteria. This allows the client time to locate a new provider.
- Provider logs were not submitted timely but it is believed the client and provider will return completed forms within a specified time period noted on a negative action notice.

Note: Any suspended payment action must be temporary. The adult services specialist should allow no more than 90 days for the situation to be resolved. (The DHS-390, Adult Services Application and the DHS-54A, Medical Needs form, are valid for 90 days after case closure). Case closure procedures should be initiated once it has been determined the situation that resulted in the suspension will not be resolved.

Notification of the Negative Action

When home help services are terminated, suspended or reduced for **any** reason, a DHS-1212, Advance Negative Action Notice, must be generated in **ASCAP** and sent to the client advising of the negative action and explaining the reason for the action; see ASM 150, Notification of Eligibility to determine need for 10 business day notice of action.

A copy of the DCH-0092, Request for Hearing form is automatically generated from ASCAP when the DHS-1212 is printed. This must be forwarded to the client with the negative action notice.

Administrative Hearing Requests

Clients have the option to request an administrative hearing on all negative actions.

If the client requests a hearing before the effective date of the negative action, and the specialist is made aware of the hearing request, continue payments until a hearing decision has been made. If the specialist is made aware of the hearing request after payments have ended, payments must be reinstated pending the outcome of the hearing. Offer the client the option of suspending payments until after the hearing decision.

Note: When payments are continued pending the outcome of a hearing, the client must repay any overpayments if the Department's negative action is upheld. Initiate recoupment procedures by sending the client a DHS-566.

ASCAP Procedures for Case Closure

All client information and corresponding screens must be updated in ASCAP prior to case closure. The **Disposition** module in

ASCAP must be completed, including a **detailed** description of the reason for case closure.

Note: All payments **must be** ended before closing procedures have been completed.

Reopening a Services Case

If a case has closed and reopens within 90 days, a new DHS-390, Services Application and DHS-54A, Medical Needs form are **not** required.

Exception: If the reason for closure was due to a Medical Needs form that indicated the client did not require services, a new DHS-54A is required.

If the case was receiving expanded home help services at closure and required MDCH approval, a new approval is not required (within 90 days) **unless** it is determined additional services are needed.

Note: The adult services specialist **must** conduct a face-to-face contact and complete an assessment prior to authorizing payment.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

PROGRAM DEFINITION

Adult protective services provide protection to vulnerable adults who are at risk of harm due to the presence or threat of any of the following:

- Abuse.
- Neglect.
- Exploitation.

PROGRAM GOAL

This program addresses the goal of protection.

This program will:

- Provide immediate (within 24 hours) investigation and assessment of situations referred to the agency when a vulnerable adult is suspected of being or believed to be abused, neglected, or exploited.

- Assure that adults in need of protection are living in a safe and stable situation, including legal intervention, where required, in the least intrusive or restrictive manner.

PROGRAM ELIGIBILITY

Program services are available to any adult who is reported to be at risk of harm from abuse, neglect, or, exploitation, and where there is a reasonable belief that the person is vulnerable and in need of protective services.

AVAILABLE SERVICES

The following services are available or may be sought and utilized for APS clients:

- Protection.

  The components are:

  - Protective services investigation.
  - Social protection.
  - Financial management.
  - Conservatorship/guardianship/civil commitment.

- Counseling.
- Education and training.
- Family planning.
- Health related medical examinations and evaluations.
- Home help special eligibility component.
- Homemaking.
- Housing.

Special Components:

- Emergency Shelter/Relocation Options.

DEFINITIONS

See Adult Services Glossary (ASG) for definitions.

LEGAL REQUIREMENTS

The legal basis for the APS program is 1939 P.A. 280 as amended by 1982 P.A. 519, 1987 P.A. 208, 1966 P.A. 189, 1988 PA422, and 1990 PA122 (See ASM 385A).

Mandatory Reporters to APS

A referral from any source must be documented and reviewed to determine if it meets requirements for investigation. Certain persons, however, are required by 1982 P.A. 519 to make an **oral report** regarding suspected abuse, neglect or exploitation of adults to the department**.** Those required persons are:

- Those employed, licensed, registered, certified to provide **or** an employee of an agency licensed to provide:
  - Health care.
  - Education services.
  - Social welfare services.
  - Mental health services.
  - Other human services.
- Law enforcement officers.
- Employees of a county medical examiner.
- Physicians.

Additionally, Michigan Department of Health and Human Services (MDHHS) **must report to a police agency any criminal activity** it believes to be occurring **upon receipt of the report.**

Mandatory Reporters to Other Departments

The following persons are required to report to the Department of Licensing and Regulatory Affairs (LARA) when there are allegations of abuse, neglect or exploitation of vulnerable adults residing in facilities licensed by LARA; see ASM 210 for a list of these facilities:

- Nursing home employee, administrator, nursing director.
- Physician or other licensed health care personnel of a health care facility to which a patient is transferred.

Note: An APS report to MDHHS is not required as provided in the Public Health Code, P.A. 368 of 1978 (MCL 333.21771), however, if an employee wishes to make an anonymous referral, they may do so by calling the Centralized Intake for Abuse and Neglect hotline (CI). The CI staff must forward this referral to LARA, **maintaining the anonymity of the referral source.**

REFERRALS

All referrals, requests and complaints that allege an adult is vulnerable and is being or is at risk of being abused, neglected or exploited must be documented accurately on ASCAP by CI. Each referral is then reviewed by a CI manager for assignment decision. The CI toll-free number is 855-444-3911; see ASM 207 for CI processes.

During Regular Business Hours

All APS referrals received during normal business hours, that meet criteria for investigation, are assigned to and addressed by an APS worker.

After Business Hours/On Call

All APS referrals received after business hours, that meet criteria for investigation, must be addressed **promptly by local office on-call staff**. Local offices must take necessary steps to ensure that prompt response and follow-up to complaints made after normal working hours are made. These steps include:

- Imminent threat of danger requires face-to-face with client as soon as possible.
- No imminent threat of danger requires:
  - 24-hour contact with the client or collateral person by phone or face-to face.
  - 72-hour face-to-face with client.

Note: APS staff (this may include adult services workers who have received APS training) provide on-call coverage for holidays and weekends. CPS staff continue on-call coverage weeknights (excluding holidays that fall on a Monday-Thursday). On-call coverage begins at 5:00 p.m. the first day of on-call and ends at

8:00 a.m. the next business day.This includes LARA licensed facilities for emergency and life threatening situations. MDHHS staff must provide services to resolve the immediate emergency and inform LARA of the referral the next working day.

Example: If a licensed nursing home requires immediate evacuation due to a natural disaster, such as a flood or fire, MDHHS is responsible to ensure the safe relocation of each resident.

Required Information

The reporting person is required to give the following information:

- Name of the adult.
- Description of the abuse, neglect or exploitation.
- Other information available to the reporting person on the cause and manner of the abuse, neglect, or exploitation.

If available:

- The adult's age.
- The identity and the address of the guardian or next of kin.
- The identity, the address, and the relationship of those with whom the adult resides.

The person who receives the referral must gather as much information as possible, such as dates, names, addresses and phone numbers of involved or knowledgeable persons. Special effort should be made to gather information which can be used to determine if the adult is vulnerable and in need of protective services.

Confidentiality

The identity of the referral source (RS) **must** be confidential unless MDHHS is given written permission by the RS or is ordered by a court to release the RS identity.

Note: To further protect the RS identity, workers should not read the referral allegations word-for-word to any individual outside of the department.

Freedom of Information Act

The entire department record, except for the identity of the referral source, as noted above, may be subject to disclosure under the Freedom of Information Act (FOIA). However, the

Freedom of Information Act provides that the **department may exempt information of a personal nature from disclosure where the public disclosure of the information would constitute a clearly unwarranted invasion of an individual's privacy.**

Since other information may also be confidential in addition to the above, **All FOIA requests must be submitted immediately to** the Policy and Field Legal Services**, FOIA** email address: MDHHS-FOIA@michigan.gov**.**

Substance Abuse Treatment Agencies

There are special confidentiality guidelines that apply when working with adults who have been referred to MDHHS by substance abuse treatment agencies. The federal regulations for confidentiality of alcohol and drug abuse are found in 42 CFR Part 2. Use the following guidelines:

- Information regarding the client's involvement in the substance abuse treatment program must be held confidential. It can be shared only if the adult is willing to sign a release. The DHS-27, Authorization to Release Information, is to be used. Other case information may be shared with other agencies when it is in the best interest of the client; see Services General Requirements Manual (SRM) 131, Confidentiality.
- Prior to involving these adults with the prosecuting attorney or in judicial proceedings contact either:

MDHHS
Aging and Adult Services Policy Unit
MDHHS-Adult-Services-Policy@michigan.gov

MDHHS
Behavioral Health and Developmental Disabilities Administration
Office of Recovery Oriented Systems of Care
517-373-4700

Social Media

MDHHS employees should comply with all confidentiality laws and policy noted in the Services General Requirements manual, item SRM 131 when using social media sites. See SRM 131, pg. 1 for additional guidance.

Note: Refer to SRM 131 for more information regarding confidentiality.

ASCAP

The Adult Services Comprehensive Assessment Program (ASCAP) is the automated workload management tool for APS. Documentation for all the APS functions must be completed on ASCAP, including all collateral and face to face contacts.

INTAKE/ REGISTRATION

- Each local office must have a designated APS complaint coordinator who reviews all referral decisions made by the CI managers. The complaint coordinator is responsible for ensuring that all assigned APS referrals are assigned to an APS worker and responded to timely, according to statutory and policy requirements.The APS complaint coordinator will review cases assigned by CI through an ASCAP command button labeled "Assignments from CI".
- The APS complaint coordinator will review cases denied or withdrawn by CI through an ASCAP command button labeled "CI Dispositions".

Note: The APS complaint coordinator must follow the reconsideration process for any assigned, denied or withdrawn decisions they disagree with. The reconsideration process can be found in ASM 207, Centralized Intake For Reports of Abuse and Neglect.

Multiple Referrals for One Individual

MDHHS may receive multiple referrals on any individual. Each referral must be documented on ASCAP by CI and reviewed by a CI manager for assignment decision.

When a new referral contains only allegations which are being addressed in an ongoing investigation, as determined by case documentation, the referral must be denied. The CI manager must send an APS Referral Denial letter to the referral source indicating

the allegations are currently under investigation. Each denial letter is printed on local office letterhead to provide the RS a local office contact number.

When a referral contains allegations that are not being addressed in an ongoing investigation, the referral must be reviewed to determine if it meets criteria for a new APS investigation. If the referral meets criteria for an APS investigation, it must be assigned. CI will transfer the referral as open to the local office.The complaint coordinatormust send an APS Referral Acknowledgement letterto the RS.

The APS worker and supervisor must ensure that ASCAP documentation is updated within 10 calendar days, and that all allegations which are being addressed are included in the case documentation, including the *Harm Types* tab in the Investigation module of ASCAP, case contacts and/or general narrative. CI will review the Harm Types tab to determine if the current allegations are being addressed in the ongoing APS investigation.

Note: When a referral contains allegations that have been previously investigated, CI must review the referral to determine if a new investigation is warranted as the client's circumstances may have changed and/or a previous intervention did not alleviate the client's needs on a long-term basis.

COMPLAINT ASSESSMENT/ ASSIGNMENT

The CI manager will review referral information and determine if there is sufficient justification to warrant assignment for an APS investigation. Both of the following criteria must be met:

- The subject of the reported referral is an adult at risk of harm from abuse, neglect, or exploitation.
- There is reasonable belief the person is vulnerable and in need of protective services.
  - MCL 400.11 defines vulnerable as "..a condition in which an adult is unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or advanced age."

Note: If it is determined, based on information provided or information that is already known to the department, that the

reported concerns are resolved and the individual is no longer at risk of harm from abuse, neglect or exploitation the referral must be denied. The information used to make this determination must be documented in CI's referral decision in the general narrative of ASCAP. CI must still determine if the referral is required to be forwarded to another investigative or regulatory authority.

If both criteria, listed above, exist, the CI manager must assign the referral to the local office APS complaint coordinator as quickly as possible . The APS complaint coordinator will review the open APS case and assign a worker for an APS investigation and assessment.The location of a vulnerable adult at risk of harm in temporary settings is not cause for denying a referral. Examples of temporary settings include, but are not limited to:

- Hospitals.
- Homeless shelters.
- Domestic violence shelters.

These are not considered safe, stable or protected settings or settings where an individual is not at risk of harm as they are temporary and the individual may require protection and assistance returning to or locating a new, appropriate setting.

APS **will** conduct investigations in temporary settings when the individual meets the criteria of vulnerable and at risk of harm to ensure relocation to a safe, stable environment.

Notification to the Complainant

The complainant **must be** notified in writing that the referral has been received and is being investigated, or that the complaint is not appropriate for an APS investigation. The APS Referral Acknowledgement letter and APS Referral Denial letter are generated on ASCAP through the forms module of the APS referral.

The APS Referral Denial letter must be printed and mailed to the RS by CI. The letter must include the specific reasons why the complaint was not accepted for investigation (for example: the individual does not meet statutory definition of vulnerable; there is not sufficient information to determine the adult is at risk of harm, etc.).

The local office APS complaint coordinator or supervisor must print and mail the APS Referral Acknowledgement letter for all APS referrals assigned by CI for investigation. The letter must include the name and contact information of the assigned APS worker.

INVESTIGATION PROCESS

The worker must commence an investigation of all assigned referrals within 24 hours of the time the complaint was received by CI to determine if the person reported as being abused, neglected, or exploited is actually an adult in need of protective services.

Note: The worker must commence the investigation as soon as possible**, if** CI determines there is risk of imminent danger to the client. A CI manager will contact the local office complaint coordinator or on-call staff when it is determined there is risk of imminent danger.

Standard of Promptness (SOP)

There must be one contact within 24 hours by phone or in-person with either the client or a collateral contact for all cases assigned for investigation.

Note: Contact with the **referral source** does not meet the above criteria for the initial contact required for the commencement of an investigation.

The purpose of this initial response is to determine need for protective services and degree of risk.

Note: Any 24-hour contact that is unsuccessful, must be documented in ASCAP using either a Misc. (collateral) contact type or a F2F attempted (client) contact type (use only for attempted F2F with client)**.**

During the investigation, the worker must conduct a face-to-face interview with the adult by means of a personal visit in the adult's dwelling, the worker's office, or any other suitable setting. **The face-to-face interview must be completed within 72 hours from the time the complaint was received** at CI**.** If a face-to-face contact

with the client is completed within 24 hours, the 72 hour face-to-face policy has been met.

The worker must make all attempts possible to conduct the initial face-to-face interview with the client **alone**. The worker must interview the alleged perpetrator during the course of the interview, unless there is reason not to do so. These reasons may include, but are not limited to the following:

- The alleged perpetrator is unknown.
- Law enforcement requests APS to not interview the alleged perpetrator.
- There is reason to believe this will increase risk of harm to the client.
- There is reason to believe this will create a worker safety issue.

Note: Any 72-hour face-to-face contact that is unsuccessful must be documented in ASCAP utilizing a F2F attempted (client) contact type**.**

Investigation

Statutory Requirements

The worker must determine in the investigation if the allegation of abuse, neglect, or exploitation is substantiated or unsubstantiated.

Pursuant to the Social Welfare Act the investigation/assessment must include:

- A determination of the nature, extent and cause of the abuse, neglect, or exploitation.
- Examination of evidence.
- Identification, if possible, of the person responsible for the abuse, neglect, or exploitation.
- The names and conditions of other adults in the place of residence.
- An evaluation of the persons responsible for the care of the adult, if appropriate.
- The environment of the residence.

- The relationship of the adult to the person responsible for the adult's care.
- An evaluation as to whether or not the adult would consent to receiving protective services.
- The adult's capacity for self-care and management of personal and financial affairs.
- The adult's willingness and capacity to use available resources and services.
- Extent to which natural helping network (friends, relatives, neighbors) is available, capable and willing to provide protection.
- Extent to which needed community resources, for example, social, medical, financial, legal, psychiatric, etc. are available, capable and willing to provide services.
- Feasibility of developing resources required to meet protective goal.

Photographs

APS may take photographs of the adult and/or their environment with the verbal consent of the adult (who is believed to have the capacity to make informed decisions) or their legal representative. The taking and/or use of photographs must end if the individual's consent is retracted.

The circumstances listed below may occur and should be handled by the AS worker in the following manner:

- If the client has a guardian but the guardian is not present to provide consent, the AS worker may take photographs of the client and common areas of the household ***with the client's consent***.
- If the client's guardian does not consent to photographs but the client does, the AS worker ***must not take photographs***.
- If the client consents to photographs but resides in the home of another who is not present to give consent, the AS worker ***may take photographs of the client and common areas of the household***.

- If the client consents to photographs but resides in the home of another who ***does not give consent*** to photograph the home, the AS worker may take photographs of the client only.

- Photographs of a home's exterior may be taken without consent as long as the photographs are taken from areas that are visible and legally accessible to the public (for example: sidewalk, side of the road). The AS worker may not enter an enclosed area, such as a fenced yard or an area posted as no trespassing to take photographs.

Both consent and/or retraction of consent must be clearly documented in the general narrative section of ASCAP including date and time consent was given and/or retracted and by whom it was given or retracted.

Risk Assessment

The purpose of the APS risk assessment is to measure the level of risk of harm to the client. It also serves to measure the impact of intervention by APS workers. This process is designed to determine client safety and possible continuation or reoccurrence of harm. The assessment is intended to:

- Serve as a guideline for prevention and service plan development.
- Manage protection and risk.
- Focus available resources to areas of highest need.

The assessment will provide a snapshot view of the case after the initial face-to-face client contact and after intervention.

The APS risk assessment consists of five risk factors:

- Client.
- Environment.
- Transportation and support service.
- Current and past referrals.
- Perpetrator.

Each risk factor is scored 1 through 5:

- **(1) No Risk:** Client is living in a safe and stable environment.

- **(2) Low Risk:** Circumstances that caused the risk are not likely to recur or to escalate in severity.

- **(3) Immediate Risk:** There is a possibility that the risk will escalate and the area of concern warrants attention.
- **(4) High Risk:** Risk is severe and places the client in danger.
- **(5) Insufficient Information:** The inability to assess the client's safety puts him or her at risk.

Completion of APS risk assessment is required at:

- Case opening.
- Case closing.
- Whenever there is a perceived change in harm or vulnerability.

Note: Risk assessments which are scored as moderate or high risk at the time the APS worker is ready to close the case, require supervisory review and written approval (to be included in the ASCAP general narrative) prior to case closure**.**

All of the above requirements are independent of substantiation status.

Provision of Protective Services

The worker must offer APS intervention when the investigation and assessment determine the adult is in need of protective services because the adult is vulnerable and at risk of harm due to the presence or threat of any of the following:

- Abuse.
- Neglect.
- Exploitation.

The worker must make available the most appropriate and least restrictive protective services to the client, in all substantiated referrals. These services are to be offered as available, directly or through approved purchase of service contracts from other agencies or professionals (MCL 400.11b(6)).

> **Note:** The worker must offer services to clients in unsubstantiated cases when a need is determined and provision of the offered services (provided directly or through approved purchase of service contracts) will reduce the risk of the need for future APS intervention. The client or their legal representative must be willing to accept any offered services.

The worker must take necessary action in all substantiated referrals to safeguard and enhance the welfare of the adult, if possible (MCL 400.11b (6)).

The worker must report any actual or suspected violations of licensing laws/rules to the appropriate authority, for example, the LARA licensing consultant for alleged noncompliance with the licensing statute, administrative rules or terms of the license.

MDHHS CI and adult services staff must report any actual criminal activity or any criminal activity it believes to be occurring to the appropriate law enforcement agency; see ASM 210.

The worker must contact the local substance abuse treatment agency to determine the availability of services when the abuse, neglect or exploitation involves substance abuse (MCL 400.11b (6)). This information must be provided to the APS client and documented in the case record.

Social Intervention Process

Social intervention/protection services involve seeking out, developing, mobilizing, and coordinating resources of the adult, the department, other social agencies, and the community at large in order to assure protection.

Worker Responsibilities

The APS worker's responsibilities in the social intervention/protection process include the following:

- Begin immediately, upon first contact with the client, to do whatever is necessary to respond directly to the client’s needs when other sources of assistance are inadequate or cannot be obtained promptly.
- Place primary emphasis upon developing and enhancing the individual's coping abilities.
- Explore and make maximum use of resources within the individual's natural helping network (for example, friends, neighbors, relatives, clergy), and the community, (utility companies, bankers, landlords, service agencies, providers and licensing personnel).

- Incorporate in the service plan, appropriate roles for involved persons or agents for the purpose of providing protection.
- Inform other responsible agents and involved parties of actions or findings they have a right and/or a need to know in order to perform their duties. **The individual's best interests are always to remain** foremost **and full rights of confidentiality and due process must be respected.**

Note: For a list of services available through APS; see ASM 220.

STANDARDS FOR ON-GOING CASES

The minimum requirements for ongoing cases are**:**

- A minimum of one face-to-face contact every 30 calendar days after the last successful face-to-face, with the client on all open APS cases.
- All alleged harm identified in the referral or discovered during the investigation must be clearly addressed in ASCAP. This may be completed in the general narrative, cause/evidence tab of the Investigation module and/or the client service plan.
- Services initiated must be provided and documented in ASCAP including how provision of services was verified. The provision of services paid for utilizing funds from the special APS home help services component must be verified, in person, and documented in ASCAP.
- Cases left open longer than six months **must** have written supervisory approval. The worker must provide documentation to the supervisor explaining why the case must remain open longer than six months. Supervisory approval must be documented in the general narrative section of ASCAP.

CASE DOCUMENTATION

Case documentation must include the following:

- **Investigation report** for substantiated and unsubstantiated cases. Unsubstantiated cases can receive prevention services.

- **Service plan** (substantiated cases, unsubstantiated cases where services are being provided, or unsubstantiated cases that remain open longer than 30 days).
- **Updated service plans** (substantiated cases, and unsubstantiated cases where services are being provided).

Handwritten or Typed Notes

Handwritten or typed notes, taken by the AS worker, must be accurately transcribed into the ASCAP system. Once transcribed, handwritten notes need not be retained.

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Documentation Standards of Promptness

- Documentation of all case activity, including any related narrative and ASCAP module updates, ***must be*** completed in ASCAP within ten (10) days of occurrence. These activities include, but are not limited to the following:All contacts.
- Alleged perpetrator details.
- Referrals to other agencies.
- Services offered.
- Alleged harm types.
- Legal interventions.
- Risk Assessment.

Investigation Report

For all cases opened to APS, the worker must complete an investigation report. The report must include:

- The nature of the client's situation/problem.
- A summary of the investigation requirements.
- A list of contacts, dates of contacts, and the nature of the contacts with client, family, and others.

- A summary of the facts/reasons for the determination that either:
  - The adult has been harmed, abused, neglected, or exploited and is vulnerable**.**
  - The adult has not been harmed and/or is not vulnerable.

Service Plan

Note: The worker must complete an initial service plan within 30 calendar days of the referral date for all substantiated cases. The worker must complete an initial service plan within 30 calendar days of the referral date for all unsubstantiated cases when services are being referred or provided **and** on all cases that remain open longer than 30 days. **If day 30 falls on a weekend or holiday, the service plan must be completed by the last working day prior to day 30.**

Services in this program must be developed with the involved adult, the adult's immediate family, whenever possible, and any other collaborative partner(s). APS must respect, to the extent possible,the client's choice regarding who he or she wishes to have involved in his or her case planning. The service plan must include:

- What issues or problems have been identified by the client or through the APS investigation.
- The steps that will be taken and who will take the identified steps, based on the information from the investigation, to address the identified problems.
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- Time frames.
- Resources given to a client including the resource name, number and purpose of the referral.
- Document the client's or their legal representative's consent to or refusal of services.

DHS 324-C, APS Service Plan

The DHS 324-C, APS Service Plan form, is for use by APS staff when developing initial service plans with APS clients. The DHS 324-C is a stand-alone form that can be printed through ASCAP

forms for each APS client. When printed, only identifying client and APS worker information is pre-filled on the form.

Note: A DHS 324-C is utilized only if the investigation requires the development of a service plan.

The APS worker completes the intial service plan, by hand, when developing the service plan with the client or their legally responsible party within 30 days. The DHS 324-C is utilized to document needs expressed by the client or observed by the worker and what steps are required to meet those needs.

Once the initial service plan is complete, the worker must sign and date the form and request the client or their responsible party sign and date the form. The signature date on the DHS 324-C provides supporting documentation that the initial service plan was initiated on that date. If no unmet needs are identified, a DHS 324-C is not required.

Note: If the client is unable to sign the service plan due to physical or cognitive limitations or is unwilling to sign, the APS worker must then obtain their supervisor's signature and date reflecting that the initial service plan has been developed.

The service plan information must still be entered in ASCAP in the Investigation module, Service Plan tab. The worker then enters the date from the 324-C form in the ASCAP Initial Service Plan Complete date on the Investigation Findings module on ASCAP.

The DHS 324-C must be maintained in the APS case file.

When the initial service plan cannot be completed within 30 calendar days, document the reason in the case record and complete the service plan as soon as possible.

Updated Service Plan

Needs identified after the 30 day, initial service plan has been completed are to be addressed in an updated service plan. An updated service plan is a written, narrative assessment of the progress toward resolving the problems identified in the service plan. The updated service plan must also include any unmet needs that have been identified after the initial service plan has been developed. The updated service plan is to be reviewed for progress or changes:

- Following each 30 day face-to-face contact.

- At the time of any significant developments affecting the service plan,the updated service plan items will be reviewed for changes and documented through progress notes in the general narrative section of ASCAP which must include:
  - Current progress of the service plan.
  - Need for continuation of services or new developments indicating need to change the plan of action.
  - A list of contacts, dates of contacts, and the nature of the contacts.

Standards For Case Closure

Services may be terminated and the case closed if any one of the following situations exists:

- An investigation/assessment has been completed and the worker has determined:
  - The referral is inappropriate, unsubstantiated, or the investigation is the responsibility of another agency**.**
  - The referral is substantiated **but** the adult is fully aware of the risks and consequences of the situation and refuses provision of services.
  - An investigation/assessment has been completed, a service plan has been developed, and:
    - The adult is living in a safe, stable situation.
    - Services paid utilizing the special APS home help services component have been verified as provided.
    - The adult dies.

      Note: When an APS client dies, the worker must complete a DHS-4712, Adult Services Death Report; see ASM 230 for instructions.
  - The referral is not substantiated, needs are identified but the adult refuses to cooperate with the completion of the

service plan and is fully aware of the consequences of the situation.

- Supervisory approval has been obtained for cases showing moderate or high risk in the risk assessment at the time the case is ready to close.
- The APS supervisor has completed the DHS-4479, Adult Protective Services Case Reading Report.

Note: When an adult is in a life threatening situation and refuses services, consideration must be given as to whether the circumstances indicate a need to petition the probate court for appropriate legal intervention. This decision **must** be documented in the closing summary.

APS cases must be closed or referred to another program when the need for protective services no longer exists and there is no ongoing probate court activity. The case should remain open long enough to determine that the service plan has provided effective protection to the client. When the client's situation has stabilized, the case may be closed to APS and transferred to another service program, if appropriate. Most cases should be closed within 90 days.

Termination of Protective Goal

When closing a case, the worker must inform the client or their legal representative and document how the client/legal representative was informed in the ASCAP general narrative.

Closing Summary

A closing summary must be completed for all APS investigations. Closing summaries are to be documented in the general narrative of ASCAP and must include:

- A summary of the investigation including any actions taken since last contact with the client.
- The investigation findings (substantiated or unsubstantiated).
- The reason for closure.

Note: If the client refuses services, the closing summary must contain the worker's evaluation of the client's ability to make informed choices.

Legal Packet

Each case record where guardianship/conservatorship is established must have a separate legal packet, which will include:

- Copy of petitions filed.
- Copy of court orders resulting from filed petitions.
- Any other available court documents, legal documents or correspondence affecting the individual's legal rights.

Forms/Documentation

Each case opened to APS must have the following forms and documentation:

- DHS-331, Investigation report.
- DHS 324-C, APS service plan (if required).
- DHS-335, Closing summary.
- Any reports from other agencies, medical providers or service providers.
- Any written correspondence related to the APS case.
- Any photographs taken by or provided to the Department.

Other forms are to be located in the case record if utilized, such as:

- DHS-721, Provider log or other invoice specifying services provided.
- DHS-93, Payment authorization invoice.
- All billings or invoices related to services paid utilizing MDHHS funds (DHS-93 payments and special APS home help services component payments).
- DHS-686, Adult services legal representation request.

Case Monitoring

The APS supervisor must monitor new APS cases monthly, targeting standards of promptness (SOP). Every APS casemust be monitored for SOP compliance by the supervisor . SOP monitoring must include the 24 hour collateral, 72 hour face- to-face and 30 day service plan requirements. **This information is obtained utilizing the AS-010, APS Standard of Promptness** report which is available monthly on ASCAP.

The APS supervisor must monitor all APS cases each month for 30 day, face-to-face contacts. **This information is obtained utilizing the AS-020, APS Monthly Ongoing SOP** report which is available monthly on ASCAP.

Adult Protective Services Case Reading Report (DHS-4479)All APS cases must have a full case reading completed by the APS supervisor prior to closure. . The full case reading must include the completion of Sections A and B of the DHS-4479, Adult Protective Services Case Reading Report.

If a supervisor determines, following the case read that further actions are required by the AS worker, the supervisor must utilize Section C of the DHS-4479 to:

- Indicate in the Case Read Findings box that the investigation is incomplete and requires further action.
- Indicate what actions are required by the AS worker.
- Provide a date that the actions must be completed and the DHS-4479 returned to the supervisor.
- Indicate this finding in the ASCAP general narrative of the APS case.

Note: The DHS-4479 must be maintained in the APS local office case file at closure.

CASE TRANSFER OUT OF COUNTY

If a client moves out of the county and the **case is**:

- **Not substantiated** - Without pending services, the case is closed and not transferred out.
- **Substantiated** - The case is open with further action needed in the new county, it must be transferred out and reassigned in the new county.

- Ongoing **investigation**/substantiation status not determined - The case is transferred out and reassigned in the new county.

RETENTION OF CASE RECORDS

APS case records must be retained for three years. However, if there are any payments attached to the case, the case records must be retained for **seven years** after date of closure.

LEGAL BASE

Staff who investigate APS referrals must become familiar with the following laws and rules in relation to the provision of adult protective services:

- Social Welfare Act, MCL 400.11-400.11f.
- Public Health Code, MCL 333.21771..
- Estates and Protected Individuals Code, MCL 700.5101 et seq.
- Code of Federal Regulations; Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

CENTRALIZED INTAKE FOR ABUSE AND NEGLECT (CI)

The MDHHS Centralized Intake for Abuse and Neglect unit (CI) is a statewide intake unit that receives all abuse, neglect and exploitation referrals regarding children and vulnerable adults.

CI Contact Information

There is one, statewide number for reporters of abuse, neglect or exploitation to use when making referrals to the MDHHS. The toll free number is **1-855-444-3911**.

Availability

Centralized intake is available and receives referrals 24 hours a day, 7 days a week, 365 days a year (including after-hours, weekends and holidays).

APS Referral Intake

CI receives APS referrals through the toll free number. An intake specialist gathers information needed to determine if the referral meets criteria for an APS investigation.

Documenting Referrals

Referral information is documented in the Adult Services Comprehensive Assessment Program (ASCAP). Once all information is gathered from the referral source, the intake specialist forwards the referral to the CI supervisor.

Walk-in Referrals

When an individual comes into a local office and wants to make an APS referral, the local office must do the following:

- Offer the reporting person use of a MDHHS phone and provide the CI complaint number so the reporting person can make the referral from the local office.
- If the reporting person refuses to call CI to report their concerns, the local office must attempt to locate an APS complaint coordinator or APS worker to receive the

information. Once the information is received, the information must be called into the CI unit who will document the referral on ASCAP and forward to a CI supervisor to make an assignment decision.

Referral Assignment and Denial

All APS referral decisions (assignment for investigation, denied or withdrawn) are completed by CI supervisors.

CI Supervisor Review Process

The CI supervisor reviews all APS referrals and determines if the referral is assigned for investigation, denied or withdrawn. CI supervisors utilize a structured decision-making tool (SDM) to assist in this process. The SDM tool is copied and placed in the general narrative of the APS referral for review by the local office APS complaint coordinator.

After review of each referral, the CI supervisor will take the following steps:

1. Referral **does not** meet criteria for APS investigation:
   a. SDM tool is copied and pasted into the General Narrative of ASCAP.
   b. Documents any contacts completed or attempted, to assist in the decision-making process, in ASCAP.
   c. Prints APS Denial letter from ASCAP and mails to referral source.
   d. Referral is denied on ASCAP and forwarded to the local office.
2. Referral **does** meet criteria for APS investigation:
   a. SDM tool is copied and pasted into the General Narrative of ASCAP.
   b. Documents any contacts completed or attempted, to assist in the decision-making process, in ASCAP.
   c. Assigns referral on ASCAP Disposition Screen to the local office transfer coordinator, which prompts the transfer of an

"open" APS case to the local office for assignment to an APS worker.

3. Referral does not meet criteria for assignment but **must be forwarded** to an agency responsible to investigate the allegations.

    a. SDM tool copied and pasted into the General Narrative of ASCAP.

    b. CI completes referral to responsible agency and documents the action in the "*Referral to Other Agencies*" tab of ASCAP.

    c. Documents any contacts completed or attempted, to assist in the decision-making process, in ASCAP.

    d. Prints APS Denial letter from ASCAP and mails to the referral source.

    e. Referral is denied on ASCAP and forwarded to the local office.

Referrals with Special Circumstances

There are some referrals that require additional procedures and/or considerations due to the nature of the referral information. These situations are outlined below.

1. If a referral indicates imminent danger to the client, CI will follow the assignment processes listed in the above section, and **will call** the APS supervisor or on-call staff to ensure they have received the referral and understand it requires attention as soon as possible.

2. If a new referral is received regarding a client with an open APS investigation, CI **may** contact the ongoing APS worker for additional information to assist in the assignment decision.

    a. If the referral allegations are being addressed in the current investigation as determined by case documentation in ASCAP, CI will:

        i. Copy and paste the SDM tool in the General Narrative of ASCAP.

        ii. Deny the referral. CI will notify the APS worker that there is a new referral that has been denied regarding their client. The APS worker must then review the

denied referral for any information that may be relevant to their ongoing investigation.

iii. Print and send the APS Denial letter informing the referral source that there is an active investigation.

b. If the referral allegations **are not** being addressed in the current investigation (ASCAP documentation does not reflect that the current allegations are known to the worker), CI will:

i. Copy and paste the SDM tool into the General Narrative of ASCAP.

ii. Document any contacts that are completed or attempted in ASCAP.

iii. Assigns the referral on ASCAP Disposition screen to the local office ASCAP complaint coordinator, which prompts the transfer of an "open" APS case to the local office for assignment to an APS worker.

Transferring Assigned Referrals to the County Office

The CI supervisor forwards all assigned referrals, via ASCAP generated email, to the designated, county APS contact and transfers the "open" referrals on ASCAP to the appropriate county APS complaint coordinator. All local office contacts must be maintained on the CI SharePoint site. CI standards of promptness for forwarding assigned referrals to the local office are:

- The CI intake specialist will attempt to submit the complaint to supervision within one hour when imminent danger is indicated.
- The CI intake specialist will attempt to submit the complaint to supervision within three hours if imminent danger is not indicated.
- The CI supervisor will complete a screening decision on all complaints as quickly as possible while assuring a thorough complaint intake was completed in compliance with policy.

Note: CI is responsible for mailing all Referral Denial letters to the referring source(s). The local office maintains responsibility for printing and mailing all Referral Acknowlegement letters to the referral source(s).

Local Office Contacts/ SharePoint

SharePoint is a collaborative software which facilitates the sharing of information between CI and the county offices. Each county must develop and maintain on-call calendars that identify who the CI contact(s) are for each day.

Each local office must maintain the following set of documents for CI utilization.

- **Intake On-Call Calendar:** Monthly calendar of on-call staff and each day's assigning supervisors for APS and CPS. On-call workers are listed daily with each worker's contact information, supervisor and supervisor's contact information.
- **Intake On-Call** Supervisor**:** Separate listing of **all** APS and CPS supervisors with their contact information.
- **Intake On-Call Staff:** Separate listing of all CPS staff taking on-call shifts and their contact information..
- **Assigning** Supervisor**:** Separate listing of all APS and CPS supervisors indicating the periods they will be responsible for receiving new complaints from CI. This list must also include the supervisors' contact information.
- **APS Supervisor(s) and Worker(s):** Each local office must have an APS folder on SharePoint. This folder must include the names and contact numbers for all APS supervisors and workers. This folder must be maintained by the local office and updated whenever there are staffing changes in the local office APS unit.

Note: The contact list **must be monitored daily** for accuracy and include both daytime and after-hours contact information. The local office may choose to utilize a group email for receipt of referrals.

Example: APS Complaint Coordinator, back up APS Complaint Coordinator and CPS Supervisor/After Hours Complaint Coordinator.

After Hours/Weekend Referrals

APS on-call staff provide investigation and intervention weekends and holidays. CPS on-call staff provide coverage for assigned APS referrals after hours Monday-Thursday. On-call staff are responsible for the following:

- Commencement of an investigation as soon as possible when there is imminent risk of harm to the vulnerable adult.
- Collateral and face to face contacts with the vulnerable adult in order to maintain required standards of promptness
- The transfer of all contact information to the assigned APS worker the next business day.

CI will contact the designated, on-call contact listed on the local office on-call calendar (SharePoint) for all APS referrals assigned after hours and weekend.

Note: APS staff (this may include adult services workers who have received APS training) provide on-call coverage for holidays and weekends. CPS staff continue on-call coverage weeknights (excluding holidays that fall on a Monday-Thursday).

Referrals from Law Enforcement (LE)

When referrals are received by law enforcement (LE) requesting immediate assistance by APS with a vulnerable adult, the CI supervisor will immediately notify the local office APS complaint coordinator or designated, on-call contact to mobilize a worker to the location.

Walk-in Referrals

When an individual comes into a local office and wants to make an APS referral, the local office must do the following:

- Offer the reporting person use of a DHS phone and provide the CI complaint number so the reporting person can make the referral from the local office.
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Referral Decision Reconsiderations by Local Offices

Reasons for Local Office Reconsiderations

The APS complaint coordinator or supervisor may request a reconsideration of the assignment or denial of an APS referral for the following reasons:

1. Technical Error.
2. The complaint is an ongoing case and the APS worker has additional information that has since been entered into ASCAP that negates the need to investigate.
3. The APS complaint coordinator or supervisor believes a rejected complaint meets criteria for assignment.
4. The APS complaint coordinator or supervisor believes the complaint does not meet criteria for assignment.

Reconsideration Process

1. APS complaint coordinator or supervisor must email the CI reconsideration email box: MDHHS-Reconsideration@michigan.gov.
2. The CI director has final decision in all reconsiderations and will make any needed contacts with APS program office to make a more informed decision.
3. When a change in disposition is made by CI, CI will document the review and summarize the reason for the change in the General Narrative of the APS case in ASCAP.
4. CI will also document their reconsideration decision in ASCAP contacts utilizing the miscellaneous (CI reconsideration) contact type.

LEGAL BASE

Social Welfare Act, MCL 400.11 - 400.11f.

REFERRALS/ COMPLAINTS THAT INVOLVE OTHER AGENCIES

This manual item outlines the Michigan Department of Health and Human Services (MDHSS) reporting and investigating responsibilities when other agencies are involved.

DHS-Pub-269, The Michigan Model Vulnerable Adult Protocal (MI-MVP)

Public Act 175 of 2012 (Social Welfare Act, MCL 400.11b(9)) required DHS, Michigan State Police, the Michigan Attorney General, Michigan Office of Services to the Aging, and a long-term care representative to develop a model protocol for investigating vulnerable adult abuse, neglect and exploitation.

MI-MVP was introduced on June 16, 2013 and is intended to assist local communities in protecting, investigating and serving older and vulnerable adults through increased collaboration. MI-MVP is a model for local communities to adapt, as needed, based on their local resources and needs.

Note: A copy of MI-MVP can be located on the DHS public website at http://michigan.gov/dhs/0,4562,7-124-7119_50647---,00.html .

MDHHS/Behavioral Health and Developmental Disability(MDHHS/ BHDD)

BHDD has responsibility for MDHHS/BHDD operated facilities.

MDHHS/BHDD operated facilities have their own process for who handles referrals/complaints.

Operated Facilities

Local office APS workers do **not** investigate referrals of abuse, neglect, or exploitation of adult residents of MDHHS/BHDD operated facilities. MDHHS/BHDD Office of Recipient Rights (ORR) will conduct investigations in these facilities. See ASM 258, for a list of these facilities. This is subject to the exceptions listed below.

Referrals from staff in MDHHS/BHDD state operated facilities must be received by the Centralized Intake for Abuse and Neglect hotline (CI) because of mandatory reporting requirements and should be handled in the following manner:

- Determine if the incident has been reported internally within MDHHS/BHDD by contacting the appropriate MDHHS/BHDD recipient rights advisor. If it has, document receipt of the report on ASCAP and take no further action. If it has not been reported internally, document receipt of the report on ASCAP and notify the appropriate MDHHS/BHDD recipient rights advisor immediately.

- MDHHS/BHDD employees may make referrals to MDHHS and wish to remain anonymous. Such confidential referrals from MDHHS/BHDD staff must be documented on ASCAP. The appropriate MDHHS/BHDD recipient rights advisor is to be notified immediately by MDHHS.The referral source (RS) information may be shared as ORR officers in MDHHS/BHDD operated facilites are MDHHS employees.

Note: ORR officers must protect the identity of the RS pursuant to MCL 400.11c (1) (2) and MDHHS APS policy. ORR must not share that information without a written release from the RS or court order and must redact all identifying RS information from their report(s).

- Referrals of abuse, neglect, or exploitation in these MDHHS/BHDD facilities from a source other than a MDHHS/BHDD employee must be documented on ASCAP and forwarded immediately to the appropriate MDHHS/BHDD recipient rights advisor.

Exception: MDHHS APS staff **are** responsible for investigating APS referrals of adult residents of these MDHHS/BHDD facilities when the incident occurred:

- Prior to admission to the facility.
- While the resident was on a leave of absence from the facility.
- While the resident was off the facility premises in the custody of another person or organization.

Local MDHHS office staff must immediately notify the appropriate MDHHS/BHDD recipient rights advisor when commencing an investigation in any of these situations. A copy of the written report on substantiated incidents in these investigations must be

forwarded to the appropriate MDHHS/BHDD recipient rights advisor.

Licensing and Regulatory Affairs (LARA)

APS is precluded from investigating suspected abuse, neglect or other incidents covered by the law in facilities licensed by LARA when that department has investigative and enforcement responsibility for such incidents under the Public Health Code. Those licensed health care facilities are the following:

- County medical care facilities.
- Freestanding surgical outpatient facilities.
- Hospitals.
- Nursing homes.

LARA has sole responsibility for investigating incidents of alleged abuse, neglect, or exploitation of patients and residents in the above facilities insofar as these incidents allege violations of LARA enforced rules and statutes.

Note: MDHHS local office staff are responsible for investigation of referrals involving adult patients and residents of LARA licensed facilities listed above if:

- The alleged violation took place **outside** the facility in the community, **or**

- Occurred inside the facility and the alleged perpetrator **is not** a facility employee, staff person or resident.

MDHHS Referrals to LARA

The following are procedures for MDHHS CI supervisors and local office APS staff to use in making referrals to LARA:

- All allegations of abuse, neglect or exploitation of a patient or resident, must be recorded on ASCAP.

- MDHHS Staff must advise the complainant to make an **oral report** immediately by telephone to the appropriate LARA complaint unit (800-882-6006) including the following information:

  - Name of the patient or resident.

- Facility name and address.
- Details of alleged incident.
- Date and time of alleged incident.
- Name(s) of available witness (es) if known.
- Name(s) of perpetrator(s) if known.

- MDHHS staff must, as soon as possible, submit the same information to LARA by telephone or in written form to ensure the complaint is reported for a timely investigation by LARA.

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To file a complaint against a state licensed or federally certified health facility, including nursing home, hospital, home health agency, hospice, surgery center, dialysis center and other providers, see the information below:

Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems - Health Facility Complaints
P.O. Box 30664
Lansing, MI 48909

Phone: 517-241-4712
Fax: 517-241-2635
Email: BCHS-Complaints@michigan.gov

Toll-free Complaint Hotline: 1-800-882-6006

LARA Bureau of Community and Health Systems (BCHS)

APS has responsibility to investigate referrals of abuse, neglect or exploitation involving residents of adult foster care (AFC) homes and homes for the aged (HFA). BCHS has responsibility to investigate any allegations of rule violations within BCHS licensed facilities. The local office must immediately make a report to the AFC/HFA licensing consultant providing them with the name of the facility, name of the resident(s) involved, nature of the allegations and any other information available that will assist in the licensing consultant's investigation.

Note: APS **may not** share referral source information with the BCHS licensing consultant as they are not MDHHS employees.

Reports or complaints to BCHS are to be made to:

Licensing and Regulatory Affairs
Bureau of Community and Health Systems
610 W. Ottawa St. -Central Office
P.O. Box 30664
Lansing, MI 48909
1-866-856-0126

When an investigation pertains to an adult residing in an AFC or HFA facility licensed by BCHS, the local office must provide the AFC/HFA licensee with the substance of the abuse or neglect allegations as soon as practical after the beginning of the investigation. Document the information provided to the licensee in the ASCAP case record. However, this information is to be provided only after the worker determines that the resident will not suffer any harm because of the report. The licensee will have the opportunity to respond to the allegations, and the response must be included in the record. (1982 P.A. 519 Sec 11b(1)).

The APS investigation must be conducted independent of the licensing investigation but coordinated with the BCHS AFC/HFA licensing consultant to the extent this is practical. Information may be shared as necessary to assist in the licensing investigation. APS must investigate any allegations of abuse, neglect or exploitation while BCHS must investigate any rule violations. The worker must send a copy of the investigation report to the AFC/HFA licensing consultant, redacting any identifying information regarding the referral source. (See SRM 131, Confidentiality)

Note: BCHS licensing consultants must also provide the APS worker with a copy of their investigation report to include in the APS case file.

Contracted Community Mental Health AFC Homes

Referrals involving BCHS licensed AFC homes which receive funding for services from community mental health services programs should be handled in the following manner:

Local office APS workers are responsible for investigating allegations of abuse, neglect, or exploitation of adult residents in these facilities. The APS worker must coordinate the investigation with the appropriate CMH recipient rights officer or rights advisor if

one is available, and the AFC licensing consultant assigned to investigate the complaint.

Note: RS information ***cannot*** be provided to recipient rights officers and rights advisors who work under community mental health service providers (CMHSP) as they ***are not*** MDHHS employees.

The following lists investigative responsibilities for each agency:

- APS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring resident safety.
- BCHS is responsible for investigating licensing rule violations.ORR is responsible for investigating rights violations.
- Law enforcement may also be conducting an investigation related to possible criminal activity in conjunction with the above.

Local offices must have signed agreements with their respective CMH boards and AFC licensing to cover roles and responsibilities for handling APS investigations in mental health settings. Procedures in the agreement must be followed for:

- Reporting.
- Investigating.
- Sharing of information.

A copy of the protocol for joint operating agreements and the model agreement are in ASM 256.

Access to CMH Recipient Information

Attorney General Opinion 6700 of 1991 states:

> "A Michigan Department of Human Services Adult Protective Services worker may, in the course of carrying out an APS investigation, obtain access to Community Mental Health recipient information regardless of the source of a report of information concerning suspected abuse, neglect, exploitation or endangerment that led to the investigation."

Attorney General Medicaid Fraud Control Unit Referrals

The Medicaid Fraud Control Unit (MFCU) in the Department of Attorney General is required to investigate allegations of abuse or neglect of patients/residents of facilities which accept Medicaid payments or provide services funded under Title XIX of the Social Security Act. Where appropriate, they can act upon such complaints and prosecute offenders under the criminal laws of the state.

Local offices **are required** to make referrals to the MFCU in the office of the Michigan Attorney General regarding referrals that include the following:

- Referrals which allege suspected abuse, neglect, or exploitation of an adult who is a patient/resident of a nursing home, home for the aged, or adult foster care home, when the facility/home is receiving Medicaid funds or providing services funded under Title XIX of the Social Security Act, **and**
- Which allege actions taken or neglected so as to cause a reasonable person to believe **physical or mental harm** could be inflicted on an adult patient/resident or misuse of an adult patient's/resident's funds or property may occur.

All such referrals must be documented on ASCAP and referred immediately to the MFCU in one of the following manners:

- Department of Attorney General
  Medicaid Fraud Control Unit
  Health Care Fraud Division
  P.O. Box 30218
  Lansing, MI 48909
- Online at www.michigan.gov/ag
- Fax 517-241-1029
  Attn: Supervisor, Patient Abuse Team - APS Referral
- Hotline at 1-800-242-2873

The referral must include:

- Name of the adult.

- Name and address of the facility in which the adult is a patient and/or resident.
- Date and time of the incident (if known).
- Name of the assailant or perpetrator (if known or if any).
- Names of any witnesses and/or individuals (if any) who may have knowledge of the abuse, neglect, or exploitation.
- Any other useful information.

Note: The report must state whether a referral was also made to a local law enforcement agency.

In making such a referral to the MFCU **local APS workers *may not* include the name of the complainant.**

Substance Abuse Treatment Agency Referrals

Substance abuse treatment agencies who sign a qualified service organization agreement (QSA) with MDHHS will make APS referrals to CI, when appropriate. Referrals will not be for treatment of substance abuse, they will be for providing APS services to adults who have been abused, neglected, exploited or endangered **and** are vulnerable.

Refer to the Confidentiality section of ASM 205 for application of confidentiality rules.

Local offices will receive copies of signed QSA's for substance abuse treatment agencies in the county.

COORDINATION WITH LAW ENFORCEMENT AGENCIES

APS workers must involve law enforcement agencies immediately in referrals involving actual criminal activity or any criminal activity it believes to be occurring, for example spouse abuse/domestic violence, other physical abuse, financial exploitation, intentional neglect, etc. The following steps must be taken in these situations:

- APS workers must first confer with their supervisor and law enforcement agency to determine if the referral is appropriate.
- If APS services are still needed, APS must coordinate investigative efforts with law enforcement, as appropriate.
- If APS services are not needed, ASCAP documentation must reflect why there was no follow-up on the referral beyond initial inquiries and notification to a law enforcement agency.

Local offices must cooperate with law enforcement agencies conducting criminal investigations and must make records or client information available as provided in SRM 131.

Note: APS may provide law enforcement with a copy of the APS report but must first redact all referral source information.

Upon request by the local department of health and human services, local law enforcement officers shall cooperate with the local office in an investigation of suspected abuse, neglect, or exploitation.

Common situations Where APS may involve law enforcement.

Domestic Violence

If the adult victim in a domestic violence situation is also vulnerable the APS worker must offer appropriate supportive or protective services.

Incapacitated Persons

The **Mental Health Code, MCL 330.1276,** provides for law enforcement intervention on behalf of incapacitated persons. It states in part that an individual who appears to be incapacitated in a public place shall be taken by the police to an approved service program or to an emergency medical service.

Note: APS workers may be responsible for bringing complaints of this nature to the attention of the appropriate law enforcement agency.

Mentally Ill And Dangerous Persons

The **Mental Health Code, MCL 330.1438,** permits a law enforcement officer to take a mentally ill person into protective custody and deliver him/her to a hospital that can provide mental health services if:

- The officer has observed that the person's behavior is personally dangerous or a threat to others, **or**
- An application for hospitalization and physician's certificate has been presented to the officer (MCL 330.1424). An application for hospitalization can be made by any person over age 18 and must allege specific facts that show the individual's behavior is an endangerment to that individual or others and that the person is in need of mental health treatment. The application must be filed with the hospital within 10 days after its execution).

This section applies only for persons with a mental illness and **does not** apply to persons who have only a developmental disability.

Without an application for hospitalization and a physician's certificate, the law enforcement officer may contact the community mental health emergency service unit which must then provide intervention services. If the individual refuses these services, the law enforcement officer shall then immediately transport the individual to a hospital. The community mental health office should be contacted for assistance in all these situations and for other procedures for admission to a mental health facility.

Entrance

With a Search Warrant:

In attempting to conduct a personal visit with an adult in the adult's dwelling, if admission to the dwelling is denied, the local county office may seek to obtain a search warrant.

The need for a search warrant must be discussed with the APS worker's immediate supervisor or such other staff as the county director prescribes. To obtain a search warrant an affidavit must be made under oath to a magistrate. Local office personnel must discuss the need for a search warrant with the county prosecuting attorney's office and follow procedures recommended by the prosecutor. The worker must present as many facts as possible to the prosecuting attorney, such as:

- Name, address, age, other identifying information about the client.
- Nature of the alleged harm and vulnerability, be specific.
- Exactly who is denying entrance, dates, and reasons if known,
- Summary of the investigation to date.
- Cite MCL 400.11b (4) as legal basis for the department to seek a search warrant.

The local MDHHS director may seek a search warrant by personally filing an affidavit; see ASM 262, Affidavit for Search Warrant, with the district court. **This must only be done when the prosecuting attorney fails to provide timely assistance**.

Upon the magistrate's finding of reasonable or probable cause, a search warrant will be directed to the sheriff or other law enforcement officer. The APS worker must accompany the law enforcement officer to the residence and conduct the interview under the protection of the law enforcement officer. Upon completion of the interview, findings must immediately be shared with the supervisor.

Without a Search Warrant:

A law enforcement officer may enter a dwelling without a warrant if the officer has reasonable grounds to believe a crime is being committed or if an individual's health is believed to be in danger and exigent circumstances exist, i.e., if time were taken to obtain a warrant, the situation would change so that a warrant would no longer be necessary, such as, the client is in danger of dying. In these situations there is a clear and present danger that cannot wait for a warrant to be issued.

If a law enforcement officer refuses to enter a dwelling without a search warrant and the APS worker feels that entrance is necessary to conduct an interview or check on the welfare of the adult, consideration should be given to consultation with the prosecuting attorney and/or magistrate to determine if a search warrant can be issued or if anything further can be done by the APS worker.

Local offices must work with local law enforcement agencies in clarifying roles and reaching agreements to facilitate both situations above.

Coordination with the Prosecutor's Office

Local offices must cooperate with the county prosecutor's office in criminal investigations and make the results of any APS investigation and all other client related information available to assist in such investigations.

The local prosecuting attorney’s office may provide consultation on cases involving legal issues including but not limited to:

- Advice on filing a guardian/conservator petition.
- Sufficiency of evidence.
- Involvement of law enforcement.

The prosecuting attorney’s office may conduct all phases of court proceedings from the preliminary hearing to the final disposition.

INTERFERING WITH INVESTIGATIONS

It is a misdemeanor for a caregiver or other person with authority over a vulnerable adult to intentionally interfere with or obstruct an APS or adult foster care/home for the aged licensing investigation per MCL 750.145p of The Michigan Penal Code.

Upon request by the MDHHS county department, local law enforcement officers must cooperate with in an investigation of suspected abuse, neglect or exploitation.

When there is interference with an investigation, APS workers may gain access to the adult by coordinating with local law enforcement and the prosecuting attorney.

When there is interference with an investigation involving an adult resident of an AFC/HFA facility, local offices must coordinate with BCHS.

LEGAL BASE

- Social Welfare Act, MCL 400.11b(9); 400.11b(1).
- Mental Health Code, MCL 330.1276; 330.1438; 330.1424.
- Search Warrants, MCL 780.651-780.659.

LEGAL INTERVENTION PROCESS

Whenever non-legal intervention fails to meet the goal of protection, the need for voluntary or involuntary legal intervention may be utilized to protect the client. The APS worker must evaluate the need for legal intervention and it should be initiated **only** when the following conditions exist:

- Endangerment cannot be eliminated with the use of the social intervention process, **and**
- The client requests or voluntarily accepts legal assistance because physical or cognitive limitations result in the inability to manage ones own affairs **or** the client does not consent to legal action but is endangered because he/she is unable to exercise independent judgment due to cognitive or physical limitations.

The APS worker must keep the case open until the legal action is completed and the client is in a safe and stable situation. The appointment of a guardian or conservator does not automatically indicate case closure or preclude continued worker involvement with the client.

- A MDHHS adult services worker must **not** serve in the following capacities for a MDHHS client:
  - Representative payee.
  - Power of attorney.
  - Conservator.
  - Guardian.

Note: If appointed as guardian or conservator by the court, the worker must notify the court in writing that the appointment must be declined.

Exception: When the client is a relative of the worker and there is no one else available to serve in this capacity, an exception may be made by the local office director or designee.

Under no circumstances is a MDHHS worker to serve as a guardian ad litem or visitor for cases in which M**DHHS is the petitioner**.

Voluntary Legal Intervention

The APS worker is responsible for the following:

- Involvement of the client in a discussion about the intervention, pertinent laws, rationale for the action, responsible parties for performing the tasks and the anticipated results.
- Being knowledgeable of the following available interventions and arranging for the intervention as indicated:
  - Support the individual in seeking assistance with establishing a power of attorney agreement if the adult is believed to have the capacity to make informed decisions. The individual with power of attorney is then authorized to act on behalf of the client. Powers should be specifically limited in scope and time.
  - Arrange for the Social Security Administration's (SSA) designation of a representative payee for social security benefits.
  - File a petition for appointment, review or termination of a guardian/conservator. Voluntary appointment of a conservator is available for an adult believed to have the capacity to make informed decisions but is unable to manage their affairs due to physical disability or impairment.
  - File a petition through probate court for appointment of a partial or plenary guardian for an individual with a developmental disability.
  - File a petition through probate court for hospitalization if the client is believed to be mentally ill and resultant behavior is harmful to self or others.

Involuntary Legal Intervention

Involuntary legal intervention must be initiated only when necessary to **avoid serious harm to the client** and when there is reasonable cause to believe **the adult lacks understanding or capacity to make or communicate informed decisions.**

The types of involuntary legal intervention include but are not limited to:

- Involuntarily acquired third party payee.
- Representative payee arrangements initiated by SSA.
- Involuntarily acquired conservator.
- Involuntarily acquired guardianship.
- Petitions to probate court for a single temporary act such as freezing a bank account.

The APS worker is responsible for completing the following actions prior to initiating involuntary legal action:

- Consult with the involved persons or agencies including relatives, physicians, community mental heath agencies and MDHHS/BCHS or service providers using a multidisciplinary approach.
- Consult with law enforcement and/or the prosecuting attorney regarding the appropriateness of a civil involuntary hospital admission, proceeding under domestic violence laws or obtaining some other form of restraint.
- Obtain written supervisory approval of the service plan.

Exception: If there is an emergent, life threatening situation secure verbal supervisory approval and complete the above steps as soon as possible.

- **Advise the individual with first hand knowledge that they are the preferred agent to seek legal action.** Assist that individual with obtaining legal action.
- Institute legal action whenever others are not available or can/will not take action.
- Obtain legal advice and/or representation from the local prosecuting attorney's office or contact the MDHHS, Children's Legal Services to request advice/representation from the Department of Attorney General by calling 517-373-2082

Note: APS workers must be represented by legal counsel for any contested probate court hearings where APS is the petitioner or is

expected to provide testimony. If the local prosecuting attorney is unable or unwilling to provide representation, follow the steps in ASM 218, Adult Protective Services Legal Represenation.

PREPARATION FOR SPECIFIC LEGAL ACTIONS FOR

Financial Management

Protective financial management includes specific arrangements which provide protective management of an individual's resources, including:

- Representative or third-party payees.
- Power of attorney agreements.
- Special contractual agreements.
- Conservator acquired voluntarily or involuntarily if serious harm to the adult is to be avoided.

Such arrangements are based upon any of the following:

- The individual's request and agreement.
- The administrative judgment of the involved agency with respect to payments it issues.
- The order of probate court.

Guideline for Evaluating Financial Management Problems

The following are general principles that can be used in guiding the APS worker in determining which type of protective financial management may be appropriate.

- Voluntary arrangements for management of the adult's finances and affairs can be used any time there is a benefit to the adult and the adult has the mental capacity to consent. If the adult is believed to have the capacity to make informed decisions, recommend the voluntary arrangements of:
    - Power of attorney.

- Special contractual agreement.

- Involuntary arrangements can be used only when there is reason to believe the adult's inability to manage ones finances and affairs will result in endangerment to the adult.

- **Conservatorship** and **third party payees** are appropriate if there is reasonable cause to believe the adult lacks mental capacity to manage personal finances or affairs. These arrangements may be used in involuntary situations. Conservatorship may also be used when the adult has adequate mental capacity but a physical disability or substance abuse problem prevents adequate management or discharge of financial and other personal affairs. Conservatorship and protective payees can also be voluntarily requested by the adult.

- Age or a particular medical or psychiatric diagnostic classification does not in and of itself imply a person's inability to manage funds.

- The cause and severity of an individual's money mismanagement problem should always be evaluated. An example of money mismanagement may be eviction as a result of nonpayment of rent or a utility-shut off due to failure to keep payments current. The cause may be an exploitative relative and the adult's inability to protect self interests, rather than a mental incapacity.

- The individual's functioning level must also be evaluated since the diminished capability may be evidenced by different behaviors. For example: poor memory may result in repeated complaints of non-receipt of Social Security checks when in fact they were received.

- It is important to determine if the individual's condition is temporary, modifiable, or permanent. Counseling or training may be a solution. The local community mental health agencies and physical rehabilitation agencies may be consulted to aid in the assessment. A survey of other resources available to the individual should be made.

Note: A sample financial management scale is available in ASM 253.

When Informal Protective Financial Management Exists

When an informal agreement with respect to handling of payments and resources exists with a landlord, relative, or some other person, APS workers must evaluate the need for some form of legal contract.

Minimally, encourage the individual and other person to write out their agreement; assist individual to obtain legal counsel before the agreement is finalized (for example: legal aid, Legal Hotline for Michigan Seniors, etc.).

Power of Attorney

Power of attorney (POA) is arranged with a legal written agreement between two adults with the capacity to make informed decisions, and it authorizes one person to act in behalf of the other person as that person's agent (i.e., in place of the other person). The POA agreement should be notarized and should show a begin and end date. The agreement should not give a general power of attorney but should state the specific limited functions and responsibilities of the agent.

Note: Effective September 30, 2012, Michigan law reqeuires that any designee under a Durable Power of Attorney must sign an acknowledgement of their responsibilities. The specific language can be located in MCL 700.5501.

The POA can be terminated at any time by the protected adult by sending notice of termination to the designated POA. A copy should be sent to other persons/entities involved in transactions with the designated POA.

The APS worker must advise the adult to seek legal counsel if they choose to enact a POA (such as legal aid, Legal Hotline for Michigan Seniors, etc.).

Representative Payee Arrangements

The Social Security Administration (SSA) is responsible for designating a person as a **representative payee** to directly receive and

manage the SSA benefits of SSA recipients whom it has determined incapable of managing their own benefits. The SSA benefits can be those received under Title VI (SSI) or under Title II of the Social Security Act.

The SSA requires that a representative payee be designated for a recipient of SSA benefits for whom a diagnosis of drug addiction or alcoholism contributes to a finding of disability.

The SSA is responsible for locating representative payees and gives primary consideration to persons who normally have responsibility and a continuing concern for the well-being of the individual, such as a guardian. Although nursing homes and other residential facilities can serve as representative payees, they are the least preferred by SSA.

A DHS-SSA agreement provides that local MDHHS offices recruit, screen and prepare volunteers to serve as representative payees. SSA may request MDHHS assistance in finding a person to serve as representative payee but only if SSA is unable to find one.

The worker must contact the MDHHS community resource coordinator for arranging a volunteer to serve as representative payee if no other person is available.

Court Appointment Of a Conservator

Involuntary appointment of a conservator must be pursued only when there is clear and convincing evidence that the individual:

- Cannot manage their resources adequately to assure proper support, care and welfare to the extent needed to avoid endangerment, **and**
- Will not or cannot make a voluntary arrangement such as representative payee, voluntary appointment of a conservator, or power of attorney.

APS staff or any interested person, including the individual adult, can petition the probate court for:

- Appointment of a conservator with broad or limited powers.
- Termination of conservatorship because there is no longer any need for one.

- Removal of one conservator and appointment of another, the petition must include the name of the new conservator.
- An order limiting the powers of the conservator or instructing the conservator to act.
- An order for the conservator to account for the adult's estate.

Voluntary appointment of a conservator is available for willing adults,with the capacity to make informed decisions, who are unable to manage their finances and affairs due to a physical disability or other impairments.

Exception: Court appointment for management of property and affairs of a developmentally disabled person must be sought under the Mental Health Code. SeeASM 215, Guardianships under the Mental Health Code.

If only a single temporary act is needed (such as freezing a certain bank account), then the probate court can be petitioned for a protective order instead of appointment of a conservator. The probate court can also exercise the same powers of a conservator.

PREPARATION FOR SPECIFIC LEGAL ACTIONS FOR

Management of The Person

Protection through personal management **includes** arrangements which provide protection for the individual adult's person and include the following:

- Guardianship (limited or full powers) under the Estates and Protected Individuals Code (EPIC).
- Temporary guardianship by probate court appointment .
- Guardianship for the developmentally disabled under the Mental Health Code (MCL 330.1600 - 1644).
- Judicial Admission under the Mental Health Code (MCL 330.1515…330.1522).
- Civil admission under the Mental Health Code (MCL 330.1400…330.1410) . Community mental health agencies

should be consulted regarding commitment procedures and may even assume responsibility for the case.

General Guidelines On the Use of Arrangements for Management of the Person

When determining the need for management of the person the APS worker must consider the following:

- Every individual has a right to self-determination and independent decision making is to be encouraged.
- The risks to the individual adult must be so great that **death or serious physical harm** will result if some management of the person is not arranged.
- The ability of the individual to make decisions relating to critical needs and in understanding the risks and consequences of decisions that are made must be so impaired as to cause endangerment.
    - The individual's refusal to accept the services offered by the department is not in itself a reason for seeking guardianship.
    - Advanced age, developmental disability or a mental illness diagnosis by itself does not mean the adult is unable to make decisions nor needs a guardian.
- The worker's evaluation must identify what will be specifically accomplished for the individual if management of the person is arranged. Meal preparation or grooming may be better accomplished by a friend or in a foster care home instead of by a guardian or in a mental health institution.
- The worker must assess if the incapacity is temporary, modifiable, or permanent. The question of treatability of the incapacity needs to be addressed as does the benefits of training.
- A multidisciplinary approach is to be used to the extent possible.

A sample guardianship scale is available in ASM 254, and can be used by workers in assessing and documenting the need for guardians and temporary guardians.

Guardianship Under the Estates and Protected Individuals Code (EPIC)

A **guardian** is a person or other entity appointed by the probate court to provide necessary supervision and care of a legally incapacitated person. The court makes the appointment only when there is clear and convincing evidence that the person is legally incapacitated and that the appointment is necessary as a means of providing continuing care and supervision of the person.

A **legally incapacitated person** is one who lacks understanding or capacity to make or communicate informed decisions about one's person because of a mental or physical impairment or because of use of drugs or chronic intoxication.

An informed decision is one made with an awareness and consideration of all relevant facts, including the risks and consequences of each decision. It focuses on the decision- making process.

Guardianship under EPIC covers mentally ill persons but not developmentally disabled persons.

Unless limited by the court order, a guardian has the following powers and duties for a legally incapacitated person as outlined in MCL 700.5314:

- Establish the person's residence.
- Visit the ward within 3 months of appointment and not less than once within 3 months after each previous visit.
- Notify the court within 14 days of any change in the person's place. of residence.
- Provide for the care, comfort, and maintenance of the person, if entitled to custody.
- Arrange for the person's training and education, if appropriate and entitled to custody.

- Secure service to restore the person to the best possible state of mental and physical well-being, if entitled to custody.
- Take reasonable care of the person's clothing, furniture, vehicles, and other personal effects.
- Give any consent necessary to enable the person to receive medical or other professional care, counsel, treatment or service.
- Institute proceedings to compel a person under a duty to support (such as a spouse responsible for monetary care of the individual) the legally incapacitated person or to pay sums for the welfare of the legally incapacitated person to perform that duty, if a conservator has not been appointed.
- Receive money and property deliverable to the person and apply it toward the person's support, care, and education.
- Report to the court the person's condition at least yearly. The report must include:
  - The person's current mental, physical, and social condition.
  - Any improvement or deterioration of the person's mental, physical, and social condition over the past year.
  - The person's present living arrangement and any changes over the past year.
  - Whether the guardian recommends a more suitable living arrangement for the person.
  - Any medical treatment received by the person.
  - Services received by the person.
  - A list of the guardian's visits and activities on behalf of the person.
  - A recommendation as to the need for continued guardianship.
  - Pay any excess funds to a conservator, if one has been appointed

APS staff or any other interested person may petition the probate court for:

- Appointment of a guardian.
- Termination of a guardian.
- Removal of one guardian and replacement by another; the petition must include the name of the new guardian.
- Modification of a guardianship.

The individual adult may also petition the probate court for any of the actions listed above.

APS staff **must** petition for appointment of a guardian as an involuntary legal action only when life or serious physical harm is threatened and the APS worker has reasonable cause to believe the endangered person lacks the understanding or capacity to make an informed decision. APS staff **may** petition for the other court actions listed above when it would be in the best interest of the adult.

The person petitioning for the appointment of a guardian **is responsible for** identifying the person or entity who will serve as the guardian.

Temporary Guardian Under EPIC

In emergencies, APS staff or an interested person may petition the probate court for appointment of a temporary guardian for a person determined as legally incapacitated by the court. The temporary guardian will have only such powers as needed to abate the emergency and for a period not to exceed six months.

The probate court can exercise the powers of a temporary guardian in emergencies if no person or entity is available to act as temporary guardian. Before a temporary guardian is appointed there must be a hearing with notice to the person alleged to be incapacitated, a showing that the person is legally incapacitated, and it must appear that no other person has the authority to act. A hearing with notice to interested parties must be held within 28 days after the court has acted.

The APS worker must petition the probate court for appointment of a temporary guardian **only when the immediacy of the threat of death or serious physical harm does not permit waiting for a full hearing on appointment of a guardian**. When filing a petition for temporary guardian the local office should simultaneously petition for appointment of a guardian unless:

- The adult is not expected to live.
- The risk of harm is known to be of short duration.
- The adult's incapacity is expected to end within a short time.

COURT ACTIONS UNDER THE MENTAL HEALTH CODE

Plenary Guardians and Partial Guardians

Plenary guardians and partial guardians can be appointed for developmentally disabled (DD) persons only under Chapter 6 of the Mental Health Code. Only a probate court can make the appointment and whenever possible must appoint a partial guardian, with powers commensurate with the DD person's abilities, instead of a plenary guardian. The court can determine that the person is DD and the level of dysfunction only by the use of clear and convincing evidence.

Unlike all other guardianships, appointment of a partial guardian does not reduce or remove the individual adult's civil rights unless specified otherwise in the court order. A partial guardian has only those powers listed in the court appointment order.

Developmental disability is defined by the Mental Health Code: 1974 PA 258, Sec. 330.1100a (21).

Note: Guardianship for DD persons must be used only as necessary to promote and protect the well-being of the person.

APS staff or any interested person or entity, including the DD person may petition probate court for appointment, removal and replacement, termination or modification of the guardian's powers.

APS staff, when initiating any of these actions, must attempt to obtain the assistance of the local community mental health agency.

A current psychological evaluation is required to accompany the petition for appointment of a guardian of a DD person.

Civil Admission

Civil admission to a hospital or institution for treatment for mental illness is provided by Chapter 4 of the Mental Health Code. Civil admission to a hospital or institution for treatment or services for persons with developmental disabilities is provided for in Chapter 5 of the Mental Health Code.

Under both Mental Health Code chapters, individuals may seek voluntary admission. A person who has been diagnosed with an intellectual disability, cannot be admitted by voluntary admission. A person diagnosed with an intellectual disability can be admitted to a MDHHS/BHDD facility for a developmental disability only by judicial order.

Chapter 4 provides for involuntary admission of the mentally ill by:

- Admission by medical certification delivered to the hospital or institution.
- Protective custody by a law enforcement agency.
- Admission by petition to court.

Chapter 5 provides for involuntary admission of developmentally disabled persons by judicial admission.

When any type of admission to a mental health or developmental disability treatment facility is to be considered, the APS worker must make a referral to the community mental health agency.

If the mental health agency is unable to initiate action and a life threatening situation exists or serious physical harm may result if no action is taken, the APS worker must initiate the appropriate action with the assistance of the local prosecuting attorney and/or the community mental health agency.

The community mental health agency should provide direction on how to proceed and provide evaluations of the person's mental condition.

When admission to a mental health or developmental disability treatment facility is being sought by other persons and there is reasonable cause to believe that the individual adult is at risk of

harm from abuse, neglect or exploitation, the APS worker must intervene to protect the adult.

PROCEDURES FOR USING GUARDIAN/ CONSERVATOR-SHIP

The procedures for using guardian/conservatorships are determined by EPIC and good case management practice. Guidance may be sought from the local prosecuting attorney's office.

Court Procedures For Guardian/ Conservatorship

When petitioning for guardian/conservatorship under EPIC, the following court proceedings can be expected:

- There must be a person or entity named in the petition who **is willing** to serve as a guardian or conservator.
- Petition forms are available on the MDHHS share point forms page, online at the State Court Administrators Office website or from your local probate court. Be sure to obtain the form appropriate for the case, for example, the petition for guardian or conservator under EPIC or the petition for plenary or partial guardian under the Mental Health Code. If there is difficulty in obtaining the appropriate forms or if the probate court will not accept a petition unless completed by an attorney, notify the Adult Protective Services program staff in central office by email MDHHS-Adult-Services-Policy@michigan.gov.
- The petition must contain specific facts about the person's condition and examples of conduct to demonstrate the need for a guardian.
- Notice of the hearing must be served personally on the individual adult and any interested parties. The petitioner or counsel for the petitioner is usually responsible for arranging the delivery of notice on forms provided by the court.
- The court must take all practical steps to ensure the person is present at the hearing.

- The probate court must appoint a guardian ad litem. The duties of a guardian ad litem, as outlined in MCL 700.5305, are:
  - Personally visiting the individual.
  - Explaining to the individual the nature, purpose, and legal effects of the appointment of a guardian.
  - Explaining to the individual the hearing procedure and the individual's rights in the hearing procedure, including, but not limited to, the right to:
    - Contest the petition.
    - Request limits on the guardian's power.
    - Object to a particular person being appointed guardian.
    - Be present at the hearing.
    - Be represented by legal counsel and that legal counsel will be appointed for the person if he or she is unable to afford legal counsel.
- Informing the individual of the name of any person known to be seeking appointment as guardian.
- Asking the individual and the petitioner about the amount of cash and property readily convertible into cash that is in the individual's estate.
- Making determinations, and informing the court of those determinations on all of the following:
  - Whether there are one or more appropriate alternatives to the appointment of a full guardian or whether one or more actions should be taken in addtion to the appoint of a guardian.
  - Whether a disagreement or dispute related to the guardianship petition might be resolved through court ordered mediation.
  - Whether the individual wishes to be present at the hearing.
  - Whether the individual wishes to contest the petition.

    - Whether the individual wishes limits placed on the guardian's powers.
    - Whether the individual objects to a particular person being appointed guardian.

- The probate court may order that the person alleged to be legally incapacitated be examined by a physician or mental health professional to help assess the level of functioning. The person alleged to be incapacitated has the right to secure an independent evaluation, at state expense, if indigent.

- The court may grant a guardian only those powers and only for that period of time which the legally incapacitated person needs. The guardianship must encourage the development of the legally incapacitated person's maximum self-reliance and independence. The court order must specify any limitations on the guardian's powers and any time limits on the guardianship.

- The court may appoint a limited guardian if the legally incapacitated person lacks the capacity to do some but not all of the tasks necessary to care for him or herself.

- Michigan court rule, MCR 2.002, provides that court costs, fees and cost of publication of notice of the hearing, if needed, may be waived or suspended by the court upon a factual showing that the person who is petitioning is indigent or a recipient of public assistance. The waiver or suspension of costs may be requested by an affidavit (mc20) which states the facts of indigence or receipt of public assistance and is made by:

    - The person who is the subject of the hearing, or
    - Another person who has personal knowledge of the facts and shows he is acting in behalf of the other person because of that person's disability or the inability to act.

When petitioning for plenary or partial guardianship under the Mental Health Code, similar probate court proceedings can be expected with the following exceptions:

- The alleged developmentally disabled person is given court appointed legal counsel if the person does not have a self-paid legal counsel.

- A recent evaluation of the alleged developmentally disabled person's mental, physical, social, educational condition,

adaptive behavior and social skills must accompany the petition or will be ordered by the court.

- The appointment order must specify the duration of the guardianship and specify the powers of a partial guardian.
- A standby guardian may also be appointed to act in the absence or incapacity of the plenary or partial guardian. The standby guardian may have only those powers and duties given the appointed plenary or partial guardian.

Review of Guardianship And Conservatorship

The probate court requires an annual report for review from all guardians and conservators on the status of the individual adult and his estate or finances. This report may be available to the local office for review at the appointing probate court.

The court must review each guardianship/conservatorship not later than one year after the appointment of the guardian/conservator and not later than every three years thereafter. At the time of the court review or at any other time the APS worker or any interested person including the individual adult may provide the court with information regarding the guardianship/conservatorship or may petition the court for any of the actions affecting the guardian/conservatorship.

A change in the guardian/conservator relationship may be indicated when the APS worker has reason to believe that the guardian is not acting in the best interest of the individual, i.e., misuse of the individual's money or refusing to authorize medical treatment critical to life.

In reviewing the guardian/conservator relationship, the APS worker must:

- Assess the individual's attitude toward the termination of guardian/conservatorship.
- Document contacts with the client indicating discussions with the client about the pros and cons of the guardian/conservatorship.

- Assess the client's functioning level, specifically indicating how the client's functioning level is different than it was at the original appointment of the guardian/conservatorship.

Any resulting recommended court action is not to be initiated until after updating the case record and obtaining supervisory approval.

Selection Of Persons To Serve As Agents

In referring persons or entities who may perform the service of representative payee, conservator, or some form of guardian the APS worker should consider the following characteristics:

- Sensitivity to the individual's (client's) wishes and needs without conflicting personal interests.
- Demonstrated or acknowledged integrity and trustworthiness in handling another's resources.
- Training or knowledge in financial matters or personal or health care.
- Physical availability and willingness to perform the functions necessary for the management of the adult's financial affairs.
- Emotional stability and functional dependability.

No adult (except for spouses) is responsible to provide assistance or financial aid to another adult. It may be difficult to find a suitable and capable person or organization willing to assume these responsibilities. Relatives and friends who have, in the past, shown an interest in the individual adult are possibilities.

Priorities in the Probate Code

For appointment of guardians and conservators, the probate code lists the following in priority of preference:

- A person designated by the individual adult.
- A spouse.
- An adult child.

- A parent.
- Other relative with whom the adult has resided for more than six months prior to the petition filing date.
- A person nominated by a person or agency providing care or benefits to the individual adult.

Nursing Homes as Agents

Neither nursing care facilities nor their staff may act as guardian or conservator for their patients, but they may act as representative payee for SSA benefits.

ADVOCACY AND PROTECTION OF RIGHTS

Under all circumstances, the APS worker must make efforts to ensure that the individual's privacy, personal and property rights are fully protected. Therefore, MDHHS interference with or intervention into an adult's life or affairs without that person's consent **is warranted only when there is a risk of harm and the adult is unable or incapable of protecting their own interest**.

When other agencies or individuals are threatening the privacy, property or personal rights of an adult who is vulnerable, the MDHHS APS worker must intervene and assist the adult in asserting and protecting these rights. This intervention may be achieved by referring the individual to an advocacy or legal services organization such as those listed below:

- ARC of Michigan will assist adults with developmental disabilities through education, training, technical assistance and advocacy. 800-292-7851 or 517-487-5426.
- Michigan Protection and Advocacy Service, Inc. will assist persons with any disability. Services include information, referrals, technical assistance and education, and direct representation including legal representation. 800-288-5923 or 517-487-1755.
- Elder Law of Michigan provides the following services to older adults:

- The Legal Hotline for Michigan Seniors provides basic legal advice and information. 800-347-5297
- Mid-America Pension Rights Project will assist retirees in finding and recovering pension benefits. 866-735-7737

- Local legal aid offices may be able to provide legal advice and representation to low-income persons. Contact information for each local legal aid office can be found in the business section of the local telephone directory under Legal Aid.

- Area Agencies on Aging can assist in identifying legal and non-legal resources for persons 60 years of age or older. Contact information can be found in the business section of the local telephone directory or through the Area Agencies Association of Michigan at 517-886-1029.

The APS worker must assist the adult, as needed, in contacting these organizations seeking legal representation or advocacy services. If another person is initiating inappropriate or unnecessary legal action on behalf of an adult and the APS worker has reasonable cause to believe that the result will be exploitation of or harm to the adult, the APS worker must intervene in that legal action. The APS worker may intervene, with supervisory approval, by communicating specific concerns and facts that act as the basis of those concerns to the appropriate persons:

- In case of a court petition for guardianship/conservatorship, the communication should be addressed to the court appointed legal counsel or guardian ad litem or to the adult's own legal counsel.

- In cases of involuntary civil admission, the communication should be addressed to the adult's legal counsel, if there is one, or to the judge hearing the case.

- In cases of exploitative power of attorney arrangements or when there is reasonable belief the adult is unable to make informed decisions or lacks the capacity to consent to a power of attorney, the department may petition the court for appointment of a conservator whose authority overrides any power of attorney or an order making the power of attorney agreement void, unless it is a durable power of attorney

LEGAL BASE

- Social Welfare Act, MCL 400.11b(6).
- Estates and Protected Individuals Code, MCL 700.5303 - 700.5319.
- Mental Health Code; MCL 330.1100a(21), MCL 330.1600 - 330.1644, MCL 330.1515 - 330.1522, MCL 330.1400 - 330.1410.
- Michigan Court Rules of 1985, MCR 2.002.

ADULT PROTECTIVE SERVICES (APS) LEGAL REPRESENTATION

When a petition for a guardian or conservator, filed by APS is contested, the APS worker must be represented by legal counsel.

There are three ways to obtain legal counsel for these contested hearings.

Local Prosecuting Attorney

The first option an APS worker must seek for legal representation is their local prosecuting attorney's (PA) office. Under some circumstances, the local PA will provide free representation. If the PA requests payment for representing APS, APS must then seek representation by a Special Assistant Attorney General.

Special Assistance Attorney General (SAAG)

The Michigan Attorney General's Office (AG) has agreed to provide representation for APS in contested hearings and has compiled a list of Special Assistant Attorney Generals (SAAG) from across the state. The AG has contracted with these SAAG's to provide APS representation for contested guardianship petitions.

A list of available SAAG's is located on the Adult Services home page on the DHS intranet. This list includes the counties each SAAG has agreed to represent.

DHS-686, Adult Services Legal Representation Request Form

The DHS-686, Adult Services Legal Representation Request Form, is used to notify the Office of Adult Services (OAS) and the AG that the local office has retained legal representation from an identified SAAG. The DHS-686 is completed by the adult services worker, signed and forwarded to their supervisor.

The adult services supervisor must review the DHS-686 for accuracy and need for representation. If approved, the supervisor signs the DHS-686 and emails a copy of the signed form to all of the following email addresses, with the subject heading "APS Legal Representation":

- Policy-Adult-Services-DHS@michigan.gov
- howdr@michigan.gov
- Blackc9@michigan.gov

Note: Retain the signed copy of the DHS-686 in the APS case file.

Payment for SAAG Services

Once representation has been provided, the SAAG will forward their invoice to the AG for review. The AG will then forward to OAS who will process the DHS-1582, Payment Voucher and forward to accounting to process payment.

Local Attorney

When the local office is unable to retain representation from either the PA or a SAAG, **they must email the OAS policy mailbox for approval and instructions** on obtaining a local attorney for needed representation. Policy-Adult-Services-DHS@michigan.gov

Note: Use of a local attorney must always be the last option after contacting the local PA and SAAG.

LEGAL BASE

Social Welfare Act, Act 280 of the Public Acts of 1939, as amended, MCL 400.11 - 400.11f.

AVAILABLE SERVICES

The following services are available or may be sought and utilized for APS clients:

- Protection: The components of protection are:
  - Protective services investigation.
  - Social protection.
  - Financial management.
  - Conservatorship/guardianship/civil commitment.
- Counseling.
- Education and training.
- Family centered planning.
- Health related medical examinations and evaluations:

  Note: A general physical examination does not include laboratory tests. If such are essential include the additional costs on form DHS-93, Authorization Invoice. For example, a complete routine urinalysis or complete blood count must be authorized on a separate form DHS-93.

  - If the examination is done by a specialist, for example: psychiatrist, neurologist, or internist, the local office may authorize payment up to the limit on the fee schedule. Payments in excess of the fee schedule may be approved by the local office director.
  - Reimbursement for medical examinations and evaluations will be based upon the Diagnostic Fee Examination Schedule, as stated in Reference Table Manual RFT 285.
- Homemaking.
- Housing assistance.
- Special APS home help services component.

  Home help services are provided to assist adults in need of protection with routine activities of daily living. These are activities which they are unable to perform and are necessary to prevent injury or harm. There are no eligibility requirements

related to income or assets for APS clients. Payments may be authorized for, but are not limited to, the following:

- Heavy house cleaning, including rentals of necessary equipment such as dumpsters, exterminator's services, and carpet cleaners.
- Household equipment such as refrigerators or air conditioners.
- Activities of daily living such as eating, toileting, bathing, grooming, dressing, transferring & mobility.
- Instrumental activities of daily living such as medication, laundry, housework, meal preparation and shopping.
- Emergency housing.

Note: Home help payments for adults in need of protection cannot exceed $1,000 within a twelve-month fiscal year. There are no exceptions to the amount available for needed services. However, exceptions may be approved for services not listed above when deemed necessary to provide for the protection of the client. **Services that can be covered under another program, such as SER or Medicaid, or are free must not be authorized.**

Exception Request

Exception requests must be sent to the Office of Adult Services for approval by email, fax or ID mail. For information on this process, contact central office APS program staff.

Process payments for HHS/APS **locally** after the following requirements are met:

- The case is open on the Adult Services Comprehensive Assessment Program (ASCAP) as an APS case.
- The provider is enrolled for HHS (eligibility 01).
- Documentation in ASCAP supports the need for HHS as a part of the adult protective services plan.
- Documentation in ASCAP supports that there are no other available funding sources for needed services.

- Exception approvals must be in the case file and documented on ASCAP.
- Payments are entered through the Payments Module on ASCAP.

Emergency Shelter/Relocation Options:

Emergency shelter/relocation options are outlined in the State Emergency Relief (ERM 303). These services can be arranged in cooperation with local ES/FIS staff when no other appropriate alternative is available and the client appears competent and is willing to relocate.

Emergency shelter is provided through resources including county Emergency Services funding with director approval and/or a contractual agreement with the Salvation Army.

LEGAL BASE

Social Welfare Act, Act 280 of the Public Acts of 1939, as amended, MCL 400.11 - 400.11f.

PURPOSE

This item establishes Department policy regarding the reporting of deaths of adult services clients.

Note: For child deaths, refer to Services Requirements Manual (SRM) item 172 Child Death Reporting Process.

REASONS FOR REPORTING

The following are the key reasons for reporting deaths of adult services clients:

- To notify key administrators of the fatality, the circumstances surrounding the fatality, and that required department procedures have been initiated.
- To respond to legislative, executive and media inquiries.
- To seek ways of learning contributing factors and, where appropriate, addressing systemic issues that could prevent further deaths.
- To meet the personal and emotional needs of clients and staff at the time the death occurs.

DHS-4712, Adult Services Death Report Form

All reports involving adult services clients must be submitted on the DHS-4712, Adult Services Death Report form. The DHS-4712 is available in the MDHHS Forms Library and includes detailed instructions and distribution information.

- The report is to be prepared and submitted to the adult services policy mailbox (MDHHS-Adult-Services-Policy@michigan.gov) no later than five business days after the death occurred or five business days after the person responsible for reporting became aware of the death.

Note: Deaths that are suspicious, that have media involvement, a criminal investigation or criminal court proceedings have **additional distribution requirements**.

- In instances involving multiple deaths, a separate report is to be prepared and submitted for each individual.

Types of Adult Services Deaths to Report

Adult Protective Services

All active adult protective services cases/investigations, where the client dies, must be reported utilizing the DHS-4712.

Independent Living Services or Adult Community Placement

Independent living services or adult community placement clients, where the circumstances surrounding the death may have an impact on Department policy, procedure or operation; and/or the nature of the death may require the Department to respond to public inquiry.

- Deaths occurring in state-regulated adult foster care homes or homes for the aged are to be reported by the Bureau of Community and Health Services within the Department of Licensing and Regulatory Affairs.
- Deaths of independent living services clients are to be reported by the adult services worker.

The Social Welfare Act MCL 400.11

MCL 400.11a Reporting abuse, neglect, or exploitation of adult; oral report; contents of written report; reporting criminal activity; construction of section.

MCL 400.11b Investigation; purpose; basis; providing licensee with substance of allegations; cooperation of local law enforcement officers; investigation not to be in place of investigation of suspected criminal conduct; scope of investigation; in-person interview; search warrant; availability of protective services; collaboration with other agencies; petition for finding of incapacity and appointment of guardian or temporary guardian; petition for appointment of conservator; providing copy of report to state department and prosecuting attorney.

MCL 400.11c Confidentiality of identity of person making report; immunity from civil liability; presumption; extent of immunity; abrogation of priviliged communication; exception.

MCL 400.11d Availability of writing to public; correction of inaccurate statements; identification of unsubstantiated statements.

MCL 400.11e Failure to make report; liability; disposition of fine.

MCL 400.11f Certain actions and investigations prohibited; report; interdepartmental agreements; coordinating investigations; agreement establishment criteria.

MCL 400.14 Additional powers and duties of department; powers and duties of county social services boards as to general public relief transferred to department; changing eligibility standards and coverages for medical care.

USE OF CLIENT EVALUATION SCALES

The following two scales, **Sample Financial Management Scale** in ASM 253, and the **Sample Guardianship Scale** in ASM 254, are intended to help workers to assess a client's capabilities and also assist them in any decision regarding the appropriateness of different types of client management arrangements. The financial management scale evaluates the client's need for help in managing personal finances and business affairs. The guardianship scale evaluates the client's ability to understand, make and communicate essential decisions about his/her person in order to avoid endangerment.

The scales could also be useful to document how decisions were reached, for supervisory review purposes and for new worker on the job training.

SCALE FOR EVALUATING FISCAL MANAGEMENT PROBLEMS

The **Sample Financial Management Scale** in ASM 253 can be used by the worker when assessing an individual case to determine if there is a need for a representative payee, power of attorney arrangement or a court appointed conservator. General guidelines for evaluating fiscal management problems can be found in ASM 205.

INSTRUCTIONS

Questions 1 through 5 of the scale measure the cognitive ability of the client. Question 6 measures the client's physical ability and questions 7 and 8 measure the client's willingness. If a client is unwilling to accept assistance in managing his/her financial affairs then only a representative payee or a conservator should be considered since all other forms of financial management require client consent.

The three columns on the right side of the scale for questions 1 through 4 measure the degree of dysfunction present and also if training can be used to adequately correct the functional deficiency.

For questions 5 and 6 these columns measure if the client could adequately function if assisted and if assistance is available.

The **Sample Guardianship Scale** in ASM 254 can be used by the worker when assessing an individual case to determine if there is a need for a court appointed guardian or a temporary guardian. General guidelines on the use of arrangements for management of the person can be found in ASM 205.

The opening paragraph on the scale describes the only circumstances in which a worker should consider the use of a guardian or temporary guardian.

Questions 1 through 9 explore the client's capability to understand and communicate regarding decisions necessary for his/her safety and protection. The three columns on the right side of the scale measure the degree of dysfunction and the adequacy of assistance from others. If other persons can be found to assist then appointment of a guardian may not be necessary. However, if the information indicates the client's functioning is inadequate and there is no one to assist, then guardianship could be considered if the client is endangered.

SAMPLE FINANCIAL MANAGEMENT SCALE (PAGE 1)

NEED FOR FINANCIAL MANAGEMENT SCALE
(Representative Payee, Power of Attorney, Conservator)

County: _____ Worker Name: _____

Client Name: _____ Date Completed: _____

Case Number: _____

INDICATORS OF NEED:	Adequately	Could do/know Adequately if Taught	Inadequately And Cannot Be Taught
Cognitive Ability to Follow a Workable Budget: OBSERVED BY WORKER OR REPORTED BY: _____			
1. Can the person manage his/her finances, as: can add and subtract; knows sources of income; knows where his/her benefit checks are and how to cash them; is able to get and use his/her food stamps; he/she knows how much money he/she has and how much he/she regularly receives; is able to manage a checking account, or OTHER: _____	☐	☐	☐
2. Are bills, taxes or mortgage payments unpaid when the person has sufficient funds to pay the bills and no valid reason not to make payment? Or are rent or other payments that are due not collected? (e.g., the person would not be expected to pay for overcharges or defective products, etc. and so non-payment in these cases would not constitute an inadequacy.)	☐	☐	☐
3. Can the person determine the amount of his/her bills and make payment.	☐	☐	☐
4. Does the person operate on a workable monthly budget for meeting his/her expenses and paying his/her debts? (An operating budget) (If client has insufficient funds to meet essential expenses, worker should review if the client is getting all the benefits he/she is entitled to and/or provide-arrange for provision of money management training or assistance the person to budget within his/her means.)	☐	☐	☐

SAMPLE FINANCIAL MANAGEMENT SCALE (PAGE 2)

INDICATORS OF NEED:	Adequate or has Adequate Assistance	Could do/know Adequately if Assisted	Inadequately And Cannot Be Assisted
5. Could the person independently follow a workable monthly budget without further money management type assistance once the budget was established or with only occasional review or help?	☐	☐	☐
6. Is the person physically able to handle banking business, pay his/her bills, collect payments due him/her or other necessary financial affairs? (e.g. not prevented by a physical handicap or hospitalization)	☐	☐	☐

	Yes	No
7. Is the person willing to learn how to follow a monthly budget, do his/her own banking, pay bills, collect payments due him/her, etc. and willing to perform these functions for him/herself in the future?	☐	☐
8. Is the person willing to have someone else (friend, relative, or other) assume all of the financial management tasks that are essential for maintaining his/her affairs and the person (client) is either unable, even after money management training, or unwilling to perform these tasks for him/herself?	☐	☐

If YES to #7, then financial management training is appropriate.

If YES to #8, the worker should explore the use of a power of attorney who could perform those specific financial management tasks that the client is unable or unwilling to perform for him/herself.

If YES to #8, and the person is receiving some income benefits (GA, SSI, etc.) which if managed properly would result in the sound management of the person's finances, then the worker should explore the possible use of a protective or representative payee.

If the person appears competent (has the capacity to make the decision) but is unwilling to permit another to assume management of his/her essential financial functions and this refusal will result in the dissipation of funds needed for the support, care, and welfare of the person (client) and the person is consequently endangered, then the worker should consider court appointment of a conservator or another protective order. If court action is to be pursued the worker must be able to show why:

a. He/She has reason to believe and can demonstrate that the person is unable to manage his/her property or affairs effectively because of a problem of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, confinement or detention, AND

SAMPLE FINANCIAL MANAGEMENT SCALE (PAGE 3)

b. He/She has reason to believe and can demonstrate that unless there is appointment of a Conservator or other protective order, the person's inability to manage his/her property or affairs will result in endangerment and in there being no funds for the support, care and welfare of the person and that all possible voluntary efforts to provide the needed management of the client's property and affairs have been tried and failed or have been considered and determined inadequate.

(DSS can function as a petitioner for a conservator only when no suitable person familiar with the circumstances is willing to petition.)

If the client's funds or property are being wasted or used by another person for reasons other than a benefit to the client with or without the client's knowledge or consent and are being used to the degree that the client is being, or at risk of being, deprived of basic necessities such as food, shelter, clothing or medical care, then:

1. Use of a protective or representative payee or a power of attorney should be considered by the worker if the client is able and willing to consent.

2. Use of a representative payee or a court appointed conservator should be considered by the worker if, under the circumstances, the client is unable or unwilling to consent.

Exploitation of the person's funds or property without his/her consent can be grounds for a criminal charge against the perpetrator and submission of a report to the county prosecutor's office may be considered by the worker in light of all other circumstances of the case.

Additional Notes:

File in Case Record when completed.

SAMPLE GUARDIANSHIP SCALE (PAGE 1)

NEED FOR GUARDIANSHIP SCALE
(Guardian and Temporary Guardian)

County: _____ Worker Name: _____
Client Name: _____ Date Completed: _____
Case Number: _____

If a client's person is in danger or at risk or is potentially in danger and the client is unable, because of a mental or physical impairment, to determine and take action necessary to avoid the danger or risk due to his/her insufficient understanding or capacity to make or communicate decisions concerning his/her person the worker should consider the court appointment:

I. Of a Guardian if:

a. The worker has cause to believe and can clearly and convincingly demonstrate that the person lacks the capacity to make or communicate informed decisions concerning his/her person, and

b. It can be clearly demonstrated that the person's inability to make decisions concerning his/her person is due to an impairment by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, and

c. It can be shown that ONLY appointment of a guardian will result in responsible decisions being made about the client's person, and reasonable communications being made to others when necessary to prevent endangerment and to assure continuing care and supervision to the person.

II. Of a Temporary Guardian if:

a. All the conditions above are met, plus

b. If immediate action is not taken, the person's life will be endangered and there is no one else willing or able to act for the person (client)

	Adequately or Someone Else is Assisting Adequately	Adequately if Someone/Thing Else Would Assist	Inadequate and No One Else to Assist
INDICATORS OF NEED:			
1. The person is able to make decisions related to maintaining his/her person in a healthy and safe state	❑	❑	❑

(continued on next page)

SAMPLE GUARDIANSHIP SCALE (PAGE 2)

INDICATORS OF NEED:	Adequately or Someone Else is Assisting Adequately	Adequately if Someone/Thing Else Would Assist	Inadequate and No One Else to Assist
1. (continued) (e.g., The person is able to recognize serious or harmful problems, The person: eats regularly and is not frequently out of food, does not wander about at night, washes or bathes regularly, is not too trusting of strangers, etc.)			
WORKER OBSERVED or REPORTED BY ANOTHER; Explain: _____ _____			
2. The person is able to understand and follow simple instructions regarding self-care and in some situations essential home management tasks (e.g., the individual does not get direction from imaginary persons or things or has "visions" or "spells" to extent he/she cannot follow instructions.)	☐	☐	☐
WORKER OBSERVED or REPORTED BY ANOTHER; Explain: _____ _____			
3. The person is able to utilize available resources (including financial resources) for his/her essential personal care and welfare.	☐	☐	☐
WORKER OBSERVED or REPORTED BY ANOTHER; Explain: _____ _____			

SAMPLE GUARDIANSHIP SCALE (PAGE 3)

INDICATORS OF NEED:	Adequately or Someone Else is Assisting Adequately	Adequately if Someone/Thing Else Would Assist	Inadequate and No One Else to Assist
4. The person is able to understand or learn how to use essential appliances safely (stove, electrical appliances, furnace thermostat, etc. are not misused)	☐	☐	☐
WORKER OBSERVED or REPORTED BY ANOTHER; Explain: _____			
5. The person knows where he/she is in time and space and knows his/her destination or his/her way back home. (e.g. the person knows the date, day of the week and time and knows where he/she is at all times. The person fails to recall immediate or recent events. The person does not get lost.)	☐	☐	☐
WORKER OBSERVED or REPORTED BY ANOTHER; Explain: _____			
6. The person knows or is able to learn what to do in emergencies (fire, burglary, etc.)	☐	☐	☐
WORKER OBSERVED or REPORTED BY ANOTHER; Explain: _____			
7. The person is able to exercise responsible judgment in regards to his/her own abilities so not to attempt endangering acts, behavior or risks.	☐	☐	☐
WORKER OBSERVED or REPORTED BY ANOTHER; Explain: _____			

SAMPLE GUARDIANSHIP SCALE (PAGE 4)

INDICATORS OF NEED:	Adequately or Someone Else is Assisting Adequately	Adequately if Someone/Thing Else Would Assist	Inadequate and No One Else to Assist
8. The person knows when assistance is needed and is able to take action to get assistance (e.g. medical services; help in relocating out of an unsafe structure or in response to eviction; to obtain common needed pharmacy supplies or prescriptions, etc. The person is understandable in conversation, does speak to others, and hears and understands what they are saying.)	☐	☐	☐
9. The person is able to behave in a way that is not a real or potential danger to others. (e.g. the person throws and destroys property when upset or gets violently angry over little things)	☐	☐	☐

WORKER OBSERVED or REPORTED BY ANOTHER; Explain:

_____

_____

WORKER OBSERVED or REPORTED BY ANOTHER; Explain:

_____

_____

Additional Notes:

File in Case Record when completed.

AGREEMENT

Following is the agreement between the Department of Human Services (DHS), formerly Department of Social Services (DSS), and the Department of Community Health (DCH), formerly Department of Mental Health (DMH):

An Agreement Between the Department Of Social Services
and the Department Of Mental Health
On Adult Protective Services Investigations
As Required Under 1982 P.A. 519 and 1974 P.A. 258

A. Introduction

Adults receiving mental health services in or through state funded facilities which are operated by the Department of Mental Health (DMH) or residential homes and facilities under contract with DMH are assured protection from abuse and neglect under the Mental Health Code. The Department of Social Services (DSS) is also mandated by Public Act 519 (1982) to provide protective services to vulnerable adults as determined necessary after investigation of reports of abuse, neglect, exploitation or endangerment. Recognizing the need to avoid duplication of services to those adults in facilities operated by DMH, Public Act 519 precludes DSS from investigations in these facilities and permits agreements concerning investigations in residential homes and facilities under contract with DMH.

B. Definitions

1. "Abuse" means harm or threatened harm to an adult's health or welfare caused by another person. Abuse includes nonaccidental physical or mental injury, sexual abuse, or maltreatment.

2. "Adult in need of protective services" or "adult" means a vulnerable person not less than 18 years of age who is suspected of being abused, neglected, exploited, or endangered.

3. "Endangered" or "endangerment" means a life threatening situation caused by the inability of the person whose life is threatened to respond.

4. "Exploitation" means an action which involves the misuse of an adult's funds, property, or personal dignity by another person.

5. "Neglect" means harm to an adult's health or welfare caused by the conduct of a person responsible for the adult's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care.

6. "Vulnerable" means a condition in which an adult is unable to protect himself or herself from abuse, neglect, exploitation, or endangerment because of a mental or physical impairment or because of the frailties or dependencies brought about by advanced age.

C. Purpose

To enter into an agreement between DSS and DMH concerning each department's statutory role in the investigation of alleged or suspected abuse, neglect, exploitation or the endangerment of adult residents of state funded and DMH operated facilities and of adult residents of

AGREEMENT (PAGE 2)

residential homes and facilities under contract with DMH in order to avoid duplication of effort. This agreement revokes and cancels all previous agreements relative to the investigation of such complaints regarding adult residents in state funded and DMH operated facilities or in residential homes and facilities under contract with DMH.

D. Legal Basis

Act No. 519, Public Acts of 1982, being MCL 400.11 through 400.11f.
Act No. 258, Public Acts of 1974, being MCL 330.1001 et. seq.

E. Statutory Requirements

1. In keeping with 1982, P.A. 519, Section 11f(1) that DSS "shall not take any action pursuant to Sections 11 to 11e in the case of a person who is residing in a state funded and operated facility or institution, including but not limited to a correctional institution, mental hospital, psychiatric hospital, psychiatric unit, or a developmental disability regional center."

2. To implement 1982, P.A. 519, Section 11f(3) which permits DSS to enter into "interdepartmental agreements to carry out the duties and responsibilities of the state department under Sections 11 to 11e in state funded and operated facilities and institutions, or to coordinate investigation in state licensed facilities under contract with a state agency in order to avoid duplication of effort among state agencies having statutory responsibility to investigate."

3. To assure compliance with 1982, P.A. 519, Sections 11 to 11e, which establish the requirements for the investigation of reports of suspected adult abuse, neglect, exploitation or endangerment, i.e.,

   a. to commence an investigation within 24 hours if there is a reasonable belief the person suspected to be at risk is an adult in need of protective services,

   b. to conduct the investigation so as to include the following:

      1) determination of the nature, cause and extent of harm,
      2) examination of evidence,
      3) identification, if possible, of the perpetrator,
      4) names, conditions of other adults in the residence,
      5) evaluation of persons responsible for care of the adult,
      6) environment of the residence,
      7) relationship of the adult to the person responsible for care,
      8) evaluation of adult's willingness to receive protective services.

   c. to conduct a personal interview with the adult,

   d. to determine if the adult is or was actually abused, neglected, exploited or endangered.

AGREEMENT (PAGE 3)

e. to make available to the adult the appropriate and least restrictive protective services and take necessary action to safeguard and enhance the welfare of the adult, if possible,

f. to prepare a written report on the investigation's findings,

g. to correct any inaccurate report and to identify any unsubstantiated statements in reports,

h. to provide an adult foster care licensee in whose licensed AFC facility an investigation is taking place, with the substance of the allegations as soon as practicable after the beginning of the investigation.

4. In keeping with 1982, P.A. 519, Section 11c(1) "the identity of a person making a report shall be confidential and subject only to disclosure with the consent of that person or by judicial process." Also to assure that any person reporting in good faith or assisting in the investigation "... shall be immune from civil liability...." Furthermore, as in (2), "any legally recognized privileged communication, except that between attorney and client..." and that accorded a physician using professional judgment in the best interest of the patient, "...is abrogated...." and cannot be used to excuse a report as required by this act.

5. In accord with 1982 P.A. 519, Section 11b(6) which requires DSS to "collaborate with....appropriate state and community agencies providing human services"....and Administrative Rule 400.6(25) which permits the sharing of client information with other agencies when this is related to the administration of the adult protective services program and to assist in services provision, provided that:

   a. the confidential nature of the information is preserved;

   b. the information is used only for the purpose for which it was released; and

   c. assurance is given steps will be taken to safeguard the information.

6. In compliance with 1974, P.A. 258, Section 330.1722(1) "A recipient of mental health services shall not be physically, sexually, or otherwise abused." And (2) "The governing body of each facility shall.....protect recipients....from abuse..., shall provide a mechanism.....for reviewing all charges of abuse, (and) shall ensure that.....disciplinary action is taken....."

7. In keeping with 1974, P.A. 258, Section 330.1748(6), "Information may be shared in the discretion of the holder of the record: (c) To providers of mental or other health services or a public agency when there is a compelling need for disclosure based upon a substantial probability of harm to the recipient or other persons."

AGREEMENT (PAGE 4)

F. Mental Health Residential Homes, Facilities and Programs Covered by This Agreement

1. DMH Funded and Operated Facilities (see attached list)

   a. Regional Psychiatric Hospitals and Special Facilities

   b. Regional Centers for Developmental Disabilities

2. Residential Homes and Facilities under contract with DMH

   a. Specialized Residential Facilities/DD Homes

   b. Specialized Residential Facilities/MI Homes

   c. Semi-Independent Settings

3. Other Mental Health Residential Homes, Facilities and Programs

   a. Private Psychiatric Hospitals and Units

   b. Public Psychiatric Hospitals and Units not operated by DMH

   c. Residential Homes, Facilities or Programs operated by or under contract with CMH.

G. Responsibility to Report Suspected Abuse, Neglect, Exploitation, Endangerment of Adult Residents

1. DMH Funded and Operated Facilities

   a. Each employee of a facility which is DMH funded and operated who has knowledge of, suspects or has reasonable cause to believe an adult resident of the facility has been abused, neglected, exploited or is endangered shall make an oral report immediately to the appropriate local DSS office to assure compliance with the mandatory reporting requirement of 1982 P.A. 519(Section 11a(1)). The local DSS office shall document receipt of the report but shall not take further action in keeping with the provisions of 1982 P.A. 519, (Section 11f(1)).

   b. Each employee shall also report, as noted above in (a), on a DMH Incident Report Form (DMH-2550) according to the established policy and procedures of the facility.

   Exception: An employee who wishes his/her identity to remain confidential, subject only to disclosure with consent or by court order, shall state this when making the oral report to DSS. The local DSS office staff person who receives such a confidential report shall forward the report immediately to the appropriate DMH facility Rights Advisor, keeping the identity of the complainant confidential.

   c. The local DSS office staff person who receives a report about an adult resident of a DMH facility, from a source other than a DMH employee of a facility noted in F-1, shall report immediately to the appropriate DMH facility Rights Advisor.

AGREEMENT (PAGE 5)

2. Residential Homes and Facilities under contract with DMH

a. Each employee of a residential home or facility which is under contract with DMH who has knowledge of, suspects or has reasonable cause to believe an adult resident of the facility has been abused, neglected, exploited or is endangered, shall make an oral report immediately to the appropriate local DSS office to assure compliance with the mandatory reporting requirement of 1982 P.A. 519 (Section 11a(1)).

b. Each employee shall also report, as noted above in (a), on a DMH Incident Report Form (DMH-2550) according to the established policy and procedures of the home or facility.

Exception: An employee who wishes his/her identity to remain confidential, subject only to disclosure with consent or by court order, shall state this when making the oral report to DSS. The local DSS office staff person who receives such a confidential report shall use the procedures noted in H-2, keeping the identity of the complainant confidential.

c. The local DSS staff person who receives a report about an adult resident of a specialized residential home or facility under contract with DMH (F-2 a,b) which is also licensed under the Adult Foster Care Act, shall notify immediately the appropriate DSS Adult Foster Care Licensing Consultant to assure a licensing investigation in accordance with the provisions of 1979 P.A. 218.

3. Other Mental Health Residential Homes, Facilities and Programs

a. Each employee of any other mental health residential home, facility and program who has knowledge of, suspects or has reasonable cause to believe an adult in a home, facility or program has been abused, neglected, exploited or is endangered, shall report immediately to the local DSS office in the county in which the home, facility or program is located.

b. The local DSS staff person who receives a report about an adult resident of a residential home or facility operated by or under contract with CMH (F-3c) which is also licensed under the Adult Foster Care Act, shall notify immediately the appropriate DSS Adult Foster Care Licensing Consultant to assure a licensing investigation in accordance with the provisions of 1979 P.A. 218.

H. Responsibility to Investigate Reports of Suspected Abuse, Neglect, Exploitation, Endangerment of Adult Residents, and to Submit Written Reports

1. DMH Funded and Operated Facilities

a. The DMH Office of Recipient Rights shall have responsibility for the investigation of reports of suspected abuse, neglect, exploitation or endangerment of any adult resident in DMH funded and operated facilities.

AGREEMENT (PAGE 6)

b. The DMH Rights Advisor shall assure that a copy of the Recipient Rights Report Form (DMH-2501), both incomplete and final, on any rights case which was reported to the DMH Rights Advisor by a local DSS office, is sent to the appropriate local DSS office when it is filed. The local DSS office shall also be informed by the Rights Advisor when such a rights case which substantiates a violation of rights is referred to a DMH bureau director or to the DMH Director for remedial action and when such action is completed.

c. The local DSS office of the county in which the alleged incident occurs shall be responsible to investigate reports of suspected abuse, neglect, exploitation, or endangerment of an adult resident of a DMH funded and operated facility whenever such an incident occurred prior to admission to the facility or occurs while the resident is on leave of absence from the facility.

d. The local DSS office APS Complaint Coordinator shall assure that a written report of the investigation of any substantiated incident involving an adult resident prior to admission to the facility or while she/he is on leave of absence is sent to the appropriate DMH facility Rights Advisor.

2. Residential Homes and Facilities under contract with DMH

a. The local DSS office receiving a report of suspected abuse, neglect, exploitation, or endangerment of an adult resident of a residential home or facility under contract with DMH shall document receipt of the report and immediately delegate responsibility to investigate the report to the appropriate DMH Rights Advisor, keeping the identity of the complainant confidential, if compliance with P.A. 519 requirements is assured. (See Section E-3 of this Agreement, Statutory Requirements.)

b. The DMH Rights Advisor shall assure that a copy of the Recipient Rights Report Form (DMH-2501), both incomplete and final, on any rights case which was delegated to the DMH Rights Advisor for an investigation, is sent to the appropriate local DSS office when it is filed. The local DSS office shall also be informed when such a rights case which substantiates a violation of rights is referred to a DMH bureau director or to the DMH Director for remedial action, and when such action is completed.

c. The local DSS office APS Complaint Coordinator shall review the report of the DMH Recipient Rights investigation and any subsequent remedial action to assure compliance with the requirements of P.A. 519.

d. If the local DSS office has reason to believe that compliance with P.A. 519 cannot be assured before the investigation or upon receiving the DMH Recipient Rights report, it shall conduct an investigation and also initiate the procedures noted in Section I-3 of this Agreement to resolve any compliance problems.

AGREEMENT (PAGE 7)

3. Other Mental Health Residential Homes, Facilities and Programs

a. The local DSS office of the county in which the incident occurs shall have responsibility for the investigation of reports of suspected abuse, neglect, exploitation or endangerment of an adult in a residential home, facility or program noted in F-3.

b. The local DSS office APS Complaint Coordinator shall assure that a written report on the outcome of the investigation of any report of abuse, neglect, exploitation or endangerment is sent to one or more of the following, as appropriate:

(1) Facility Director of private psychiatric hospital/unit/ or public psychiatric hospital/unit not operated by DMH;
(2) DMH Licensing and Accreditation Division, when facility is licensed by DMH;
(3) DSS Adult Foster Care Licensing Consultant when residential home/facility is licensed under 1979 P.A. 218;
(4) CMH Agency Director, when residential home/facility/ program is operated by or under contract with CMH;
(5) CMH Officer of Recipient Rights, when residential home/facility/program is operated by or under contract with CMH;
(6) DMH Office of Recipient Rights, in all cases.

I. Administration

1. In accordance with the statutory requirements of P.A. 519 and P.A. 258 and to fulfill each agency's responsibility to investigate and provide protective services to vulnerable adults, case records and other information pertinent to the investigation may be mutually shared provided confidentiality requirements are maintained when applicable.

2. DMH shall provide to DSS a list of all residential homes and facilities under contract with DMH and a list of all licensed private psychiatric hospitals and units by county of location with address, telephone number and facility director noted, within sixty days of the effective date of this Agreement and on a quarterly basis thereafter.

3. Resolution of any problems regarding the implementation of this Agreement shall first be attempted between the field organizations involved. If no solution acceptable to both parties is possible at the field level, the matter shall be referred to either the DMH Office of Recipient Rights or the DSS Office of Adult and Family Community Services, Adult Protective Services, as appropriate.

4. This Agreement shall be effective upon signature of the Directors of DSS and DMH. It may be reviewed for the purpose of revision at the request of either DSS or DMH at any time, but shall be reviewed at least annually.

AGREEMENT SIGNATURES (PAGE 8)

-8- DSS/DMH

Agnes M. Mansour
Director: signature
Michigan Department of
Social Services

12/29/83
Date

C Patrick Richard
Director: signature
Michigan Department of
Mental Health

1/17/84
Date

AGREEMENT BETWEEN DSS & CMH ON APS INVESTIGATIONS

Inter-Agency Agreement for the Provision of Adult Protective Services

DCH/MH OPERATED FACILITIES

Michigan Department of Community Health/Mental Health (DCH/MH)

Centers for the Developmentally Disabled	Director	Phone Number
Michigan's centers for the developmentally disabled have closed.	N	
Psychiatric Hospitals - Adults	**Director**	**Phone Number**
Caro Center 2000 Chambers RoadCaro, MI 48723	Rose Laskowski, R.N., B.S.N.	(989) 673-3191 FAX: (989) 673-6749
Kalamazoo Psychiatric Hospital Box A, 1312 Oakland Drive Kalamazoo, MI 49008	James J. Coleman, Ed.D.	(269) 337-3000 FAX: (269) 337-3350
Walter Reuther Psychiatric Hospital 30901 Palmer Road Westland, MI 48185	Shobhana Joshi, M.D.	(734) 367-8400 FAX: (734) 722-5562

Mental health services are coordinated through local Community Mental Health Services Programs (CMHSP). An alphabetical list of local CMHSP's can be located at http://www.michigan.gov/documents/cmh_8_1_02_37492_7.PDF.

REVISED AGREEMENT BETWEEN DSS & PUBLIC HEALTH (PAGE 1)

REVISED
MEMORANDUM OF AGREEMENT
between the
MICHIGAN DEPARTMENT OF SOCIAL SERVICES
and the
MICHIGAN DEPARTMENT OF PUBLIC HEALTH

This Agreement outlines responsibilities for both the Michigan Department of Public Health (DPH) and the Michigan Department of Social Services (DSS) in the resolution of complaints of abuse, neglect, or exploitation of adult patients or residents in facilities licensed by the Department of Public Health.

The following are adopted as policy and procedure standards for both Departments in accord with the provisions of 1978 P.A. 368, as amended, and 1982 P.A. 519 as amended.

1. DPH will have sole responsibility for investigating complaints of abuse, neglect, or exploitation of adult patients and residents insofar as these incidents allege violations of DPH rules and statutes by facility staff or nonstaff that occur in licensed health care facilities. Licensed health care facilities are nursing homes, hospitals, homes for the aged and free-standing surgical outpatient facilities.

2. DSS local office staff shall continue to be responsible for the investigation of complaints involving adult patients and residents of DPH licensed facilities if the alleged violation is not within DPH statutory authority or took place outside the facility in the community, e.g., exploitation of a hospital or nursing home patient's fiscal/property resources by a guardian or relative, abuse of a hospital or nursing home patient by a family member or other person while the patient is on a home visit, etc.

3. Both Departments will have an intake mechanism for receiving complaints.

4. DSS will advise all complainants who report alleged violations of DPH rules and statutes to submit a written complaint directly to the DPH. If DSS personnel and/or complainants feel that an adult patient or resident is seriously at risk, a telephone call will be made by the APS worker directly to the DPH Complaint Unit in Lansing 1-800-882-6006.

5. DPH will make referrals for services to the local office DSS in the county where the licensed health care facility is located whenever other social services are needed.

REVISED AGREEMENT BETWEEN DSS & PUBLIC HEALTH (PAGE 2)

-2-

6. DPH will provide feedback to the local DSS office on all individual written complaint referrals from DSS upon completion of the DPH investigation, and DSS will provide feedback to DPH on all referrals from DPH.

7. Since DSS provides after hours Adult Protective Services coverage, there may be occasions when complaints of abuse, neglect, or exploitation arising in DPH facilities are reported to on-call DSS staff after normal working hours, on weekends, or holidays. Such incidents will be referred to DPH on the next working day. However in emergency, life-threatening situations, DSS staff will provide APS services, but not investigation activities, as necessary to resolve the immediate problem.

8. Either Department may refer appropriate complaints to the Health Care Fraud Division, Department of Attorney General, for investigation of incidents involving alleged abuse, neglect, or exploitation.

9. DPH/DSS will share activity reports at least annually, informing each other of abuse and neglect investigation activities in accordance with the Public Health Code, Section 21771(2), and 1982, P.A. 519.

This Agreement takes effect the day it is signed by both directors. It will be reviewed at least annually, and changes adopted when both parties agree.

Director: signature

6/1/94
Date

Director: signature

6/2/94
Date

PUBLIC ACTS 1966 - NO. 189

Search Warrants

An act to provide procedures for making complaints for, obtaining, executing and returning search warrants; and to repeal certain acts and parts of acts.

AFFIDAVIT FOR SEARCH WARRANT (PAGE 1)

MC 231: Affidavit for Search Warrant

OFFICIAL USE

Accessing the Law Enforcement Information Network (LEIN) must only occur as authorized by the Department of Human Services (DHS) in the performance of official duties. Any inappropriate access, use, or disclosure of LEIN information will result in disciplinary action.

County directors are responsible for authorizing appropriate staff to access LEIN and for maintaining the security, confidentiality and the appropriate use of LEIN information.

DEFINITIONS OF TERMS APPLICABLE IN THE DISCLOSURE OF LEIN INFORMATION

The following four (4) listed terms are used throughout the Adult Services Manual (ASM) to assist in clarifying the LEIN process. Adult Protective Services (APS) workers must be familiar with these terms and their definitions when implementing the LEIN policy.

General Statement

A statement which summarizes the behavior of an individual but does not use the legal terminology found on LEIN documents, e.g., “information obtained from law enforcement indicates that Mr. X has a history of illegal sexual acts that do not include minors.”

LEIN Documents

The actual printed paper (or photocopy) report received from a law enforcement agency or generated from the DHS-based LEIN terminal, in response to a LEIN request.

LEIN Information

The information contained in the LEIN document, e.g., “Mr. X was convicted of second degree criminal sexual conduct (CSC)”.

Verified LEIN Information

Information obtained from credible sources, such as police or court personnel, which **corroborates** information obtained from LEIN. This information may be the same as the actual LEIN information itself.

Examples include, but are not limited to:

- "The Wayne County Sheriff's department confirmed that Mr. X was convicted of second degree criminal sexual conduct (CSC)."
- A police report that contains information about an arrest for violence in the home, etc.
- Law enforcement officers may be subpoenaed to testify, as needed in court.

Note: Consultation with the prosecutor or DHS legal representation is encouraged regarding evidential value of this information.

DISCLOSURE OF LEIN INFORMATION

The law granting DHS enhanced LEIN access, (MCL 28.214) clearly states that DHS "shall not disclose information from the LEIN to a private entity for any purpose..." The following categories of people, although **not** an exhaustive list, may not be given LEIN information, either directly or indirectly, by DHS:

- Individuals.
- Guardians/conservators.
- Licensed facilities.
- Agencies and any entities external to DHS.

Penalty for Improper Release of LEIN Information

MCL 28.214 prohibits the disclosure of LEIN information to any private entity for any reason.

- First offense - misdemeanor punishable by not more than 93 days imprisonment or a fine of not more than $500.00, or both.
- Second offense - felony punishable by not more then four (4) years imprisonment or a fine of not more than $2,000.00, or both.
- Staff found to have misused LEIN information will be subject to disciplinary action up to and including dismissal.

All suspected violations of LEIN policy pertaining to unauthorized access, use, or disclosure of LEIN information are to be immediately forwarded to the Office of the Inspector General (OIG).

LEIN Overview

Adult protective services has access to information on the LEIN through a services agreement with the Michigan State Police. This access to Michigan LEIN information includes the following:

- State of Michigan criminal history information.
- Sex offender registry.
- Missing/wanted persons.
- Concealed weapon permit (CCW).
- Personal protection orders (PPO).
- Officer safety cautions.

LEIN also interfaces with the following agency applications:

- Michigan Secretary of State information (SOS) to provide driving and vehicle records.
- Michigan Department of Corrections (CMIS) to provide prison/parole/probation records.

EVALUATING/CONDUCTING LEIN REQUESTS

Workers are to evaluate all information received from the referral source, the client or other collateral sources of information that an adult caretaker and/or alleged perpetrator has a history of violent behavior or was arrested or convicted for a crime. APS may conduct LEIN clearances during the course of any investigation when it is believed a LEIN clearance will provide additional information.

At a minimum, a LEIN check must be conducted for:

- All alleged perpetrators for all sexual abuse.
- Serious physical abuse.
- Serious neglect.
- Financial exploitation.
- Suspected caretaker substance abuse.
- Cases where domestic violence allegations may be present.

LEIN checks on these serious situations listed above may include criminal, arrest, warrants, personal protection order/injunction (PPO) and officer cautions. APS must also conduct a LEIN check on other individuals involved in APS cases when there is reason to believe this information is necessary to make a decision regarding client or worker safety.

Note: It is **recommended** that all LEIN clearances be completed and evaluated by the investigating worker **prior** to making contact with the client or alleged perpetrator.

Documented Risk

In situations in which DHS has documented a risk that leads to a reasonable apprehension regarding the safety of performing a home visit, workers **must** complete a LEIN clearance prior to contact with the client or alleged perpetrator. This will enable the worker to evaluate both client safety issues as well as worker safety issues.

FORM FOR REQUESTING A LEIN CLEARANCE

When requesting LEIN clearances, APS workers must utilize form DHS-269A “Criminal History Information Request”. Documentation must include a reason for requesting a LEIN clearance on a specific person. A copy of the DHS-269A must remain with LEIN Operator Log and a copy must be maintained in the Legal packet of the APS case file.

EVALUATION OF LEIN INFORMATION

History of Violence

Where an adult caretaker has a history of violent behavior or was convicted of a violent crime, workers must evaluate any information received from:

- A parent.
- Relatives or others.
- A LEIN check.
- An I-Chat clearance.
- Any other collateral source of information.

Care and discretion must be used in evaluating the information received.

Arrest/Criminal Record

The existence or nonexistence of an arrest or criminal record is only one factor in assessing risk. **The nonexistence of an arrest or criminal record is not necessarily an indication of low or no risk.**

The existence of an arrest or criminal record must be assessed in light of when (how long ago) the offense occurred and whether any treatment was provided and/or was effective. The information obtained is to be included in assessing risk and the decision regarding the safety of the client.

Information indicating the alleged perpetrator was involved in violent behavior, or convicted for crimes against persons or crimes against self, including substance abuse, must be given particularly close attention. This may be a clue as to the dynamics within the relationship that could place a vulnerable adult at risk from the alleged perpetrator's behavior.

Confidentiality

Due to confidentiality issues, LEIN information and/or documents must not be shared via phone, fax or electronic mail (email).

OUTSTANDING WARRANTS

County offices **must** contact local law enforcement agencies when DHS becomes aware of the whereabouts of a person with any outstanding warrant. DHS must inform local law enforcement services of the location of the individual and the individual's involvement, if any, with a DHS case.

This notification to local law enforcement must be recorded in the adult services comprehensive assessment program (ASCAP) contacts section and the referral to other agencies section of the ASCAP client module noting the reason for the referral under agency referral reason.

REBUTTAL PROCESS

If a person challenges the accuracy of a criminal history check, refer the person to the nearest law enforcement agency to follow that law enforcement agency's process for challenging the criminal record. The individual must be advised that once the response to their challenge is received, that information must be provided to DHS.

Note: Workers cannot disclose that LEIN had been accessed to obtain criminal history information or disclose any unverified criminal history information, including the existence of a warrant, to the individual on which the LEIN check was completed or any entity external to DHS (except for the local law enforcement agency, as indicated above).

LEIN DOCUMENT RELEASE/DISPOSAL

LEIN documents must not be filed in the case record. LEIN documents must be cross-cut **shredded after review, verification of pertinent data (APS and safety issues) and incorporation of this information in narratives, safety plans and/or petitions. The word LEIN or Law Enforcement Information Network must not appear in any reports, narratives or documentation.**

Information which is being used as evidence of adult abuse/neglect/exploitation must be cited in petitions and case narratives and backed up by corroborating information from the

source of the LEIN, e.g., reports from the law enforcement services or entity that entered the information onto the LEIN.

Release of LEIN Documents/Information

LEIN documents can only be released through a court order or court issued subpoena-Do not process; forward to MSP LEIN Field Services for Processing, to avoid confusion**. Upon receipt of a court order, the LEIN inquiry must again be requested.**

Information obtained from verification of LEIN information can be cited in court petitions. LEIN documents can not be attached to, or submitted, with petitions. Case narratives and court reports can include information obtained from verification of LEIN information when such information is the basis for case decision making.

Verified information is information obtained from credible sources, e.g. police or court personnel, which corroborates information obtained from LEIN. For example, police reports that contain information about arrests for violence in the home, etc. Law enforcement officers may be subpoenaed to testify, as needed, in court. Consultation with the prosecutor or DHS legal representation is encouraged regarding evidential value of this information.

When petitions or general narratives are shared with other entities external to the DHS, the fact that a LEIN check was done and the specific information obtained from LEIN must be redacted. General statements do not need to be redacted. For example, if the narrative states that information obtained from law enforcement indicates that a person has a history of violent behavior, this type of statement would not need to be redacted. The specific details obtained from LEIN must be redacted.

LEIN information is NOT subject to Freedom of Information Act (FOIA) requests and can only be released through a court order or court issued subpoena.

TRACKING METHODS (AUDIT)

As a requirement of the agreement with the Michigan State Police granting DHS direct LEIN access, county offices must document all LEIN clearances by completing the DHS-269A and log all requests on a DHS-268. These forms are to be completed as part of the audit process and must be maintained on file at the local office.

APS should utilize the APS case number generated at the intake stage as a permanent tracking number for all LEIN clearances conducted in reference to that APS case.

LEGAL BASE

Adult protective services authority for LEIN access is cited in C.J.I.S Policy Council Act, MCL 28.214 (ii).

MISSION STATEMENT

Adult services seeks to maximize the independent functioning of adults and the independent control of adults over their own lives; to protect vulnerable adults from abuse, neglect, and exploitation; and to advocate for the aged and disabled.

Principles

In carrying out this mission, certain operating principles are to be considered. These are:

- Adults have a right to make their own decisions. This includes:
  - Decisions as to whether they want service, what services or how much and from whom,
  - Decisions as to where they live, and
  - Decisions to determine a plan of service.
- Services must recognize the role of the family. Family involvement should be supported by:
  - Seeking out the family,
  - Involving them in service planning, and
  - Directing services and resources toward the family in their role as caregiver.

  If the interest of the family and the adult compete, the adult's interest is primary.
- Services should be the least intrusive, least disruptive and least restrictive.
- Services should be part of a coordinated network of community-based services, using all appropriate existing community services and identifying the need for developing additional services.
- In providing services to adults, the full range of social work skills focused on person centered planning should be used to inform clients of services and alternatives available and the impact of decisions to assure informed choices. Workers should consider strength based solution focused techniques.

Program Goals

Assist adults and their families in selecting the most appropriate and least restrictive care and:

- Assist adults to continue or resume living independently by arranging for in-home services, e.g., Home Help.
- Assist adults and their families in locating and arranging for out-of-home care.

For adults living independently, help arrange services to ensure basic well-being and safety--including medical, home help, and other social, educational or vocational services.

For adults in out-of-home care, maximize independent functioning by arranging medical, mental health, social, educational or vocational services; facilitate movement to an independent living arrangement, if appropriate, or assist in maintaining the adult in out-of-home care.

Provide immediate investigation and assessment of situations referred to the department when an adult is suspected of needing protection.

For those found to be in need of protection, provide services to assist the adult in achieving a safe and stable status, including using legal intervention, where required, in the least intrusive or restrictive manner.

Death Reporting Process

All deaths in open Adult Protective Services (APS) cases and the deaths in Home Help cases which meet the definition of required reporting as outlined in the Services Requirements Manual must be reported. See SRM 173 for complete reporting instructions.

Deaths in Adult Foster Care facilities must be reported to the Department of Human Services, Office of Children and Adult Licensing. The investigation of those deaths should be coordinated with APS and the Office of Children and Adult Licensing.

APPENDIX A

INTRODUCTION

The community placement program for adults has been under increasing scrutiny since deinstitutionalization began on a large scale in 1962. Concern for concepts of normalization and least restrictive alternatives, a wish to place people in appropriate community settings with necessary support services, and the need for financial resources to be in place upon exiting, produced the 1975-76 Adult Community Placement Agreement between the Department of Social Services and the Department of Mental Health.

During the past five years there have been many changes in the area of adult services. Increasing numbers of aged persons need services, one being community placement. The same is true for the physically handicapped. Many persons exiting mental health institutions are more impaired, requiring highly specialized residential settings and follow-up services. Concerns about inefficient resource use and duplication have caused problems in obtaining adequate funding from the legislature. There is also a strong desire for single accountability related to placement and follow-up for mental health clients.

While the three-party Placement Review Committee (PRC) process worked well in some areas of the state, in others it did not. Given the changing demands of those in need of dependent care and the increased need to use staff more effectively, it is appropriate and timely that CMH and MDHHS develop systems for administering community placement programs geared to distinct populations with particular needs. This separation is based on the conviction that funding, administration and service delivery will be improved as a result.

The following plan is intended for use in all counties except Wayne where the transfer of responsibility began in October 1979. The philosophy and principles reflected in this plan also appear in the Wayne plan.

The issues of recipient rights protection, training of providers/staff, neglect/abuse investigation, licensing, and other aspects of the 1975-76 Adult Community Placement Agreement will be dealt with separately as necessary and appropriate. They are not an integral part of this plan.

Extensive written and verbal comment was received relative to the February 1980 progress report and April Preliminary Plan. Most individuals who reacted supported the concept, but reflected concern about the multitude of details and clarification needed prior to total implementation. They also questioned the availability of additional resources. The incremental, phase-in arrangement herein proposed will allow time to develop necessary working arrangements at the local level and at the same time, allow for preparation of requests for necessary funds.

Prior to FY 81/82, DMH produced community standards for system entry. Screening the population that exited institutions prior to 1976 will continue, and CMH will examine their integration strategies and agreements to determine what modifications will be necessary to make adult community placements and provide follow-up services without the assistance of MDHHS services staff.

DEFINITIONS AS USED IN THIS PLAN & LIST OF PARTICIPATING DMH INSTITUTIONS

1. **Adults with Combination Diagnoses** - DD or MI adults who are also aged or physically handicapped.

2. **Adults with Dual Diagnoses** - Adults with developmental disabilities whose presenting problem/behavior fits the definition of mental illness.

3. **Dependent Care** - Adult Foster Care (AFC) Homes, Homes for the Aged (HA), Nursing Care Facilities.

4. **Developmental Disability** - Per Act 258 of 1974, Sec. 500(h) developmentally disability means "an impairment of general intellectual functioning or adaptive behavior which meets the following criteria:

   (i) It originated before the person became 18 years of age;

   (ii) It has continued since its origination or can be expected to continue indefinitely;

   (iii) It constitutes a substantial burden to the impaired person's ability to perform normally in society;

(iv) It is attributable to 1 or more of the following:

(A) Intellectually disabled, cerebral palsy, epilepsy, or autism.

(B) Any other condition of a person found to be closely related to intellectually disabled because it produces a similar impairment or requires treatment and services similar to those required for a person who is intellectually disabled.

(C) Dyslexia resulting from a condition described in sub-paragraph (A) or (B), per Section 500 of Act 258 as amended."

5. **CMH** - Institution, region, or CMH, based upon who is determined responsible for the action.

6. **SER** - State Emergency Relief.

7. **Formerly Institutionalized Adult** - An adult who has been a resident in a DMH or CMH in-patient setting but not during the preceding twelve (12) months.

8. **HA** - Homes for Aged.

9. **MA** - Medicaid Assistance.

10. **Mental Health (MH) Recipients** - Persons who, because of their individual "care, treatment, or rehabilitation" needs related to mental illness or developmental disability, are eligible and registered to receive the types and scopes of services provided through the public mental health system per Sec. 300.1116 of Act 258 of 1974.1

11. **Mental Illness (MI)** - ". . . means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life," per Act 258 of 1974, Sec. 400(a).

12. **Never Institutionalized Adult** - An adult who has never been a resident in a DMH or CMH in-patient setting.

13. **Recently Institutionalized Adult** - An adult who has been a resident in a DMH or CMH in-patient setting within the twelve (12) months preceding a request for dependent care placement.

14. **Specialized Residential Facility** - Any dependent care setting reimbursed in whole or in part by CMH and/or under contract for service with CMH. These settings are governed by DMH Administration Manual requirements.

15. **System Entry** - Criteria for establishing eligibility as a mental health recipient.

[1]Act 258 of 1974, Sec. 116, "Pursuant to section 51 of article 4 of the constitution of 1963 . . . and pursuant to section 8 of article 8 of the constitution of 1976, which declares that services for the care, treatment, or rehabilitation of those who are seriously mentally handicapped shall always be fostered and support; the department shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state . . ."

16. Institutions for the Developmentally Disabled

Alpine Regional Center.
Caro Regional MH Center.
Coldwater Regional Center.
Hillcrest Regional Center.
Oakdale Center.
Macomb/Oakland Regional Center.
Mt. Pleasant Center.
Muskegon Regional Center.
Newberry Regional MH Center.
Northville Residential Training Center.
Plymouth Center for Human Development.
Southgate Regional Center.

17. Institutions for the Mentally Ill

Caro Regional MH Center.
Clinton Valley Center.
Detroit Psychiatric Institute.
Kalamazoo Regional Psychiatric Hospital.
Lafayette Clinic.
Walter P. Reuther Psychiatric Hospital.
Michigan Institute for Mental Health.
Newberry Regional MH Center.
Northville Regional Psychiatric Hospital.

[1] See Fifth Edition of DMH Program Policy Guidelines, Fiscal Year 1981-82 (June 1980), page 44.

Traverse City Regional Psychiatric Hospital.
Ypsilanti Regional Psychiatric Hospital.

18. The following terms, when used by the CMH, mean as follows:

    a. **Home Recruitment** - The process of identifying new homes to provide residential services to meet the special needs of persons requiring dependent care.

    b. **Home Development** - The process of assisting potential or licensed providers, be they new to the field or with many years of experience, to improve and upgrade the quality of care and services provided residents by means of training, technical assistance and consultation. This may include initiation of a contract between CMH and a provider.

    c. **Placement** - The act of matching individual client needs for dependent care with placement resources and support services in the community, plus arranging for the actual physical move to the facility.

    d. **Client Services Management/Follow-up** - Singular responsibility for assuring that these administrative, facilitative, and advocacy activities are carried out: that appropriate and required client assessments are performed; that an individualized plan of service is developed, implemented, reviewed, and updated; and that essential planning, coordination, facilitation, monitoring, recordkeeping, and advocacy activities are taking place on behalf of the recipient.[2]

MDHHS PRIORITIES FOR TRANSFER OF DEPENDENT CARE PLACEMENT & FOLLOW-UP

Incremental assumption of sole responsibility by CMH is the most reasonable course of action from a management and resource perspective: thus, the recommendation that this realignment occur over the next three fiscal years (FY 80/81 exits and recent exits, see pages 5 & 6 for DD, and pages 6 & 7 for MI; FY 81/82 never institutionalized, see page 7; FY 82/83 formerly institutionalized,

[2] See Fifth Edition of DMH Program Policy Guidelines, Fiscal Year 1981-82 (June 1980), page 44.

see page 8). Flexibility has been built in to the extent possible and acceleration of the time frames is encouraged whenever possible.

CMH ASSIGNMENT OF RESPONSIBILITY

It is the intent of the MDHHS to lodge resources and responsibility for home recruitment/development, placement, and client service management with CMH to the extent possible regardless of placement request source. This is in keeping with the intent of P.A. 258 requiring the department to transfer to the community responsibility for planning and services delivery as CMH displays willingness and capacity to assume same.[2] By 10/1/80, each Regional Director will submit to the Director for Operations a list by county indicating whether MDHHS or CMH will be responsible for home recruitment/development and placement/follow-up so that accountability can be clearly identified.

JOINT MEETINGS

Recognizing that MDHHS and CMH management units are not congruous, MDHHS has coordinated the identification of appropriate counterparts. On receipt of information from MDHHS Central Offices regarding geographical service areas, Regional Directors convened meetings involving MDHHS staff (local, Central Office program staff, Field Services Administration), and local CMH.

[2]Sec. 116.(e)(ii) "In the administration of Chapter 2, it shall be the primary objective of the department to shift from the state to a county the primary responsibility for the direct delivery of public mental health services whenever such county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of such county."

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES OUT-STATE FOR DD ADULTS EFFECTIVE 10-1-80 FOR FY 80/81

1. CMH will provide placement and follow-up services for adults exiting any DD institution into any kind of dependent care (AFC, HA, nursing care facilities). The placement review committee process involving institutional and CMH staff will

continue but MDHHS involvement will consist only of providing information on request about facilities and vacancies. Services cases will not automatically be open for pre-placement planning in either the liaison or placement county. Clients exiting special nursing homes for the intellectually disabled and Alternative Intermediate Services (AIS) facilities into other dependent care facilities in the community will go through a CMH placement review committee process.

2. MDHHS will close service cases on clients who are receiving residential services from a provider who is reimbursed in whole or in part or under contract with CMH. Service cases will remain open if the clients are part of a current complaint investigation. These cases were originally to be maintained as open cases in MDHHS per the Addendum to the Agreement dated October 1976.

3. Responsibility for placement and follow-up of recently institutionalized adults clearly rests with CMH.* Accordingly, when such adults seek placement from MDHHS, they will be referred to and advised by CMH of their right to service under the Mental Health Code and encouraged to seek placement and follow-up services through CMH. Only after such services are declined in writing will MDHHS accept an application for placement from such clients. CMH will provide MDHHS with technical assistance and consultation. The numbers of such adults accepting and declining CMH services will be recorded as will the number of referrals for such services received by MDHHS from CMH.

   *DMH appropriations boiler plate language since 1975.

4. Never institutionalized and formerly institutionalized adults in the community not currently in dependent care will continue to receive placement and follow-up services from MDHHS in AFC non-special residential facilities, HA, and nursing care facilities. MDHHS is encouraged to refer all such adults to the CMH single entry system for assessment and assistance in obtaining appropriate services. When MDHHS has no appropriate vacancies a referral is to be made to CMH for development of new facilities, placement, and/or for mental health services as needed. In short, this plan is not to be construed to preclude referrals to CMH by MDHHS at any time.

5. MA, SER and complaint investigations will continue to be available from MDHHS for eligible clients.

SPECIFIC AGENCY ROLES & RESPONSIBILITIES OUT-STATE FOR MI ADULTS IN FY 80/81

1. Effective 10-1-80 placement and follow-up of adults exiting any MI institution into AFC special residential facilities will be the responsibility of CMH. The placement review committee process involving institution and CMH staff will continue but MDHHS involvement will consist only of providing information on request about facilities and vacancies. Service cases will not be open for pre-placement planning in either the liaison or placement county.

2. Effective 10-1-80 the placement review committee process as described in the 1975 DMH (MDHHS) Agreement will continue for adults exiting MI institutions into AFC non-special residential facilities, Homes for the Aged, and nursing care facilities. Provision of necessary MH services by CMH will continue after placement.

3. Effective 10-1-80 DMH (MDHHS) will close service cases on clients who are receiving residential services from a provider who is reimbursed in whole or in part by or under contract with CMH. Services cases will remain open if the clients are part of a current complaint investigation. These cases were originally to be maintained as open cases in DMH (MDHHS) per the Addendum to the Agreement dated October 1976.

4. Effective 7-1-81 CMH will assume expanded responsibility for placement and follow-up of adults exiting MI institutions into non-contract AFC homes, Homes for the Aged, and nursing care facilities.*

5. Never institutionalized and formerly institutionalized adults in the community not currently in dependent care will continue to receive placement and follow-up services from MDHHS in AFC non-special residential facilities, HA, and nursing care facilities. MDHHS is encouraged to refer all such adults to the CMH single entry system for assessment and assistance in obtaining appropriate services. When MDHHS has no appropriate

vacancies a referral is to be made to CMH for development of new facilities, placement, and/or for mental health services as needed. In short, this plan is not to be construed to preclude referrals to CMH by MDHHS at any time.

6. Responsibility for placement and follow-up of recently institutionalized adults clearly rests with CMH.** Accordingly, when such adults seek placement from MDHHS, they will be advised by CMH of their right to service under the Mental Health Code and encouraged to seek placement and follow-up services through CMH. Only after such services are declined in writing on DMH 3809 will MDHHS accept an application for placement from such clients. CMH will provide MDHHS with technical assistance and consultation. The numbers of such adults accepting and declining CMH services will be recorded as will the number of referrals for such services received by MDHHS from CMH.

7. MA, SER and complaint investigations will continue to be available from MDHHS to eligible clients.

*Regional DMH (MDHHS) directors may approve acceleration of timeframes based on local plans approved by CMH and local MDHHS. A copy of these plans will be sent to MDHHS Adult Community Placement Analyst, Lansing, and to the Director Operations.

**DMH appropriation boiler plate language since 1975.

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES OUT-STATE FOR FY 81/82

1. Effective 10-1-81, utilizing DMH (MDHHS)community system entry standards, CMH will assume expanded responsibility for placement and follow-up into dependent care (AFC, HA, and nursing care) of never institutionalized adults who are determined to be mental health recipients.

2. DMH (MDHHS) will, to the extent possible, fund PRR's to assure CMH assumption of placement and follow-up responsibility for the never institutionalized population. (See DMH (MDHHS) Program Policy Guidelines for FY 81/82).

SPECIFIC AGENCY ROLES & RESPONSIBILITIES OUT-STATE FOR FY 82/83

1. The CMH will evaluate formerly institutionalized adults residing in dependent care upon referral from MDHHS utilizing DMH community system entry standards. CMH will then register and incrementally assume full responsibility for sustaining, through client service management, those determined to be public mental health recipients. This process was initiated by the April 1979 MDHHS/DMH/DPH "Interagency Agreement on Screening, Referral, and Mental Health Evaluation of Adults Placed in Alternative Care Settings Prior to January 1, 1976." That agreement stated that as the needs of this population are registered by the public mental health system, individuals will either receive services based on current resources, or be put on waiting lists pending receipt of new resources. It is anticipated that CMH assumption of responsibility for this population and the closing out of most MDHHS services cases (not MA, SER and complaint investigations) will occur by the end of FY 82/83 if not before.

2. A MDHHS services case may need to remain open or be opened to authorize transportation to a sheltered workshop, to conduct a neglect/abuse investigation, or to authorize Emergency Needs Program eligibility.

3. Not all formerly institutionalized adults will need mental health services or become mental health recipients. If they do, responsibility for these clients will be transferred to CMH. If they do not, responsibility will remain with MDHHS.

LEVEL OF CARE DETERMINATIONS

The MDHHS has secured the authority to perform SSI level of care determinations statewide. Accordingly, MDHHS or CMH depending upon which has placement responsibility in each county, is negotiating with its area Social Security Administration (SSA) office to work out arrangements for processing initial and subsequent level of care determinations.

ADULTS WITH COMBINATION DIAGNOSES

Clearly many adults requesting dependent care and/or follow-up services will not simply be aged or physically handicapped or developmentally disabled or mentally ill. They will represent combinations of needs and strengths. In situations involving combination diagnoses (mental health and non-mental health), whichever agency is contacted first shall be responsible for initiating an interagency mechanism such as a placement review committee to resolve the issue of agency responsibility utilizing MDHHS community system entry standards. The decision will be based on presenting problem.

HOME RECRUITMENT/ HOME DEVELOPMENT

As stated in the February Progress Report and the April Preliminary Plan, CMH assumed sole responsibility for home recruitment/development of dependent care resources for potential public mental health recipients on October 1, 1979. On the same date MDHHS assumed singular responsibility for recruiting and developing homes for the aged and physically handicapped. In keeping with MDHHS's mandate to transfer responsibility to CMH for planning and services delivery (see page 5), home recruitment/development responsibilities statewide, exclusive of placement and client services management, will be the responsibility of CMH to the extent possible.

CMH and MDHHS will coordinate their activities at the state and local level so as to ensure community involvement in the process of establishing new community residential facilities. Linkages at the local level are essential to maximize community support.

Every effort will be made to utilize already licensed AFC facilities with vacancies as CMH implements its home recruitment/home development responsibilities. The CMH will not contract with a facility for occupied beds since this would cause persons already in care to be needlessly relocated.

GENERAL REVIEW OF FUNCTIONS/RESPONSIBILITIES BY DEPARTMENT CMH

1. Continue PRC process for adults exiting State institutions.
2. Assist client to prepare necessary application for financial assistance (SSI, SER, MA).
3. Complete Level of Care Determination for SSI clients.
4. Recruit/develop residential settings for mental health clients both from communities and institutions.
5. Develop standards for system entry from community.
6. Provide services under recipient rights protection.
7. Provide crisis intervention/emergency services.
8. Develop contracts with providers.
9. Work with MDHHS in placing recently institutionalized clients, clients who refuse CMH services, and clients with combination diagnoses.

MDHHS

1. MA-FIS/ES staff
2. Licensing-regulatory staff
3. Protective Services and complaint investigations - adult services staff
4. Home recruitment/development for aged and physically handicapped - adult services staff
5. Provide CMH with information about existing AFC facilities - adult services staff
6. Authorize SER - FIS/ES staff
7. Work with CMH in placing recently institutionalized clients, clients who refuse CMH services, and clients with combination diagnoses - adult services staff.

Realignment of MDHHS/DMH Adult Community Placement Agreement/Re-write of Out-State Plan Issued June 1980

The following reflects the rationale for rewrites/additions inserted on the attached. For each rewrite/addition there is a vertical sign in the margin noting the line(s) affected/added. The page numbers and items referred to below are specific to the revised plan which is attached for your information/use. Upon receipt of this publication please obsolete your June, 1980 copy of the "Final Plan for Out-State Implementation of changes in the DMH/MDHHS Adult Community Placement Agreement."

INTRODUCTION

Some minor changes were made to reflect events that have occurred since April, 1980 when the Preliminary Plan for Outstate was distributed.

DEFINITIONS AS USED IN THIS PLAN AND LIST OF PARTICIPATING DEPARTMENT OF MENTAL HEALTH INSTITUTIONS

Page 2, #1 and 2 -- revised to reflect Department of Mental Health/Community Mental Health usage of expression "dual diagnosis" as referring to developmental disabilities/ mentally ill. Combined diagnoses would be an individual whose needs span the functions of the Department of Social Services and Department of Mental Health/Community Mental Health.

Page 2, #7 -- expanded to include utilization of private inpatient settings under contract with community mental health.

Page 3, #11 -- expanded to reflect that person is registered for services and therefore has been found eligible in keeping with Section 330.1116 of Act 258 of 1974.

Page 3, #13 -- expanded to include utilization of private inpatient settings under contract with Community Mental Health.

Page 3, #14 -- expanded to include utilization of private inpatient settings under contract with Community Mental Health.

Page 3, #15 -- revised to reflect community mental health board operated homes and homes not under contract but receiving an allotment.

Page 3, #17 -- revised to clarify what the program represents.

Page 4, #19 -- changed to reflect new name of facility.

Page 4, #20 -- a. revised to better explain the differences in roles.

b. revised to better explain the differences in roles.

DMH/MDHHS PRIORITIES FOR TRANSFER OF DEPENDENT CARE PLACEMENT AND FOLLOW-UP

Page 5 -- no change

CMH ASSIGNMENT OF RESPONSIBILITY

Page 5 -- no change

JOINT MEETINGS

Page 5 -- revised to reflect what has already occurred.

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES OUT-STATE FOR DEVELOP-MENTALLY DISABLED ADULTS EFFECTIVE OCTOBER 1, 1980 FOR FY 80/81

Page 6, #2 -- changed to clarify that the Department of Social Services will continue to carry open service cases in mixed homes on clients who are not covered by a contractual arrangement between Department of Mental Health/Community Mental Health and the provider.

Page 6, #3 -- revised to include reference to boilerplate language (under #3 and in footnote at bottom of page). "Referred to" added since the only way the Department of Mental Health/Community Mental Health could advise individuals of their rights would be upon referral.

Page 6, #4 -- revised to reflect that this paragraph does not address current adult foster care residents. Also "specialized residential facility" replaces "contract homes."

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES OUT-STATE FOR MENTALLY ILL ADULTS IN FY 80/81

Page 6, #1 -- "special residential facility" replaces term "contract homes."

Page 6, #2 -- same as above

Page 6, #3 -- changed to clarify that the Department of Social Services will continue to carry open service cases in mixed homes on clients who are not covered by a contractual arrangement between the Department of Mental Health/Community Mental Health and the provider.

Page 7, #5 -- revised to reflect that this paragraph does not address current adult foster care residents. Also "specialized residential facility" replaces "contract homes."

Page 7, #6 -- revised to include reference to boilerplate language (under #3 and in footnote** at bottom of page). "Referred to" added since the only way the Department of Mental Health/Community Mental Health could advise individuals of their rights would be upon referral.

Page 7* -- changed to reflect "local" Department of Social Services office approval and copy to the Department of Social Services zone manager.

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES OUT-STATE FOR FY 81/82

Page 7 & 8 -- no change.

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES OUT-STATE FOR FY 82/83

Page 8 -- no change.

APPENDIX B

DEFINITIONS AS USED IN THIS PLAN & LIST OF PARTICIPATING MDHHS INSTITUTIONS

1. **Adults with Combination Diagnoses** - DD or MI adults who are also aged or physically handicapped.

2. **Adults with Dual Diagnoses** - Adults with developmental disabilities whose presenting problem/behavior fits the definition of mental illness.

3. **Dependent Care** - Adult Foster Care (AFC) Homes, Homes for the Aged (HA), Nursing Care Facilities.

4. **Developmental Disability (DD)** - An impairment of general intellectual functioning or adaptive behavior which meets the following criteria:

   (i) It originated before the person became 18 years of age;

   (ii) It has continued since its origination or can be expected to continue indefinitely;

   (iii) It constitutes a substantial burden to the impaired person's ability to perform normally in society;

   (iv) It is attributable to 1 or more of the following:

      (A) Intellectual disability, cerebral palsy, epilepsy, or autism.

      (B) Any other condition of a person found to be closely related to intellectually disabled because it produces a similar impairment or requires treatment and services similar to those required for a person who is intellectually disabled.

      (C) Dyslexia resulting from a condition described in sub-paragraph (A) or (B), per Section 500 of Act 258 as amended.

5. **MDHHS/CMH** - Institution, region, or central MDHHS, or CMH, based upon who is determined responsible for the action.

6. **SER** - State Emergency Relief.

7. **Formerly Institutionalized Adult** - An adult who has been a resident in a MDHHS or CMH in-patient setting but not during the preceding twelve (12) months.

8. **HA** - Homes for Aged.

9. **MA** - Medical Assistance.

   *From MH Code, Sections 500(h), 400(a) respectively.

10. **Mental Health (MH) Recipient** - Persons who, because of their individual "care, treatment, or rehabilitation" needs related to mental illness or developmental disability have been registered as eligible to receive the types and scopes of services provided through the public mental health system per Sec. 330.1116 of Act 258 of 1974.[1]

11. **Mental Illness (MI)** - "Mental illness" means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

12. **Never Institutionalized Adult** - An adult who has never been a resident in a MDHHS or CMH in-patient setting.

13. **Recently Institutionalized Adult** - An adult who has been a resident in a MDHHS or CMH in-patient setting within the twelve (12) months preceding a request for dependent care placement.

14. **Specialized Residential Facility** - Any dependent care setting reimbursed in whole or in part by MDHHS/CMH and/or under contract for service with MDHHS/CMH. **System Entry** - Criteria for establishing eligibility as a mental health recipient.

    *From M.H. Code, Sections 500(h), 400(a) respectively.

15. **Institutions for the Developmentally Disabled -**

    Alpine Regional Center.
    Caro Regional MH Center.

[1] See Fifth Edition of MDHHS Program Policy Guidelines, Fiscal Year 1981-82 (June 1980), page 44.

Coldwater Regional Center.
Hillcrest Regional Center.
Oakdale Center.
Macomb/Oakland Regional Center.
Mt. Pleasant Center.
Muskegon Regional Center.
Newberry Regional MH Center.
Northville Residential Training Center.
Plymouth Center for Human Development.
Southgate Regional Center.

16. Institutions for the Mentally Ill -

Caro Regional MH Center.
Clinton Valley Center.
Detroit Psychiatric Institute.
Kalamazoo Regional Psychiatric Hospital.
Lafayette Clinic.
Walter P. Reuther Psychiatric Hospital.
Michigan Institute for Mental Health.
Newberry Regional MH Center.
Northville Regional Psychiatric Hospital.
Traverse City Regional Psychiatric Hospital.
Ypsilanti Regional Psychiatric Hospital.

17. The following terms, when used by the MDHHS/CMH, mean as follows:

    a. **Home Recruitment** - The process of identifying new homes to provide residential services to meet the special needs of persons requiring dependent care.

    b. **Home Development** - The process of assisting potential or licensed providers, be they new to the field or with many years of experience, to improve and upgrade the quality of care and services provided residents by means of training, technical assistance and consultation. This may include initiation of a contract between MDHHS/CMH and a provider.

    c. **Placement** - The act of matching individual client needs for dependent care with placement resources and support services in the community, plus arranging for the actual physical move to the facility.

d. **Client Services Management/Follow-up** - Singular responsibility for assuring that these administrative, facilitative, and advocacy activities are carried out: that appropriate and required client assessments are performed; that an individualized plan of service is developed, implemented, reviewed, and updated; and that essential planning, coordination, facilitation, monitoring recordkeeping, and advocacy activities are taking place on behalf of the recipient.

MDHHS/CMH PRIORITIES FOR TRANSFER OF DEPENDENT CARE PLACEMENT & FOLLOW-UP

Incremental assumption of sole responsibility by MDHHS/CMH is the most reasonable course of action from a management and resource perspective; thus, the recommendation that this realignment occur over several fiscal years. Flexibility has been built in to the extent possible and acceleration of the time frames is encouraged whenever possible.

*See fifth edition DMH (MDHHS) Policy Guidelines FY 1981/82 (June 1980), pg. 44.

MDHHS/CMH ASSIGNMENT OF RESPONSIBILITY

It is the intent of the MDHHSMDHHS to lodge resources and responsibility for home recruitment/ development, placement, and client service management with CMH to the extent possible regardless of placement request source. This is in keeping with the intent of P.A. 258 requiring the department to transfer to the community responsibility for planning and services delivery as CMH displays willingness and capacity to assume same.[2] If CMH is not willing or able, MDHHS, thus, is responsible.

[2] See Fifth Edition of MDHHS Program Policy Guidelines, Fiscal Year 1981-82 (June 1980), page 44.

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES FOR DD ADULTS

1. Effective 10-1-79, MDHHS/CMH will provide placement and follow-up services for adults exiting any DD institution into any kind of dependent care (AFC, HA, nursing care facilities). The placement review committee process involving institutional and CMH staff will continue but MDHHS involvement will consist only of providing information on requests about facilities and vacancies. MDHHS services cases will not automatically be open for pre-placement planning. Clients exiting special nursing homes for the intellectually disabled and Alternative Intermediate Services (AIS) facilities into other dependent care facilities in the community will go through a MDHHS/CMH placement review committee process.

2. Responsibility for placement and follow-up of recently institutionalized adults clearly rests with CMH.** Accordingly, when such adults seek placement from MDHHS, they will be referred to and advised by CMH of their right to service under the Mental Health Code and encouraged to seek placement and follow-up services through MDHHS/CMH. Only after such services are declined in writing will MDHHS accept an application for placement from such clients. CMH will provide MDHHS with technical assistance and consultation. The numbers of such adults accepting and declining CMH services will be recorded as will the number of referrals for such services by MDHHS from CMH.

   **DMH/CMH/MDHHS boilerplate language since 1975.

3. Effective 10-1-79, never institutionalized and formerly institutionalized adults in the community not currently in dependent care will continue to receive placement and follow-up services from MDHHS in AFC non-specialized residential facilities, HA, and nursing care facilities.* MDHHS is encouraged to refer all such adults to the CMH single entry system for assessment and assistance in obtaining appropriate services. When MDHHS has no appropriate vacancies a referral is to be made to CMH for development of new facilities, placement, and/or for mental health services as needed. In short, this plan is not to be construed to preclude referrals to CMH by MDHHS at any time.

MA, SER, and complaint investigations will continue to be available from MDHHS for eligible clients.

4. By the end of FY 80/81, MDHHS will close service cases on clients who are receiving residential services from a provider who is reimbursed in whole or in part by or under contract with CMH. Service cases will remain open if the clients are part of a current complaint investigation. These cases were originally to be maintained as open cases in MDHHS per the Addendum to the Agreement dated October 1976.

5. Effective 10-1-81, utilizing MDHHS community system entry standards, CMH will assume expanded responsibility for placement and follow-up into dependent care (AFC, HA, and nursing care) of never institutionalized adults who are determined to be mental health recipients.

6. Effective 82/83, CMH will assume responsibility for eligible formerly institutionalized adults. The CMH will evaluate formerly institutionalized adults residing in dependent care upon referral from MDHHS utilizing MDHHS community system entry standards. CMH will then register and incrementally assume full responsibility for sustaining, through client service management, those determined to be public mental health recipients. This process was initiated by the April 1979 MDHHS/DPH "Interagency Agreement on Screening, Referral, and Mental Health Evaluation of Adults Placed in Alternative Care Settings Prior to January 1, 1976." That agreement stated that as the needs of this population are registered by the public mental health system, individuals will either receive services based on current resources, or be put on waiting lists pending receipt of new resources. It is anticipated that CMH assumption of responsibility for this population and the closing out of most MDHHS services cases (not MA, SER and complaint investigations) will occur by the end of FY 82/83 if not before. Not all formerly institutionalized adults will need mental health services or become mental health recipients. If they do, responsibility for these clients will be transferred to CMH. If they do not, responsibility will remain with MDHHS.

   * Regional MDHHS director may approve acceleration of time-frames based on local plans approved by CMH and local MDHHS. A copy of these plans will be sent to MDHHS Adult Community Placement Analyst, and to Director Operations, MDHHS.

SPECIFIC AGENCY ROLES AND RESPONSIBILITIES FOR MI ADULTS

1. Effective 7-1-80, CMH, thru case management agencies, will provide placement and follow-up of adults exiting any MI institution into any kind of dependent care. The placement review committee process (community placement process) involving institution and CMH staff will continue but MDHHS involvement will consist only of providing information on request about facilities and vacancies. MDHHS service cases will not be open for pre-placement planning.

2. Responsibility for placement and follow-up of recently institutionalized adults clearly rests with CMH.* Accordingly, when such adults seek placement from MDHHS, they will be advised by CMH of their right to service under the Mental Health Code and encouraged to seek placement and follow-up services through CMH. Only after such services are declined in writing will MDHHS accept an application for placement from such clients. CMH will provide MDHHS with technical assistance and consultation. The numbers of such adults accepting and declining CMH services will be recorded as will the number of referrals for such services received by MDHHS from CMH.

3. Effective 7-1-80, never institutionalized and formerly institutionalized adults in the community not currently in dependent care and not receiving case management services will continue to receive placement and follow-up services from MDHHS in AFC non-special residential facilities, HA, and nursing care facilities. MDHHS is encouraged to refer all such adults to the CMH single entry system for assessment and assistance in obtaining appropriate services. When MDHHS has no appropriate vacancies a referral is to be made to CMH for development of new facilities, placement, and/or for mental health services as needed. In short, this plan is not to be construed to preclude referrals to CMH by MDHHS at any time.

   MA, SER and complaint investigations will continue to be available from MDHHS to eligible clients.

4. Effective 10-1-81, utilizing MDHHS community system entry standards, MDHHS/CMH will assume expanded responsibility for placement and follow-up into dependent care (AFC, HA,

and nursing care) of never institutionalized adults who are determined to be mental health recipients.

*DMH (MDHHS) boilerplate language since 1975.

5. Effective 82/83, CMH will assume responsibility for eligible formerly institutionalized adults. The CMH will evaluate formerly institutionalized adults residing in dependent care upon referral from MDHHS utilizing MDHHS community system entry standards. CMH will then register and incrementally assume full responsibility for sustaining, through client service management, those determined to be public mental health recipients. This process was initiated by the April 1979 MDHHS/CMH "Interagency Agreement on Screening, Referral, and Mental Health Evaluation of Adults Placed in Alternative Care Settings Prior to January 1, 1976." That agreement stated that as the needs of this population are registered by the public mental health system, individuals will either receive services based on current resources, or be put on waiting lists pending receipt of new resources. It is anticipated that CMH assumption of responsibility for this population and the closing out of most MDHHS services cases (not MA, SER and complaint investigations) will occur by the end of FY 82/83 if not before. Not all formerly institutionalized adults will need mental health services or become mental health recipients. If they do, responsibility for these clients will be transferred to CMH. If they do not, responsibility will remain with MDHHS.

LEVEL OF CARE DETERMINATIONS

CMH, depending upon which has placement responsibility, will process SSI authorizations for adults seeking placement from MDHHS institutions. CMH responsibility for subsequent level of care determinations for each population enumerated above (never and former) will occur as placement and follow-up are transferred to CMH.

ADULTS WITH COMBINATION DIAGNOSES

Clearly many adults requesting dependent care and/or follow-up services will not simply be aged or physically handicapped or developmentally disabled or mentally ill. They will represent combinations of needs and strengths. In situations involving

combination diagnoses (MH and non-mental health), whichever agency is contacted first shall be responsible for initiating an interagency mechanism such as a placement review committee to resolve the issue of agency responsibility utilizing MDHHS community system entry standards. The decision will be based on presenting problem.

HOME RECRUITMENT/ HOME DEVELOPMENT

CMH assumed sole responsibility for home recruitment/development of dependent care resources for potential public mental health recipients on October 1, 1979. On the same date MDHHS assumed singular responsibility for recruiting and developing homes for the aged and physically handicapped. In keeping with MDHHS's mandate to transfer responsibility to CMH for planning and services delivery (see page 4), home recruitment/development responsibilities statewide, exclusive of placement and client services management will be the responsibility of CMH to the extent possible.

MDHHS/CMH will coordinate their activities at the state and local level so as to ensure community involvement in the process of establishing new community residential facilities. Linkages at the local level are essential to maximize community support.

Every effort will be made to utilize already licensed AFC facilities with vacancies as CMH implements its home recruitment/home development responsibilities. The CMH will not contract with a facility for occupied beds since this would cause persons already in care to be needlessly relocated.

GENERAL REVIEW OF FUNCTIONS/RESPONSIBILITIES BY DEPARTMENT CMH

1. Continue PRC process (community placement process for adults exiting MDHHS institutions.

2. Assist client to prepare necessary application for financial assistance (SSI, SER, MA).

3. Complete Level of Care Determination for SSI clients.

4. Recruit/develop residential settings for MH clients both from communities and institutions.

5. Develop standards for system entry from community.

6. Provide services under recipient rights protection.

7. Provide crisis intervention/emergency services.

8. Develop contracts with providers.

9. Work with MDHHS in placing recently institutionalized clients, clients who refuse MDHHS services, and clients with combination diagnoses.

MDHHS

1. MA - FIS/ES staff
2. Licensing - regulatory staff
3. Protective Services and complaint investigations - adult services staff
4. Home recruitment/development for aged and physically handicapped - adult services staff
5. Provide MDHHS/CMH with information about existing AFC facilities - adult services staff
6. Authorize SER - FIS/ES staff
7. Work with CMH in placing recently institutionalized clients, clients who refuse CMH services, and clients with combination diagnoses - adult services staff.

APPENDIX C

MEMORANDUM OF AGREEMENT between the MICHIGAN DEPARTMENT OF CORRECTIONS and the MICHIGAN FAMILY INDEPENDENCE AGENCY

The Department of Corrections and the Family Independence Agency agree that the placement of pre-parolees into licensed adult foster care facilities will comply with the principles and procedures herein stated for the purpose of assuring the appropriate and legal use of licensed adult foster care facilities.

The Department of Corrections agrees to:

- Notify the local office of the Family Independence Agency when considering the use of a licensed adult foster care facility for a pre-parolee, and prior to initiating any placement arrangements.
- Recommend for placement in licensed adult foster care facilities only those pre-parolees who can be classified as adults in need of foster care.
- Provide the local office of the Family Independence Agency with sufficient background information on the pre-parolee to enable the Family Independence Agency to make an assessment as to the appropriateness of the referral, and to accept the determination made by the Family Independence Agency as to whether the proposed placement is or is not compatible with the residents of an adult foster care facility.

The Family Independence Agency agrees to:

- Review each proposed pre-parolee placement requested to determine the appropriateness of the referral.
- Forward to the Department of Corrections a statement of concurrence or non-concurrence and the basis for the determination within 45 days of having received the placement referral.
- Cooperation with the Department of Corrections in locating appropriate adult foster care facilities for a pre-parolee whose need for foster care has been agreed to by the Family Independence Agency.

- Notify the zoning authority having jurisdiction when an adult foster care facility licensed for six residents or less, located in a single family dwelling zoned area is being proposed as a placement resource for a pre-parolee. The placement shall be considered approved by the zoning authority unless notification of disapproval has been received by the Department within 30 days of receipt of notice.

- Provide the Department of Corrections with the names and locations of licensed adult foster care facilities of which it has knowledge, which do not have any adult foster care residents, and thereby enable the department of Corrections to offer the licensee an option of continuing their licensed status, or accepting pre-parolees from the Department of Corrections in compliance with applicable statutes and local ordinances.

The Department of Corrections and the Family Independence Agency will immediately initiate, on a coordinated basis, a careful assessment of each pre-parolees currently residing in a licensed adult foster care facility. Those pre-parolees whose placements are found to be inappropriate and inconsistent with the above stated principles, are to be relocated by the Department of Corrections.

APPENDIX D

PUBLIC MENTAL HEALTH MANUAL

MICHIGAN DEPARTMENT OF MENTAL HEALTH

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PROGRAM AND SERVICES ADMINISTRATION	CLIENT SERVICES MANAGEMENT	IV	001	0001
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ELIGIBILITY FOR CMH CLIENT SERVICES MANAGEMENT FOR ADULTS IN OR REQUESTING DEPENDENT CARE		H	5-18-83	1

I. SUMMARY:

The content of this guideline establishes minimum standards to assist community mental health (CMH) and Department of Social Services (DSS) staff in determining which agency shall be responsible for client services management, placement and follow-up of adults currently in non-specialized dependent care or seeking dependent care. The establishment of this guideline and the standards and policies herein is in keeping with the 1979-80 DSS/CMH/DMH Adult Community Placement Agreement. Its implementation is intended to regularize, to the extent possible, communication and referrals between the two major public systems that administer those programs and services required by some developmentally disabled and formerly mentally ill adults if they are to remain in the community. Without ready access to the resources of both systems, the adults in question may experience crisis, go unserved, be inappropriately served or be unnecessarily institutionalized. While referrals on behalf of anyone in need may be made at any time to DSS and/or CMH, this guideline addresses specific populations and suggests time intervals and major variables to assist in the referral process, particularly when referring to CMH. Clearly, many of the adults who require ongoing placement and follow-up services are active recipients of community mental health services. The objective of these standards is to bring those adults most at risk of institutionalization to the attention of the public mental health system so they may be given priority for client services management (CSM) and follow-up service. Lastly, these entry standards do not preclude CMH from serving individuals who exceed these standards, nor do they relate to any other entry/exit criteria utilized by CMH.

II. APPLICATION:

A. Regional psychiatric hospitals operated by the Department of Mental Health (DMH).

B. Regional centers for developmental disabilities operated by the Department of Mental Health.

C. Community mental health boards as specified in their contracts with the Department of Mental Health and any state facility subcontracts negotiated as part of the master contract.

III. POLICY:

A. FOR ONE YEAR FOLLOWING THEIR EXIT FROM A STATE HOSPITAL OR CENTER, REGARDLESS OF WHETHER SUCH PERSONS MEET THE ENTRY STANDARDS ENUNCIATED IN THIS GUIDELINE, CMH (DMH) SHALL BE RESPONSIBLE FOR PLACEMENT AND FOLLOW-UP OF ALL ADULTS WHO CONSENT TO AND ENTER SERVICE PROGRAMS WHERE CSM IS PROVIDED. THE ONLY EXCEPTION WOULD BE THE INDIVIDUAL FOR WHOM A SECOND CERTIFICATION CANNOT BE SECURED FROM A DMH PSYCHIATRIST LEADING TO IMMEDIATE DISCHARGE.

Approved:

Technical Approval By:

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III. POLICY: (Cont.)

B. WHETHER SERVED BY CMH OR DSS, WRITTEN INFORMED CONSENT IS REQUIRED; THUS, AN INDIVIDUAL WHO DECLINES PUBLIC MENTAL HEALTH SERVICES MUST DO SO IN WRITING BEFORE AN APPLICATION FOR DSS SERVICES IS PROCESSED.

C. CMH (DMH) SHALL USE THE ENTRY STANDARDS ENUNCIATED IN THIS GUIDELINE AS INDICATORS IN DETERMINING ELIGIBILITY FOR ENTRY INTO THE CSM SYSTEM FOR PURPOSES OF PLACEMENT AND FOLLOW-UP OF ALL ADULTS DEFINED IN THE DSS/DMH/CMH AGREEMENT AS NEVER OR FORMERLY INSTITUTIONALIZED WHO CONSENT TO TRANSFER FROM DSS TO THE PUBLIC MENTAL HEALTH SYSTEM.

D. THE GLOBAL ASSESSMENT SCALE (GAS), REFERRED TO IN THE STANDARDS, IS BUT ONE INDICATOR TO BE UTILIZED WHEN DETERMINING NEED FOR SERVICES. THE INDIVIDUAL'S CURRENT GAS SCORE IS A TRIGGER TO ACTIVATE A REFERRAL TO CMH OR DSS.

E. CMH BOARDS MAY, AT THEIR DISCRETION, PROVIDE CSM FOR INDIVIDUALS WHOSE FUNCTIONING EXCEEDS THESE ENTRY STANDARDS BUT NOT IF IT PRECLUDES PROVIDING NEEDED SERVICES TO THE MORE SEVERELY IMPAIRED.

F. BY VIRTUE OF THE AGREEMENT, ADULTS WHO APPEAR TO BE ELIGIBLE FOR CMH CLIENT SERVICES MANAGEMENT BASED ON THE STANDARDS HEREIN ARE:

1. NEVER INSTITUTIONALIZED PERSONS REQUESTING DEPENDENT CARE FOR THE FIRST TIME;

2. NEVER INSTITUTIONALIZED ADULT FOSTER CARE RESIDENTS WHO WERE IN DEPENDENT CARE PRIOR TO FY 81-82; AND

3. FORMERLY INSTITUTIONALIZED RESIDENTS OF NON-SPECIALIZED ADULT FOSTER CARE HOMES WHO EXITED A DMH INSTITUTION AT LEAST ONE YEAR PRIOR TO THE DATE OF THE REFERRAL.

G. REFERRALS BY CMH AND DSS WILL BE MADE ON AN INDIVIDUAL BASIS AS STAFF PERFORM THEIR QUARTERLY IN-PERSON CONTACTS WHICH ARE REQUIRED TO VERIFY THE RESIDENT'S ELIGIBILITY FOR TITLE XIX PERSONAL CARE PAYMENTS. REFERRALS MAY, OF COURSE, BE MADE AT ANY OTHER TIME WHEN DEEMED APPROPRIATE.

H. THE PARTICIPATION OF THE INDIVIDUAL IS ESSENTIAL. CONSENT OF THE INDIVIDUAL OR THE EMPOWERED GUARDIAN SHALL BE SECURED IN WRITING. THIS CONSENT SHALL EXPLICITY INCLUDE COOPERATION IN THE PURSUIT OF THIRD-PARTY PAYMENTS FOR SERVICES.

Approved: C Patrick Bahl

Technical Approval By: Wilmot Lorenz

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III. POLICY: (Cont.)

I. IN THE EVENT THE INDIVIDUAL REFUSES TO CONSENT TO RECEIVE SERVICES FROM CMH, DSS WILL ACT AS THE RESPONSIBLE AGENCY AND CMH WILL PROVIDE TECHNICAL ASSISTANCE AND CONSULTATION AS REQUIRED.

J. CMH WILL RESPOND TO EACH REFERRAL WITHIN NO LESS THAN 30 DAYS. IF THE INDIVIDUAL REMAINS WITH DSS AS THE RESPONSIBLE AGENCY, CMH WILL PROVIDE WRITTEN DOCUMENTATION INDICATING WHY THE REFERRAL WAS NOT ACCEPTED AND ANY RECOMMENDATIONS THEY MAY HAVE FOR PROVIDING SERVICE TO THE INDIVIDUAL.

K. ENTRY INTO THE CMH CLIENT SERVICES MANAGEMENT SYSTEM SHALL OCCUR ALONG THE FOLLOWING CONTINUUM:

1. REFERRAL FOR CSM NOT ACCEPTED; DSS CONTINUES TO BE RESPONSIBLE FOR PLACEMENT AND FOLLOW-UP;

2. REFERRAL FOR CSM NOT ACCEPTED; RECIPIENT TO RECEIVE SERVICE VIA INVOLVEMENT IN ONE OR MORE PROGRAM ELEMENTS, RESPONSIBILITY FOR PLACEMENT AND FOLLOW-UP REMAINS WITH DSS; AND

3. REFERRAL FOR CSM ACCEPTED; CMH ASSUMES RESPONSIBILITY FOR CSM, PLACEMENT AND FOLLOW-UP. IN ADULT FOSTER CARE, THIS MEANS BEING THE RESPONSIBLE AGENCY AS DEFINED IN P.A. 218 OF 1979.

L. IF CMH BECOMES RESPONSIBLE FOR PLACEMENT AND FOLLOW-UP (AS DEFINED IN P.A. 218 OF 1979), THAT RESPONSIBILITY SHALL CONTINUE FOR NO LESS THAN SIX MONTHS AND SHALL INCLUDE THE PURSUANCE OF ALL THIRD-PARTY BENEFITS FOR WHICH A RECIPIENT MAY BE ENTITLED.

M. BASED ON THE STANDARDS BELOW IN V., EITHER PARTY MAY AT ANYTIME REQUEST A CONFERENCE TO DISCUSS THE TRANSFER OF AN INDIVIDUAL. INFORMATION GERMANE TO THIS PURPOSE MAY BE SHARED WITHOUT BREACHING CONFIDENTIALITY. IN THE EVENT OF DISAGREEMENT OVER WHICH AGENCY SHOULD PROVIDE CSM, RESPECTIVE DSS ZONE AND DMH AREA MANAGEMENT ARE TO BE CONSULTED FOR ASSISTANCE.

N. THE DETERMINATION THAT AN INDIVIDUAL IS IN NEED OF MENTAL HEALTH SERVICES AND THE DECISION TO PROVIDE SAME IS CLEARLY A CLINICAL DECISION THAT CAN BE MADE ONLY BY THE PUBLIC MENTAL HEALTH SYSTEM.

IV. DEFINITIONS:

None

Approved:

Technical Approval By:

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V. STANDARDS:

A. Adults accepted for CSM by a CMH agency for purposes of placement and follow-up services shall be:

1. developmentally disabled in accordance with Chapter 5, Section 500h of P.A. 258 of 1974, as amended, and display behavior requiring some physical assistance in self-care skills, or supervision due to periodic behavioral problems or physical limitations (a level forty or below on the DD Global Assessment Scale, see Exhibit A); or

2. display symptomology or functional impairments that would cause most clinicians to think the individual obviously requires treatment or attention; e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, mild but definite manic syndrome (a level fifty or below on the MI Adult Global Assessment Scale, see Exhibit B).

B. Referrals shall address the following in addition to the current Global Assessment Scale:

1. Strengths and limitations of the individual, not reflected in GAS score, that may impact on the person's capacity to remain in the community.

2. The role of the family in supporting or interferring with the individual's mental health treatment plan.

3. The capacity of the provider to assist in furthering the individual's mental health treatment plan.

4. Any other information deemed important to help determine whether the individual should receive placement and follow-up services from CMH or DSS.

VI. REFERENCES AND LEGAL AUTHORITY:

A. Public Act 218 of 1979.

B. Section 116 of Public Act 258 of 1974, as amended, being MCL 330.1116, Mental Health Code.

VII. EXHIBITS:

A. Global Assessment Scale DD.

B. Global Assessment Scale MI Adult.

Approved:

Technical Approval By: Hubert Carson

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EXHIBIT A

Global Assessment Scale for Developmentally Disabled

Rate the client's lowest level of functioning on the DD Matrix scale. The rating is based on observed and reported functioning for the week prior to the last contact. Rate actual functioning independent of diagnosis, treatment, or perceived potential.

100–91 Independent in self-care skills and advanced daily living skills, problems never seem to get out of hand, participates in many activities.

90–81 Independent in self-care skills and advanced daily living skills; transient symptoms, every day problems occasionally get out of hand, without impairment of functioning.

80–71 Independent in self-care skills, some advanced daily living skills, minimal disruption of functions due to transient emotional reaction.

70–61 Independent in self-care skills, but may require very minimal supervision. Some physical assistance may be required, but only if due to physical handicap. Generally, no behavioral problems.

or

May have some advanced daily living skills, but has intermittent socially inappropriate behaviors which require some intervention.

60–51 Can carry out self-care skills, but requires supervision. May require verbal prompts in self-care areas, but will only require minimal physical assistance due to physical handicap or behavior problems which require intervention may occur, but they are only intermittent.

50–41 Requires verbal and physical prompts for self-care. No ongoing pattern of behavior problems that require intervention. Generally willing to participate in activities; however, behavior problems which require intervention may occur.

40–31 Requires some physical assistance in self-care skills, can participate in activities with supervision for periodic behavioral problems or physical limitations.

or

May have self-care skills with intermittent serious behavior problems (assaultive or abusive).

30–21 Requires some physical assistance in self-care, with some willingness to participate, but requires regular intervention due to behavioral problems.

or

Requires extensive physical assistance due to handicap, but demonstrates willingness to participate and carry out tasks within physical limitations.

20–11 Requires physical assistance in self-care, is often unwilling to participate.

or

Requires regular intervention due to serious behavior problems (assaultive or self-abusive).

10–1 Requires nearly total physical care.

or

Requires constant supervision due to regular need to intervene due to serious behaviors (assaultive or self-abusive).

Approved:

Technical Approval By: Wilbur Brown

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EXHIBIT B

MI Adult
Global Assessment Scale (GAS)
Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph.D.

Rate the client's lowest level of functioning on a hypothetical continuum of mental health-illness. The rating is based on observed and reported functioning for the week prior to the last contact. Rate actual functioning independent of diagnosis or treatment.

100–91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity. No symptoms.

90–81 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "every day" worries that only occasionally get out of hand.

80–71 No more than slight impairment in functioning, varying degrees of "every day" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70–61 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick".

60–51 Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50–41 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40–31 Major impairment in several areas, such as work, family relations, judgment, thinking or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), or single suicide attempt.

30–21 Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts grossly inappropriately).

20–11 Needs some supervision to prevent hurting self or others, or to maintain personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (e.g., largely incoherent or mute).

10–1 Needs constant supervision for several days to prevent hurting self or others (e.g., requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

Approved:

Technical Approval By: [signature]

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APPENDIX E

Level of Care Change/Patient Transfer

Level of care changes as determined by MSA Exception Operations based on the MDPH review will result in referrals by MSA to local office adult services staff in the following situation:

- Patient's level of care is evaluated as non-nursing and the MA recipient is residing in a nursing facility.

MSA Exception Operations will first determine if the recipient has been in continuous residence for one year or more or was involuntarily transferred within the past year. This is done to see if the 'transfer trauma' provision of the Borton v. Califano case applies. (Note: Transfer trauma does not apply if a facility is decertified.) Continuous residence means the recipient has resided in a specific facility without a break for at least one year. An absence for impatient care in a hospital with immediate re-admission to the same facility does not interrupt the continuity of residence. A referral packet will be sent to local office adult service staff for action as follows:

Continuous Residence

One Year or More (A)	Less Than One Year (B)
1. Referral Packet FIA-133 R-10/R-19 MSA Letter Transfer Trauma Information Client/Worker Form Supplemental Information Form	1. Referral Packet FIA-133 FIA-1184 R-10/R-19
2. Worker contacts recipient, guardian, designated represent active or family, and facility staff to determine if recipient is willing to move;	2. Worker contacts recipient, guardian, designated representative or family, and facility staff to determine if recipient is willing to move;

One Year or More (A)	Less Than One Year (B)
3. If recipient **is** willing to re-locate, the worker:	3. If recipient **is** willing to re-locate, the worker:
a. Completes client/worker form and returns to MSA by date specified; MSA sends new referral packet;	a. Assists the recipient/family in transfer if requested; client must move within 21 days of date on FIA-1184;
b. Assists the recipient/family in transfer if requested; client must move within 21 days of date on FIA-1184;	b. Notifies MSA Exception Operations by Rite-O-Gram when move is completed;
If there is no appropriate vacancy,	If there is no appropriate vacancy,
c. Completes supplemental form and returns to MSA within 21 days to secure a 30-day extension; additional 30-day extensions require a memo signed by L.O. Director or designate to MSA indicating reasons for request, i.e., 1)No available placement within 50 miles of nearest family member, or 2)No available placement within the county and more time is needed to search in other counties;	c. Sends a memo signed by L.O. Director or designate to MSA requesting a 30-day extension and indicating reasons for the request; i.e., 1)No available place-ment within 50 miles of nearest family member, or, 2)No available place-ment within the county and more time is needed to search in other counties;

One Year or More (A)	Less Than One Year (B)
4. If recipient is **not** willing to relocate, the worker:	4. If recipient is **not** willing to relocate, the worker:
a. Completes the client/worker form and returns to MSA by date specified, adding comments as appropriate;	a. Advises recipient/family MA payments for care will stop on date specified on FIA-1184 unless client files for an administrative hearing within 10 days;
b. MSA will refer case to MDPH for review to see if transfer trauma may result from the involuntary move; if yes, recipient remains in the facility and MA payments continue; if no, MSA sends referral packet to local office and procedures 1-4 in Column B are followed.	b. Assists recipient/family in filing for hearing if requested noting this may only delay need to relocate; if hearing decision is favorable, recipient remains in the facility and MA payments continue; if unfavorable, MSA sends another Referral Packet to local office and procedures for relocation are followed.

APPENDIX F

HEALTH CRITERIA FOR PLACEMENT AND CONTINUED RESIDENCY IN AFC AND HA

1. AFC and HA are appropriate settings for residents who need assistance with activities of daily living. Residents who need continuous nursing care shall not be admitted or retained in AFC and HA facilities. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care. Continuous nursing care is defined as the ongoing (at least daily) interaction between patient (client/resident) response and nurse (provider) judgment based on observation, assessment and identification of patient risk (See Appendix F).

2. Residents may take prescription drugs as prescribed by a physician, and may be given assistance in taking their medication in accordance with the physician's directions.

3. Since insulin and vitamin B are usually self-administered, unlicensed facility personnel can administer them if appropriately trained. Other scheduled injections may be arranged through the resident's physician.

4. Residents dependent on walker, wheelchair, or motorized device, should be in a barrier free facility with access to the out-of-doors. Residents should be independently mobile with the use of such devices.

   Note: If residents are not able to transfer independently from bed to wheelchair, it must be determined how many such persons a home can reasonably care for at one time. In case of emergency, adequate staff must be available.

5. Physical restraints are permitted in Family Home per Rule 400.1414 to minimize or eliminate substantial risk to the resident. The need for such must be documented in the client’s assessment plan. The use of physical restraint to punish or to restrict movement by binding, tying or confining is prohibited per Family Home rule 400.1412. The need for assisting devices to promote the enhanced mobility, physical comfort, and well-being of the resident is allowable. The need must be

documented in the client's assessment plan and agreed upon by the resident or his designee. therapeutic supports must be authorized in writing by the resident's physician. (Small Group rule 400.14306, Large Group 400.15306.)

6. The following health care conditions or characteristics would preclude placement or continued residence in AFC or HA.

   a. Intravenous fluids*

   b. Nonemergent oxygen administration

   c. Mechanical life support, i.e., respirator

   d. An infectious disease (or diseases) which require isolation in a separate health care facility.

   e. An unstable or uncontrolled medical condition which required (at least daily) medical dispensation, evaluation, and intervention by health care profession.

*This does not include occasional or future anticipated need for intravenous injection when such injections are performed by health care professionals not directly employed by the licensee.

APPENDIX G

REVISED MEMORANDUM OF AGREEMENT between the MICHIGAN FAMILY INDEPENDENCE AGENCY and the MICHIGAN DEPARTMENT OF PUBLIC HEALTH and MICHIGAN DEPARTMENT OF MENTAL HEALTH

In recognition of the positive effect that a normative environment has on developmentally disabled, emotionally disturbed and physically handicapped individuals, the Departments of Social Services, Public Health and Mental Health support the development and placement of individuals into licensed community-based residential care facilities.

To facilitate program development and assure that this is carried out in compliance with the intent of Act 116, P.A. of 1973, as amended, and Act 218, P.A. of 1979, as amended, the Departments of Social Services, Public Health and Mental Health agree to the following principles and practices:

THE FAMILY INDEPENDENCE AGENCY, as the licensing agent, agrees to:

- License adult foster care facilities, foster homes for children and child caring institutions in accordance with Michigan's licensing statutes and corresponding administrative rules.
- Define and apply the term "continuous nursing care" in accordance with Attachment A of this Agreement.
- Develop and implement policy and procedures which outline the manner in which the terms of the agreement are to be implemented.
- Provide its licensing staff with a copy of this Agreement and Attachment A and to provide orientation and training for its licensing staff as to the application of the Agreement.

THE DEPARTMENT OF PUBLIC HEALTH, as the certifying agent, agrees to:

- Certify adult foster care facilities and homes which are in compliance with the federal IFC/MR regulations for AIS/MR programs.
- Inform the Departments of Social Services and Mental Health of those individuals who have been determined by the

Department of Public health to be in need of "continuous nursing care" as defined in Attachment A of this Agreement.

- Develop and implement policy and procedures for Public Health staff with outline the manner in which the terms of this Agreement are to be implemented.
- Provide Department of Public Health certification staff with copy of this Agreement and Attachment A and to provide orientation and training for its certification staff as to the application of this Agreement.

THE DEPARTMENT OF MENTAL HEALTH, as the operating agent, agrees to:

- Place individuals into licensed AIS/MR homes, adult foster care facilities, and child caring institutions in conformance with Attachment A of this Agreement.
- Develop and implement policy and procedures which outline the manner in which the terms of this Agreement are to be implemented.
- Provide Department of Mental Health and Community Mental Health staff with a copy of this Agreement and Attachment A and to provide orientation and training for its staff as to the application of this Agreement.

IN WITNESS WHEREOF, THE MICHIGAN DEPART OF SOCIAL SERVICES, THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH, AND THE MICHIGAN DEPARTMENT OF MENTAL HEALTH HAVE CAUSED THIS AGREEMENT TO BE EXECUTED BY THEIR RESPECTIVE OFFIECERS DULY AUTHORIZED TO DO SO.

Date at _____, Michigan

This _____day of _____, 1984

MICHIGAN FAMILY INDEPENDENCE AGENCY

By: _____

Agnes M. Mansour, Ph.D., Director

Witness

Dated at _____, Michigan

This _____day of _____, 1984

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

By: _____

Gloria R. Smith, Ph.D.,
Director

Witness

Dated at _____, Michigan

MICHIGAN DEPARTMENT OF MENTAL HEALTH

This _____day of _____, 1984

By: _____

C. Patrick Babcock,
Director

Witness

ATTCHMENT A TO THE REVISED AGREEMENT BETWEEN THE DEPARTMENTS OF SOCIAL SERVICES, PUBLIC HEALTH AND MENTAL HEALTH

PART I

PURPOSE OF THE AGREEMENT

Section 3(4) of Act 218, Public Acts of 1979, as amended, prohibits the admission of individuals into adult foster care facilities who require “continuous nursing care”.

Section 1 of Act 116, Public Acts of 1973, as amended, defines child caring organizations as excluding a nursing home. For purposes of this Agreement this applies to child caring institutions which are prohibited from receiving for care or maintaining in care children who are in need of continuous nursing care as defined within this document.

The purpose of this Attachment is to establish criteria to assist the Departments of Social Services, Public Health and Mental Health in carrying out their respective missions and goals. The criteria are to be applied in a manner which facilitates the placement of developmentally disabled, emotionally disturbed and physically handicapped individuals into normative environments and assures their health, safety and well-being.

This Attachment is to equally apply to the existing placement of, as well as to the future placement of, individuals into adult foster care facilities and child caring institutions.

PART II

ASSUMPTIONS

A. Nursing care functions can be delegated to individuals who are qualified by education, training or experience and who have been provided with the necessary knowledge and skills to safely and properly carry out these functions, under the supervision of a nurse.

B. An individual who has delegated nursing care functions to another is responsible for the supervision of that individual and remains accountable, liable and ultimately responsible for the outcomes of the delegated nursing care functions.

PART III

DEFINITIONS

A. Professional Nursing Care

Professional nursing care is defined as those nursing care activities which supplement an individual's knowledge, will and/or strength with the objective of maintaining existing health, and moving an individual from dependence to independence, and from needing acute care to self-care. Those nursing care activities which are viewed as facilitating the above are:

- Assessments of biological, psychological, social and developmental needs.
- Planning for appropriate nursing care intervention.
- Implementation of the individual plan of service.
- Periodic reevaluation of the individual plan of service.
- Appropriate revision to the individual plan of service.

B. Continuous Nursing Care

Continuous nursing care is defined as the ongoing (at lest daily) interactions between a patient's (client/resident) response and a nurse's (provider) judgment based on observation, assessment and identification of patient risk.

PART IV

CRITERIA WHICH ARE TO GOVERN THE PLACEMENT OF INDIVIDUALS INTO ADULT POSTER CARE HOMES AND CHILD CARING INSTITUTIONS

Category A:

The following are those health care conditions which require continuous nursing care as defined above. Residents having any of these clinical conditions shall be prohibited from existing or future placement:

1. Intravenous fluids.*
2. Nonemergent oxygen administration.
3. Mechanical life supports, i.e., respirator.
4. An infectious decease (or diseases) which requires isolation in a separate health care facility.
5. An unstable or uncontrolled medical condition which requires ongoing (at least daily) medication dispensation, evaluation, and intervention by a health care professional.

*This does not include occasional or future anticipated need for intravenous injections when such injections are performed by health care professionals not directly employed by the licensee.

Category B:

Individuals with the following patterns of behavior such as pica, self-abuse and physical aggressive may be prohibited from existing or future placement. The critical factors governing the placement decision in these situations are:

1. The ability to assure the health, safety and well-being of other residents in care.
2. The ability to assure the health, safety and well-being of the resident exhibiting these patterns of behavior, especially if health care intervention may be required.
3. The ability of staff to appropriately and completently handle residents who exhibit behavior such as pica, self-abuse and physical aggression.

INTERAGENCY AGREEMENT FOR NURSING FACILITY CLOSURES

I. PURPOSE OF THE AGREEMENT

The purpose of this Agreement, among the Department of Community Health (DCH), including the DCH Office of Services to the Aging (OSA), the Department of Consumer and Industry Services (DCIS), and the Family Independence Agency (FIA), is to delineate when residents of licensed nursing facilities must be relocated due to facility closure. This Agreement applies to both for-profit and no-for-profit nursing facilities, including those that are county medical care facilities or hospital long-term care units.

II. PRINCIPLES OF THE AGREEMENT

The health, safety and welfare of the nursing facility residents are the primary determinants for the implementation of this Agreement. The Departments recognize that their primary responsibilities to protect the rights, dignity, and self-determination of residents must be balanced with the need to respect the rights of nursing facility owners when faced with resident relocation and facility closure. The Departments also recognize that the varying situations which warrant resident relocation and closure action - voluntary closure, federal and state regulatory or enforcement action, or declared life safety emergency - will affect the staffing, resources, timeliness and procedures required to implement the steps in the closure process.

The following guiding principles will be incorporated in relocation and closure efforts:

A. Interagency and interdisciplinary coordination and cooperation will be maximized at both the state and local levels.

B. A team approach will be used for the relocation of residents in nursing facility closure situations. In a situation where DCIS initiates an enforcement order to take a regulatory action or to protect the life and safety of nursing facility residents, closure teams will be convened by DCIS at both the Sate and local levels to assure that needs of

the affected residents are addressed. In the case of a voluntary closure, a Sate and/or Local Team may be convened at the request of the DCH and/or FIA. For purposes of this Agreement, a voluntary closure is any closure or resident relocation not required by a CDIS-initiated enforcement order. Such closure could result from an action by DCH to decertify a nursing facility for failure to comply with Medicaid conditions of participation or be initiated by a facility owner wishing to discontinue operations.

C. When the closure of a facility is required by a DCIS-initiated enforcement order, the DCIS or its designated representative will serve as the Local Team leader. In the case of a voluntary closure, the DCH and/or FIA, or a designated representative, will serve as the Local Team leader. The department designee may be a Contract Closure Agent.

D. The general responsibilities of the two teams will be as follows:

1. The **State Team** will provide ongoing policy direction, mobilization of resources and oversight for the Local Team. The State Team will include representatives from the DCH, including the OSA, the DCIS, and the FIA. At the time of imminent closure, the State Team will consult with a Contract Closure Agent and other appropriate parties, as necessary.

2. The **Local Team** will provide direct assistance and local leadership at the facility for operations and relocation support. It will be made up of local representatives of the Departments comprising the State Team and will also include, as appropriate, other local organizations that should be involved. The Local Team, when convened, will confer regularly.

E. Each team will hold pre-closure meetings prior to implementing any resident relocation or facility closure action. The teams will confirm leadership roles, affirm the closure rationale, and set the operating rules for resident relocation and facility closure.

F. Respect for resident rights, dignity, and self-determination will be honored by involving residents, their families, or

their responsible representatives, in placement decision-making to the extent possible. The Departments' intent is to affect an orderly, safe, expedient, and humane relocation process.

G. The needs and preferences of residents and their families will be assessed to ensure that the least restrictive placement is offered, including return to their own home or other community living setting.

H. Alternative placements will meet the medical, social, mental and physical needs of residents. To the fullest extent possible, residents who have closely bonded together in the current nursing facility will be relocated together.

I. Resident relocation and facility closure are separate activities. In general, a closure will always include resident relocation, but relocation does not always require a closure. For purposes of this Agreement, "closure" used alone will include resident relocation. In the event of a closure necessitated by a DCIS-initiated enforcement order, the DCIS, directly or through a Contract Closure Agent, will monitor both the day-to-day operations of the facility owner/operator and the resident relocation activities of the Local Team. In the event of a voluntary closure, the DCH and FIA will jointly determine the necessity for and extent of convening teams under this agreement. The DCH and FIA will also determine the necessity for involving a Contract Closure Agent.

III. DEPARTMENT RESPONSIBILITIES

The State Team is responsible for coordinating the relocation and closure process. It will work through the Local Team to implement closure of a designated nursing facility and to facilitate resident relocation. The State Team concludes the closure process through a post-closure review of actions and reporting to the represented Departments.

The State Team will serve as a standing work team and will include representatives from the following organizational work units:

- DCH/Medical Services Administration
- DCH/Health Legislation and Policy Development
- DCH/Office of Services to the Aging

- DCH/OBRA Office
- DCIS/Bureau of Health Systems
- DCIS/Enforcement and/or Field Services Representative
- FIA/Executive Office
- FIA/Office of Adult Services
- FIA/Local Office Adult Services Representative
- DCIS/Contract Closure Agent

A. The DCH/Medical Services Administration representative will convene and lead the ongoing regular State Team meetings for policy development and oversight.

B. The DCIS/Bureau of Health Systems representative will lead the State Team in its operational mode during a nursing facility closure required by a DCIS-initiated enforcement order. The DCH and/or FIA will lead the State Team, if convened, in its operational mode during a voluntary nursing facility closure.

C. The FIA, through its local staff, will have primary responsibility for the physical relocation of residents.

D. The State Team will mutually develop: a) a written facility closure and relocation protocol to be followed by the State and Local Teams and any Contract Closure Agent; b) the framework for an agreement with a Contract Closure Agent that identifies expectations and responsibilities; and c) proposed policy within the respective Departments that facilitates a timely and resident-centered relocation and closure process.

E. State Team members will assure that their Local Team representatives are informed about and prepared to implement the provisions of this Interagency Agreement.

F. The State Team will oversee this Interagency Agreement by meeting on at least a quarterly basis. At such meetings, the State Team will: a) review the Agreement language for continued accuracy, proposing amendments as necessary; b) revise protocol documents if appropriate; and c) discuss any related issues of interest to the group.

G. State Team members will meet to conduct a debriefing within one month following any nursing facility closure. Local Team members involved in the closure will be invited to the meeting as appropriate to provide insight into

related events. The results of the debriefing will be written and shared with appropriate representatives of the Departments.

H. State Team members will be expected to participate in State Team activities during any relocation and closure process required by a DCIS-initiated enforcement order, and during any voluntary relocation and closure process for which the State Team has been convened. A list of State Team members, with designated alternates, will be maintained and updated on a regular basis in the DCIS/Bureau of Health Systems Director's Office. The list will include telephone numbers for 24-hour availability. State Team members will each be given a copy of this list.

I. The DCIS Communications Office will coordinate the State's notification to the media and response to their inquiries related to involuntary nursing facility closures. Information regarding both notifications and media response will be shared in a timely manner with Communications staff in the other Departments. The DCH and FIA Communications Offices will jointly coordinate such activities related to a voluntary closure.

The **Local Team** will provide operational support and local leadership to assist and monitor facility-based relocation activities. In the case of a closure required by a DCIS-initiated enforcement order, the Local Team will be chaired by the DCIS, directly or through a Contract Closure Agent. In the case of a voluntary closure for which a Local Team has been convened, the Local Team will be chaired jointly by DCH and FIA, directly or through a Contract Closure Agent. The Local Team will include, at a minimum, representatives from the following organizational work units:

- DCH/Medical Services Administration
- DCIS/Bureau of Health Systems (Licensing Officer)
- FIA/Local Office (Adult Protective Services or Community Placement)

A. The facility relocation and closure protocol developed by the State Team will identify other local organizations that should also be involved, as appropriate, in closures with the activities that these organizations will be expected to perform.

B. Team members will meet and confer regularly during relocation and closure to assure that each member's designated responsibilities are carried out in coordination with the other team members.

C. The Local Team will conduct informational meetings for residents, families and other interested parties to make information available related to the rationale for relocation and closure, identification of agencies to be involved, description of steps to be taken for relocation, and discussion of care alternatives available.

The **Contract Closure Agent** may be designated by and represent the DCIS at a nursing facility ordered closed by that Department. If designated, the Contract Closure Agent will oversee the resident relocation activities of the Local Team. The DCIS and DCH will co-author an agreement specific to each closure for which a Contract Closure Agent's services are necessary. Such agreement will identify the Contract Closure Agent's authority during and after the closure. The agreement may include authorization to make expenditures from any available Medicaid funds for day-to-day operation of the facility and for the protection of resident health and safety during the facility closure and relocation process if the owner/operator fails to comply with applicable operating standards and legal duties.

The Contract Closure Agent's responsibilities will include, at a minimum, the following:

A. Responsibility for monitoring day-to-day operations of the nursing care facility in cooperation with the facility staff for the period during which the facility is undergoing closure. In any closure and/or relocation process, the owner/operator of the facility will continue to be responsible for compliance with all applicable operating requirements and legal duties until the last resident is moved from the facility. This will include ensuring that: a) the facility is adequately staffed; b) necessary food, medications and supplies are available; c) residents and their belongings are safe and secure; and d) resident medical and financial records and personal belongings are protected and available for relocation with the resident.

B. Provision of direction and support to the Local Team related to resident assessment and identification of post-relocation care needs. This will include ensuring that: a) the Minimum Data Set for Discharge is completed for each resident; b) resident care

plans for both health and social services are up to date; and c) on-site visits to other appropriate and proposed nursing facility or community living settings are offered and arranged for residents and/or family members or authorized representatives.

In the event of a Voluntary closure, the DCH may author a similar agreement that identifies the Contract Closure Agent's authority during and after the closure.

V. SIGNATORIES

In witness thereof, the parties sign their names as evidence of their approval of this Interagency Agreement for Nursing Facility Closures.

James K. Haveman, Jr., Director — Date 2/5/01
Michigan Department of Community Health

Lynn Alexander — Date 2/14/01
Lynn Alexander, Director
Office of Services to the Aging, Michigan Department of Community Health

Kathleen M. Wilbur — Date 2/14/01
Kathleen M. Wilbur, Director
Michigan Department of Consumer and Industry Services

Douglas E. Howard — Date 2/22/01
Douglas E. Howard, Director
Michigan Family Independence Agency