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CASE MANAGEMENT

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ADULT SERVICES CASE MANAGEMENT

3.1 Case management

The case management process is a systematic approach essential to effective service delivery that actively involves the service worker, the adult, and the adult's family in developing, achieving, and maintaining meaningful goals. The purpose of case management in Adult Services is to structure the service worker's focus and activities to assist the adult in reaching his or her goals and to assure that the adult receives appropriate services in a timely manner.

3.2 Definitions

The following words and terms are defined in state regulation and the Code of Virginia. When used in this chapter, they shall have the following meaning, unless the context clearly indicates otherwise:

Term	Definition
Adult	An individual 18 years of age or older, or under the age of 18 if legally emancipated (§ 51.5-144 of the Code of Virginia).
Adult Services	Services that are provided by local departments of social services to an adult with an impairment (§ 51.5-144 of the Code of Virginia).
Adult with an impairment	An adult whose physical or mental capacity is diminished to the extent that he needs counseling or supervisory assistance or assistance with activities of daily living or instrumental activities of daily living (§ 51.5-144 of the Code of Virginia).

Term	Definition
Auxiliary Grants Program	A state and locally funded assistance program to supplement income of a Supplemental Security Income (SSI) recipient or adult who would be eligible for SSI except for excess income, who resides in an assisted living facility or in adult foster care with an approved rate (22 VAC 30-80-10).
Department	Department for Aging and Rehabilitative Services (§ 51.5-116 of the Code of Virginia).
Direct Service	Services provided to adults directly by local social services staff (22 VAC 40-780-10).
Eligibility Determination	The process of deciding whether an individual or family meets the criteria for receiving a service (22 VAC 40-780-10).
Local Department (LDSS)	Any local department of social services in any county or city in this Commonwealth. (§ 63.2-100 of the Code of Virginia).
Purchased Service	Services provided by paid resource other than local social services staff (22 VAC 40-780-10).
Service Worker	The worker responsible for case management or service coordination and meeting the Department's requirements for the provision of services.
SSI (Supplemental Security Income)	A federal cash transfer program to help assure individuals a minimum income. Begun in 1974, SSI replaced the federal-state assistance program for the low-income aged, blind, and disabled that was originally established under the Social Security Act of 1935.
Universal Access	The provision of services without regard to income or membership in an income maintenance group (22 VAC 40-780-10).

3.3 Confidentiality

The Code of Virginia and federal laws and regulations require that an individual's information be kept confidential. With certain Adult Protective Services (APS) program exceptions, the adult shall give written permission before information may be obtained

from other sources or given to another person or agency. The form, entitled [Consent to Exchange Information](#) is located on the VDSS internal website and should be used when sharing information. See Chapter 6, “Confidentiality” for additional information on confidentiality.

3.4 Adult services intake

Intake services provide an initial access point for services provided by the LDSS. Upon determining that there is no valid APS report, the worker proceeds with the adult services intake process. The initial contact may be made by telephone, office visit, and/or through a referral from another agency. Services provided may include information and referral, initial screening and assessment, crisis intervention, and assistance with emergency needs if indicated by the case situation or assessment.

3.4.1 Information and referral

Information and referral is one way to handle a request for services. Providing information and referral helps the individual locate and use resources to meet his or her needs. Any adult is eligible for information and referral assistance, regardless of income or eligibility for benefit or service programs.

Situations that may be handled by providing information and referral may include:

- The adult asks for information only.
- The service about which the adult inquires is provided by another organization or program.

An ASAPS case is not opened for information and referral. If assistance is needed beyond information and referral, the adult may complete a Service Application.

3.4.1.1 Information

The service worker provides information on the availability, accessibility, and use of resources. This may be all the individual needs to make his or her own arrangements to access a resource.

3.4.1.2 Referral

The service worker contacts a resource and helps the adult arrange to receive the needed service. This is appropriate for individuals who are unable to use the information without additional help.

The Statewide Information and Referral (I&R) System, also known as 211, provides citizens of the Commonwealth with free and confidential information

and referral to health and human service resources. To access 211, individuals may dial “211” on their phone or visit the [211 website](#).

3.5 Application for adult services

Anyone may apply for services. There shall be no requirement as to citizenship or length of residence in the jurisdiction. The application may be requested in person, by mail, or by telephone. Telephone calls to the LDSS are not considered an “application” unless the LDSS started a department-initiated application or the request is for PAS. A Service Application is available on the following VDSS websites:

[Internal Website](#)

[Public Site](#)

3.5.1 LDSS responsibilities

- LDSS shall accept all applications.
- Eligibility shall be determined as promptly as possible. LDSS shall notify the individual of its decision or lack of decision promptly but no later than 45 days after the application is received. **Note:** A service application for preadmission screening (PAS) shall be processed as quickly as possible, but no later than 30 days from the date the screening was requested. It is appropriate to complete the service application during the screening visit.
- An individual shall be given the opportunity to complete a service application on the day services are requested. An application requested by mail or telephone shall be mailed the same day. The individual should be informed that applications are also available on the VDSS public website.
- Assistance with completing the application shall be given if the individual requests assistance. A home visit may be necessary if the individual is unable to get to the department. If the individual is capable, the worker shall discuss the service request with the individual to ensure that the services requested or applied for are desired by the individual.
- The following shall be explained at intake:
 - How eligibility is determined.
 - Rights and responsibilities of the individual applying for services. Rights and responsibilities are listed on the service application.
- The individual shall be referred for financial assistance when appropriate.

3.5.2 Service application initiated by the individual

If the individual or authorized representative applies for services, a service application shall be completed.

The application may be initiated as pending or approved. The term "case" refers only to an approved case. Until approval, it is considered a pending application.

3.5.3 LDSS-initiated service application

The service application may be initiated by the LDSS for any of the following reasons:

- When the applicant is unable to sign the application or is incapacitated;
- A request for services is made from another agency or individual within or outside of the Commonwealth; or
- The application may be taken and processed by a service vendor if the agreement/contract with the vendor specifies this responsibility.

Service applications are not required for case type "ALF Reassessment" if the only service provided is the annual reassessment or case type "Guardian Report" if the only service provided is the review of the Annual Report of the Guardian (**Note:** the Application Date for the Case Info screen in ASAPS would be the date the case information is received in the LDSS). If additional services are provided beyond the service required for each of these case types, a signed service application shall be obtained. For additional information on case types see [Section 3.11](#).

3.5.4 Date of application

The date of application is one of following:

- The day the completed and signed Service Application or program-specific form is received by the LDSS.
- The date of the receipt of a valid Adult Protective Services (APS) Report. The report serves as the application until a disposition is made. If the disposition is "Needs Protective Services and Accepts", the worker will obtain a signed and dated application from the individual or his representative or the worker will complete a department-initiated application.
- The date an individual requests a preadmission screening. See examples below:

- Mrs. Williams calls the LDSS on May 3, 2015 and requests a PAS. May 3, 2015 is entered as the application date by the appropriate LDSS staff person. The application is taken to the screening visit and completed in the home by the LDSS PAS team member.
- Mr. Smith's daughter calls the LDSS on May 15, 2015 and requests a preadmission screening for her father. The application is completed in the home during the screening visit. If the date of the request was not entered on the application when his daughter called, the date of the application must be backdated to reflect the date of her request.
- The date a vendor receives the application, when the vendor is responsible, per the agreement/contract, for receiving the service application and determining eligibility.

3.5.5 When a new application is needed

A new application is needed only when a case is properly closed and the individual wishes to reapply. A new application is not needed when a new service is added to an open case or when the basis of eligibility for service changes.

3.6 Determining eligibility and opening a case

A service case is opened based on eligibility, determination of need, and the availability and intent to deliver the service. Financial eligibility requirements as designated by local social services boards in local policy shall be considered.

3.6.1 Target populations and criteria

An adult who receives Adult Services (i.e., companion, chore, or homemaker services, adult day services, or adult foster care) shall fall within one of the target populations and meet one of the following criteria:

- Be 60 years of age or older; or
- Be an adult with an impairment.

An individual does not need to be determined eligible for SSA, SSI, or SSDI benefits prior to receiving services from the LDSS.

Adult protective services are provided to incapacitated adults 18 years of age or over and adults 60 years of age or over who are abused, neglected or exploited or at risk of abuse, neglect, or exploitation.

“Incapacitated person” is defined as:

([22 VAC 30-100-10](#)). Any adult who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age or other causes to the extent that the adult lacks sufficient understanding or capacity to make, communicate or carry out reasonable decisions concerning his or her well-being. This definition is for the purpose of establishing an adult's eligibility for adult protective services and such adult may or may not have been found incapacitated through court procedures.

3.6.2 Case opening procedures

To open a case to Adult Services, proper procedures shall be followed regarding ASAPS and Notice of Action. See the [ASAPS-Robo Help](#) on the VDSS internal website.

3.6.3 Notification

The LDSS shall notify the individual of application decisions promptly, but no later than 45 days after the application is received. See [Section 3.5.1](#) for information on application for PAS.

3.7 Financial eligibility

Eligibility for services shall be determined by a service worker or a volunteer under the supervision of a service worker. Eligibility is documented on the General Information screen in ASAPS.

To receive services an individual or family shall be found eligible in one of three categories:

- Universal Access
- Income Maintenance
- Eligibility Based on Income

3.7.1 Universal access

Individuals receiving services under universal access are eligible for services without regard to income. The LDSS may elect to provide all direct services on a universal access basis. Certain purchased services are universal access, depending on APS program requirements and local board policy. The LDSS may choose one of two options in providing direct services on a universal access basis:

- All individuals needing direct services may be served on a universal access basis.

- Only individuals needing the following services/components may be served on a universal access basis.
 - APS.
 - Services provided to elderly and incapacitated adults at risk of abuse, neglect, or exploitation.

An individual who requests a preadmission screening is not required to apply for Medicaid prior to the screening. Therefore, for a preadmission screening, the LDSS selects universal access on the Eligibility/Income section of the General Information Screen in ASAPS.

3.7.2 Income maintenance

Individuals are eligible for services in this category because they receive SSI or Auxiliary Grant. The applicable direct and purchased services available in this category are those provided by the LDSS within the limits set by the local board. Income verifications are recorded in the “Eligibility/Income” section on the General Information screen in ASAPS.

3.7.2.1 Verification of receipt of income maintenance

- The service worker views written verification or verifies the SSA income information by accessing SVES, SOLQ, or the SDX listing.
- Auxiliary Grant eligibility should be verified by Benefit Programs staff at the LDSS that processed the individual’s AG application.

3.7.3 Eligibility based on income

Eligibility in this category is determined by measuring the gross income and the number in the family unit against the State Median Income (SMI) chart. The SMI is issued by a Broadcast each year prior to September 1st. The SMI chart is available within the “Eligibility/Income” section on the General Information screen in ASAPS and the VDSS [internal website](#). The local board of social services selects the percentage cut-off point used and records this decision in the board minutes. The applicable direct and purchased services available to this broad category are those provided by the LDSS within limits set by the local board. Verifications are recorded in the “Eligibility/Income” section on the General Information screen in ASAPS.

Example of completed eligibility/income section in ASAPS:

Eligibility/Income

Eligibility Type

Income Eligible Income Maintenance (GR, AG, SSI) Universal Access

Income [Add](#)

	Source	Monthly Amount	Verification Source	Received By	Begin Date	End Date	Include?
Edit	Social security	1198	Award Letter	Client	01/05/2012		Y

Income Summary

Total Income Countable Income

No. in Family Unit Percentage Income Limit [Show SMI Chart](#)

3.7.3.1 Verification of income eligibility and determination of monthly income

- Count only income (not resources). Income counted or excluded is listed in [Appendix B](#). Income shall be verified, and the individual is expected to assist with the verification process. To obtain a monthly income, multiply a weekly income by 4 and 1/3.
- To verify income, viewing of recent written verification is acceptable.
 - If income fluctuates, the amount should be averaged over a period sufficient to take fluctuations into consideration. Usually three (3) months is sufficient; however, for farm income or seasonal employment, a year may be necessary.
 - Accept an individual's statement (preferably in writing) that he or she has no income unless there is reason to doubt the statement.

3.7.3.2 Family size and income

- For the AS/APS program, the family is the basic unit for social services delivery. Family means any individual adult, spouses or adult(s) who function as a family unit.
- For purposes of determining financial eligibility, base the family size on the number of family members in the case (see [Section 3.7.3.3](#)).
- Count the income from those family members as well as income received from any legally responsible adult who may not be living in the family. Count income from family members temporarily absent from the

household for whom the family claims financial responsibility for tax purposes.

3.7.3.3 Case composition

For purposes of opening a case in ASAPS, each individual has a separate case. For example, if one spouse needs companion services and the other spouse does not, a case would only be opened on the spouse needing services. If both spouses needed services, two separate cases would be opened in ASAPS.

However, when determining eligibility, spouses are considered a family of two and this should be reflected in the section “Number in Family Unit” in the Income/Eligibility section of the General Information screen.

Adult children are always considered a family of one. Common narrative can be linked through “Linked person” function in ASAPS (see ASAPS-Robo Help).

3.7.3.4 Use of the Median Income Chart

The State Median Income (SMI) Chart identifies the maximum income levels by family size by percentage of median income. Except for special condition groups, the maximum percentage of median income is 50 percent. If a local board decides to limit the incremental percentage below 50 percent for any service, the percent selected shall be documented in local board minutes or in local board approved policy.

Twenty percent above the selected SMI percentage is used for individuals with a disability including individuals who are blind, deaf, have an intellectual disability, cerebral palsy, epilepsy, or autism. Adults at risk of institutionalization may be included at local option.

3.7.3.5 Effective dates and annual redetermination dates

The effective date is the date that the service began for the current eligibility period. The effective date for Universal Access is usually the date of the service application and the date that financial eligibility conditions are established for Income Maintenance and Eligibility Based on Income cases. The annual redetermination date is one year and one day less than the effective date.

- Example: Effective date is 1/5/12. Annual redetermination date is 1/4/13.

The screenshot shows a 'Case Actions' form with a yellow background. It contains several date input fields with calendar icons to their right. The fields are arranged in two rows. The first row includes: '*Application Date' (01/05/2012), 'Application Disposition Date' (01/05/2012), and 'Effective Date' (01/05/2012). The second row includes: 'Redetermination Date' (01/04/2013), 'Close/Denial Date' (empty), and 'Special Review Date' (empty). Below these is a 'Special Review Reason' dropdown menu showing '----'. At the bottom of the form is a large empty text box with up and down arrow buttons on its right side.

See [Section 3.18](#) for information on redetermination of eligibility.

3.8 Fraud

The LDSS shall explain to individuals applying for Adult Services the importance of providing accurate and thorough information and of notifying the LDSS of changes during service delivery. Anyone who causes the LDSS to make an improper vendor payment by withholding information or by providing false information may be required to repay the amount of the improper payment. Section [63.2-522](#) of the Code of Virginia deems any person guilty of larceny who obtains assistance or benefits by means of a willful false statement or who knowingly fails to notify the LDSS of a change in circumstances that could affect eligibility for assistance. Individuals deemed guilty of larceny, upon conviction, are subject to penalties as specified in the [§ 18.2-95](#) of the Code of Virginia.

3.9 Assessment process

3.9.1 Basis

The assessment process is a mutual process between the service worker and the adult that begins at intake. Completing the assessment is the first step in service planning. The purpose of assessment is to determine whether the adult is in need of services, and, if so, to identify what services are needed. Assessment should take place throughout the entire case management process and is essential to service planning. When an individual applies for a service, a preliminary assessment shall be made to determine the presenting issue(s) or immediate need(s). The assessment is to continue on a mutual basis between the individual and service worker in order to document further service needs as a basis for the setting of long-range service objectives, the selection of services to fulfill those objectives, and the

choices of resources to be used. These activities will be reflected in the completed service plan.

3.9.2 The Virginia Uniform Assessment Instrument (UAI)

The UAI is used by public human services agencies in the Commonwealth to assess adults for service needs and service eligibility. The definitions used and procedures for completing the UAI are found in the User's Manual: Virginia Uniform Assessment Instrument. The [User's Manual](#) and the [UAI](#) are available on the VDSS internal website.

The UAI is also found in ASAP (see ASAP-Robo Help) and may be printed as needed.

The following are guidelines for use of the UAI by an LDSS:

- At a minimum, the following five areas shall be addressed in the assessment process: the individual's physical health, psychosocial status, functional abilities, support systems, and physical environment. The UAI provides a format that assesses each area.
- If, during an assessment, it is determined that the individual is being abused, neglected, or exploited or is at risk of being abused, neglected, or exploited, an APS report shall be made and APS procedures followed according to Chapter 2.
- The entire UAI shall be completed for any purchased services including home-based services (companion, chore, and homemaker), and adult day services. When the entire UAI is completed, the worker has met the assessment requirements for the development of the service plan for an Adult Services case. In an Adult Protective Services case, an assessment to determine the need for protective services is required (see Chapter 2). If services are provided after the determination of the protective services needs, the entire UAI shall be completed.
- The UAI shall be completed in its entirety for PAS and entered into the ePAS system. LDSS workers who are part of a PAS team are not required to enter the UAI into ASAP as long as the individual is seeking PAS only and not receiving other services, such as homemaker or protective services. However, the LDSS worker is still required to open an ASAP record on *any adult who is receiving a PAS* and shall document that the individual's UAI is located in ePAS as well as the ePAS Assessment Reference Number (ARN). See [Section 3.11.1](#) for additional information on case typing PAS only cases.

- The UAI shall be completed for assisted living facility (ALF) assessments per guidance in the Assisted Living Facility Assessment Manual. For ALF assessments, the UAI is used for the initial assessment and one reassessment.
- For case types AS (Adult Services) and AS – Intensive Services that are NOT purchased services (e.g., assisting with SSI or Social Security issues) pages 1 through 4 *plus pages 5, 8, and 12*) shall be completed. *In doing so*, the worker shall ensure that all required assessment areas (e.g., physical health, psychosocial status, etc.) are addressed.
- The UAI shall be used for reassessments. The term "Reassessment" and date shall be noted on the front of the UAI to indicate that it has been used for this purpose. When using the UAI in ASAPS, follow the instructions in ASAPS Robo Help for placing a copy of the UAI in "History" and revising the current UAI.
- For ALF assessments and reassessments and preadmission screenings, the original UAI should be sent to the facility in which the individual will reside.
- The UAI is not required for case type "Guardian Report" if review of the guardian report is the only reason the case has been opened.

3.9.3 Required assessment areas

Assessments shall be performed in all of the five following areas for all adult services cases. Completion of the UAI meets this requirement. Additional assessments may be necessary as determined by the worker.

3.9.3.1 Physical environment (section 1 of UAI)

An assessment of the individual's physical environment provides information about safety and health risks. When assessing the physical environment, the worker should consider:

- An evaluation of the dwelling for structural soundness, safety hazards, utilities, cleanliness, and barriers to mobility or use.
- Identification of type and feasibility of needed improvements or changes to the individual's environment.

3.9.3.2 Functional status (section 2 of UAI)

An assessment of the individual's ability to manage activities of daily living (ADLs) and instrumental activities of daily living (IADLs) shall be made when

assessing an individual's need for services. Some areas to consider when assessing functional capacity include:

- The physical, emotional, and cognitive status of the individual, assessing how well he or she performs the various ADL tasks including bathing, dressing, eating/feeding, toileting, transferring in and out of a bed or chair, and maintaining continence.
- The physical, emotional, and cognitive status of the individual, assessing how well he or she performs the various IADL tasks which include meal preparation, housework, laundry, shopping, transportation, money management, using the telephone, and/or home maintenance.

3.9.3.3 Physical health assessment (section 3 of the UAI)

The assessment of physical health may be based on the individual's reports of illness, disabilities, and symptoms, the individual's friends or family members, the individual's physician with an authorized release of information, other contacts or records, or based on worker observations. Some areas to consider when assessing physical health include:

- The individual's current medical condition, including any diagnosis or prognosis available, and any services being used.
- Symptoms observed by the worker that may not have been diagnosed or treated, including signs of physical injury.
- The number and type of medication(s) the individual is currently taking (prescription and non-prescription) and whether medication is being prescribed by multiple physicians. (**Note:** The worker may ask to see medication containers to get more accurate information.)
- Diet and eating habits (nutrition).
- The individual's general appearance and whether it is consistent with the adult's circumstances and environment.
- The adult's need for assistive devices (e.g., eyeglasses, hearing aids, dentures, mobility aid to compensate for physical impairments, etc.).

3.9.3.4 Psychosocial (mental health) assessment (section 4 of the UAI)

The worker's assessment of an individual's psychological functioning cannot take the place of a formal clinical evaluation. However, the worker's findings may suggest that a psychiatric problem is present and contributing to the

individual's need for services. This assessment can also provide the worker with documentation for recommending a more complete assessment by health professionals to rule out organic and/or physical causes of psychological symptoms. Some areas to consider when assessing psychosocial status include:

- Evidence that the individual is lonely, isolated, or lacking stimulation.
- The individual's perceived emotional or behavioral condition(s).
- Any manifestations of emotional, mental, or behavioral problems (e.g., insomnia, nightmares, crying spells, depression, agitation, unusual fears, thoughts, or perceptions, delusions, hallucinations, etc.).
- Any major life change/crisis in the past year (e.g., death of a significant person, divorce, loss of income, a move, an illness, institutional placement, etc.).
- A suspected untreated mental illness where the individual likely needs, but is not receiving, psychotropic medications or other appropriate treatment.
- Use of any psychotropic medication(s), who prescribed them, and for what purpose.
- The individual's orientation to person, place, and time as well as memory and judgment capacity.

3.9.3.5 Support systems (sections 1, 4, and 5 of the UAI)

The support systems assessment includes an assessment of the individual's family and community support system. It is important that the worker identify those family, friends, neighbors, faith-based, and other voluntary groups and formal supports that comprise the individual's social network. Some areas to consider when assessing support system(s) include:

- Any strong dynamics among family members/caregiver(s)/formal support systems as related to the care of the individual.
- Frequency and quality of contacts from informal and formal support systems.
- Social contacts and activities the individual has in the community and changes in the pattern of these contacts.

3.10 The service plan

A service plan will be initiated that includes the services to be provided, resources to be used to meet the presenting or immediate problem area(s), and an identification of initial target dates. The Service Plan may be printed from ASAPS. It is recommended that the adult or the adult's representative sign a completed service plan.

3.10.1 Service plan requirements

- The Service Plan Screen in ASAPS shall be used (see ASAPS Robo Help for details) when developing a service plan.
- Service plans are not required for case types “ALF Reassessment” and “Guardian Report” if the ALF reassessment or the review of the guardianship report is the only service provided.
- A case in which the only service being offered is a preadmission screening is not required to have a service plan. If the adult will be receiving other services and the case will remain open, a service plan is required.
- The details in the service plan will vary according to the individual's situation and will be based on the assessment of the individual's strengths and needs.
- Within 15 days of the date of eligibility, the service plan shall be entered into ASAPS. Service plans are formulated jointly between the individual and the service worker as well as the individual's family, when appropriate.
- The service plan shall address the long-term and short-term needs of the adult. Components of the plan include:
 - Goal(s).
 - Unmet need(s).
 - Objective(s).
 - Task(s) (e.g., services to be provided, service-related activities, resources to be used).
 - Target dates for meeting objectives.
 - Evaluation of services once tasks are completed.

3.10.2 Goals, unmet needs, objectives, tasks, and target dates

3.10.2.1 Goals

The following are goals for Adult Services cases:

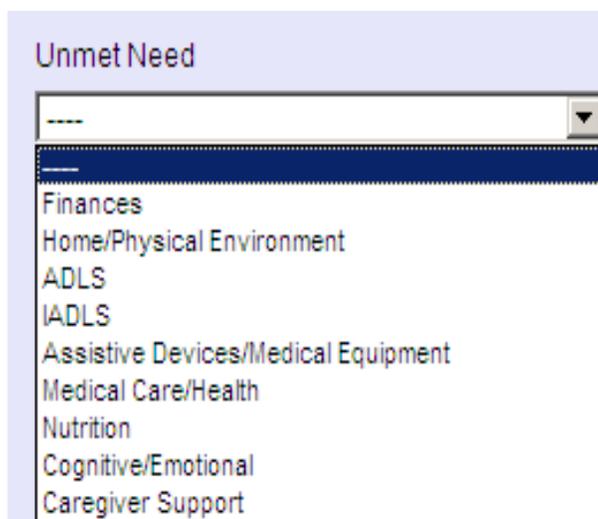
- To assist the individual to remain in his or her own home as long as possible provided that this is the most appropriate plan of care.
- To restore or retain the individual's independent functioning to the greatest extent possible.
- To assist in arranging out-of-home placement when that is appropriate and the individual or the guardian consents.

Other goals as deemed appropriate may be described on the hard copy of the service plan when printed.

See Chapter 2, Section 2.18.13.1 for service plan goals for APS cases.

3.10.2.2 Unmet needs

An unmet need is an identified need that is not currently being met in a way that assures the safety and welfare of the adult. Unmet needs appear in section 5 (Assessment Summary) of the UAI. They are identified after the completion of the assessment and should correspond to the unmet needs identified in the services plan. Unmet needs are listed in ASAPS as follows:



The image shows a screenshot of a software interface titled "Unmet Need". It features a dropdown menu with a list of categories. The categories listed are: Finances, Home/Physical Environment, ADLS, IADLS, Assistive Devices/Medical Equipment, Medical Care/Health, Nutrition, Cognitive/Emotional, and Caregiver Support. The first item in the list is currently selected and highlighted in blue.

3.10.2.3 Objectives

- Objectives should reflect the consensus of the individual, the individual's family (where appropriate), and service worker regarding the desired outcome(s) of service delivery. Objectives and services selected should be relevant to the goal.
- Each objective shall state clearly WHAT will happen in order to accomplish the goal(s).
- Objectives should be:
 - Identified by the individual or representative and worker to eliminate or diminish identified unmet need(s).
 - Supportive of the goal(s) selected.
 - Stated in terms of measurable result(s) to be achieved or desired outcome(s).
 - As behaviorally specific as possible.
 - Updated as the individual's situation changes.
 - Example of an objective: To assist client in obtaining medical care to manage health issues.

3.10.2.4 Tasks

Tasks describe the actual provision of services, identifying HOW to achieve each objective, WHO will be involved in accomplishing each objective, WHERE services will be provided, and WHEN services will be provided. Tasks shall be specific and measurable. All services types shall be selected from the drop down menu provided in ASAPS.

- Example of a service: Transportation
- Example Task: Worker will assist client in securing transportation to medical appointments.

If a provider is providing the service, the provider, the number of hours per week the service will be provided and the rate of pay shall be identified on the service plan.

3.10.2.5 Start and target dates

The service plan shall include dates for services to start and target dates for achievement of objectives. Target dates should be realistic, and should not exceed the redetermination date on the Case Info screen in ASAPS.

3.10.2.6 Date resolved

The date resolved will indicate when the objective is met and closes out the service in the service plan. If the objective is not achieved by the target date, the reasons should be documented in the “Evaluation of Services” section on the Service Plan in ASAPS.

3.10.2.7 Evaluation of services

The evaluation of services describes the status of the task at its conclusion, and whether or not objectives were accomplished in a timely manner. The adult and the service worker shall conduct, collaboratively, an evaluation of progress towards meeting goals and objectives and the delivery of services at the time of any completion or termination of a service or at other times as appropriate, not to exceed the time standards for case reviews and redetermination. The evaluation of the service delivery shall be documented in the “Evaluation of Service” section in the service plan. If additional space is needed the service worker should enter the information in the ASAPS Narrative and identify the type of contact as a “Case Action.” When all services have been completed and evaluated, the service plan is closed.

3.10.2.8 Service plan: an example

Service Plan

[Save](#)

Goals

- To stop the abuse, neglect and/or exploitation by providing the protection the adult requires with the least restriction of his/her liberty
- To assist the adult in remaining in his/her home as long as possible and as long as this is the most appropriate plan of care
- To restore or retain independent functioning to the greatest extent possible
- To assist in arranging out-of-home placement when that is appropriate and it is the choice of the adult or guardian or the court orders placement

Service Objective

Unmet Need: Objective:

[Add Objective](#)

Needs/Objectives/Services

1. Finances
2. Home/Physical Environment
 - To assist client in locating housing [edit](#) [Add Service](#)

Service Type	Waiting List	Start Date	Target Date	Date Resolved	Tasks	Evaluation of Service	Service Provider	No. of Hours Per Week	Prov of Pa
edit Housing Services	No	01/15/2012	05/15/2012		SW will assist client in exploring available housing that is affordable.				
3. ADLS
4. IADLS
5. Assistive Devices/Medical Equipment
6. Medical Care/Health
7. Nutrition
 - To improve client's nutritional intake by arranging for companion services to prepare meals. [edit](#) [Add Service](#)

Service Type	Waiting List	Start Date	Target Date	Date Resolved	Tasks	Evaluation of Service	Service Provider	No. of Hours Per Week	Prov of Pa
edit Companion	No	01/15/2012	05/15/2012		Companion provider will prepare lunch 3x per week.		Bay Way Services	3	10.00
8. Cognitive/Emotional

3.11 Case type selection

Each open service case shall have a primary "case type" designated. Cases shall be opened according to one of the following case type definitions:

APS

When the APS report has been investigated and the disposition was "Needs Protective Services and Accepts" the case should be case typed APS, Protective services are being provided except there are no home-based care services being provided. Contacts shall be made at least **monthly** with the adult, legal representative or designated primary caregiver.

APS – home-based care

When the APS report has been investigated and the disposition was “Needs Protective Services and Accepts” and home-based care (companion, chore, or homemaker) is one of the protective services being provided, the case should be case type APS-home-based care. The “-Home Based Care” extension was added to make it easier to identify a case with home-based care services within a caseload listing. Contacts shall be made at least **monthly** with the adult, legal representative or designated primary caregiver.

APS investigation

When the APS report is being investigated and no disposition has been made, the case should be case typed APS investigation. Once a disposition has been made, the case type is changed if the case remains open, or the case is closed.

AS

A case in which intervention is primarily needed to maintain and monitor on-going services to promote self-sufficiency and enhance functioning of the adult should be case typed AS. At least a **quarterly** contact with the adult, legal representative or designated primary caregiver shall be made.

AS – home-based care

A case in which intervention is primarily needed to maintain and monitor on-going services to promote self-sufficiency and enhance functioning of the adult should be case typed AS-home-based care. Home-based care (companion, chore, or homemaker) is one of the services being provided. The “-Home Based Care” extension makes it easier to identify a case with home-based care services within a caseload listing. At least a **quarterly** contact with the adult, legal representative or designated primary caregiver shall be made.

AS – intensive services

A case in which intervention may be intense and require many resources in an attempt to stabilize the situation should be case typed AS-intensive services. Frequent and planned contacts with the adult/collateral are documented in the service plan. Contacts shall be made at least **monthly** with the adult, legal representative or designated primary caregiver.

AS – intensive services-home based care

A case in which intervention may be intense and require many resources in an attempt to stabilize the situation should be case typed AS-intensive services-home based care. Frequent and planned contacts with the adult/collateral are documented in the service plan. Home-based care (companion, chore, or homemaker) is one of the services being provided. The “-Home Based Care” extension makes it easier to identify a case with

home-based care services within a caseload listing. Contacts shall be made at least **monthly** with the adult, legal representative or designated primary caregiver.

ALF reassessment

A case in which the only service being provided is the annual reassessment of the adult in an ALF a requirement to maintain eligibility for AG should be case typed ALF reassessment. The case is opened and the redetermination date is the date the reassessment is due.

Guardian report

A guardian report case is a case in which the only service being provided is the receipt and review of the Annual Report of the Guardian as required by [§ 64.2-2020](#) of the Code of Virginia. The case is opened and the redetermination date is the date the initial or annual report is due. See Chapter 7, Guardianship and Conservatorship for details on the required time frames for guardian reports.

3.11.1 Case typing PAS only

Depending on the adult's situation, cases in which the only service offered is PAS should be case typed AS or AS-Intensive. A "Home Based Care" extension case type should not be used if the only service being provided is a preadmission screening.

PAS only cases, in which the individual is under age 18 at the time of the screening, shall not be entered into ASAPS.

3.12 Resource appraisal and selection

The individual may require a service provider outside of the LDSS. [Guidance manuals](#) listed below provide references on resources and are available on the VDSS internal website:

Long-Term Care Services	Chapter 4
Adult Services Providers	Chapter 5

The [Local Finance Guidelines Manual](#) is also available on the VDSS internal website.

Purchase of Services	Local Finance Guidelines Manual, Section 5.20 –Purchase of Services
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3.13 Service delivery

Social services shall be provided directly, by referral, or by purchase as required in order to assure appropriate service delivery and resource utilization necessary for implementation of the service plan.

3.13.1 Direct services

Direct services are those services provided, arranged, monitored, and/or referred by the LDSS staff as outlined in the service plan. Case management is an inherent part of the provision of direct services.

3.13.2 Referrals

Referrals are made when the worker directs the adult to an outside source for assistance.

3.13.3 Purchased services

Purchased services are those services purchased for adults by LDSS from approved providers, including department-approved providers and providers with whom the LDSS contracts. A [Purchase of Services Order](#) is available on the VDSS internal website.

3.13.4 Ongoing service planning and delivery

Following the initiation of the service plan, the assessment is to continue on a mutual basis between the individual and worker in order to document further service needs as a basis for the setting of long-range service objectives, the selection of services to fulfill those objectives, and the choices of resources to be used.

3.14 Waiting lists

If department funds are inadequate to maintain the level of service to adults of an optional service or service mandated to the extent funds are available, localities should maintain a waiting list. Service by date of request is an acceptable means of administering a waiting list. Any other proposed policy for a waiting list, such as by degree of need or at-risk status, shall be sent to the appropriate Adult Protective Services Division Regional Consultant for approval prior to submission to the local board of social services. Waiting list criteria shall be uniformly applied to all individuals requesting the service. Waiting lists should be updated at least annually.

The service worker should indicate on the Service Plan if the individual has to be placed on a waiting list for the designated service. See [ASAPS-Robo Help](#) for additional information about placing an individual on a waiting list.

3.15 Fees for services

The LDSS may also charge fees for other services. Agencies are encouraged to test fee systems where appropriate. Fee systems for service programs should be submitted to the appropriate Adult Protective Services Division Regional Consultant for review prior to being submitted to the local board for approval.

3.16 Required contacts

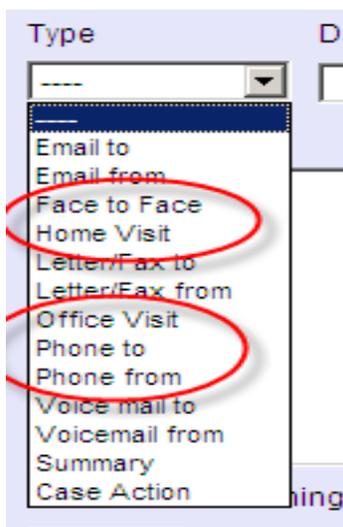
For adult services and adult protective services, contact includes communication with the adult, the adult's legal representative or the adult's designated primary caregiver. More frequent contact should occur as needed. The worker should verify by observation or personal interview that the adult is receiving the planned services and identify any changes in his or her situation. The worker shall make timely, regular contacts with providers to monitor the provision of services and the well-being of the individual. All contacts should be documented in the ASAPS case narrative.

Required provider monitoring contacts should be documented on the Compliance Form for Agency Approved Providers (See Chapter 5, Section 5.25).

3.16.1 Types of contact

For purposes of meeting the requirements of a case contact, contact with the adult, the adult's legal representative, or the adult's designated primary caregiver shall be in the form of face-to-face, home visit, office visit, phone to/from.

Example of visit types in the ASAPS narrative screen:



All contacts, including other types of contacts such as fax to/from and email to/from shall also be documented in ASAPS. Contacts should be conducted for the purpose of determining the individual’s progress toward achieving objectives stated in the service plan.

The following table identifies who is considered a legal representative or designated primary caregiver:

Legal Representative	Designated Primary Caregiver
Power of Attorney, guardian, and conservator	Father, mother, daughter, son, spouse, wife, and husband

Example of case contact with adult’s daughter:

Narratives					
	Contact	Type	Date	End Date	Narrative
edit	Smith, Betsy	Office Visit	04/20/2012 09:00	04/20/2012 10:01	Mrs. Smith dropped off a copy of her father recovering from recent surgery. Home t

Example of case contact with the adult:

edit	Client, John	Home Visit	04/27/2012 13:14	04/27/2012 15:14	Met with client to discuss need for transportation to next r transport him. Have arranged for Care Van to pick him up daughter will be spending the next few nights with him.
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3.16.2 Cases requiring monthly contact

For case types AS-Intensive Services, AS-Intensive Services-Home Based Care, APS and APS-Home Based Care, contacts shall be made at least monthly. More frequent contacts may be needed depending on the case situation.

3.16.3 Cases requiring quarterly contact

For case types AS and AS-Home Based Care, contacts are required at least every three months (quarterly). LDSS are strongly encouraged to conduct a face-to-face contact every six months.

3.16.4 Collateral contacts

Collateral contacts with other interested parties, vendors of service, other community providers/agencies, volunteers working with the individual, and the court may include face-to-face, telephone conversations, and written or email correspondence.

3.16.5 Written correspondence

Written correspondences, including letter to/from, fax to/from, and email to/from and collateral contacts do not count toward the monthly and quarterly contact requirements.

3.16.6 Regular quarterly contact not required

Regular quarterly contacts are not required for the following:

- Case type “Guardian Report.”
- Case type “ALF Reassessment.”
- The individual’s whereabouts prevent the department from having contact within the required time frame. The case record shall specify why the contact was not made.

3.17 Monitoring

Monitoring is the process by which the service worker maintains contact with the individual, support systems, and service provider(s) to ensure the efficient and effective delivery of services relating to the achievement of the stated objectives. The monitoring function shall begin upon delivery of service(s) and shall be continuous. The LDSS will be responsible for the monitoring of service delivery whenever it uses a vendor or non-agency provider to offer services to an individual.

3.18 Redetermination

Redetermination shall be performed at least annually. Redetermination shall be conducted in the same manner as the initial determinations (the adult does not have to sign a new service application). Verification is recorded in the “Eligibility/Income” section on the General Information screen in ASAPS. The effective date and redetermination dates on the General Information page in ASAPS are updated to reflect the updated/new eligibility period.

If information is received in the interim that affects eligibility, redetermination shall be performed **within 30 days** of receipt of information.

3.19 Reassessment

The service worker shall reassess a case when there is significant change in the individual's circumstances, but no less than once every 12 months. A significant change in an individual's condition occurs when the change is expected to last more than 30 days or appears to warrant a change in the individual's service plan or level of care. The reassessment shall include an updated UAI and a brief summary evaluation of the effectiveness of service delivery and an update of the service plan as appropriate. Follow the instructions in the ASAPS-Robo Help for placing a copy of the UAI in "History" and revising the current UAI.

Based on the UAI reassessment, the worker shall document:

- The effectiveness of the service plan; the service plan shall be updated, if necessary.
- A description of the individual's current situation with input from the individual and family, if applicable, to determine if there are needs which should be addressed.
- An indication of whether additional services are needed. If so, the service plan shall be revised accordingly. If no further services are needed, the case should be closed.

3.20 Closure of an adult services case

An adult services case may be closed under any one of the following circumstances:

- The service plan goals and objectives have been met.
- Services are no longer needed.
- The individual requests closure, and, in the worker's professional judgment, the individual has the capacity to make that decision.
- The individual is no longer eligible due to excess income.
- The capable individual fails to follow the mutually agreed upon service plan, and the case record documents repeated attempts by worker to implement the plan.
- The LDSS is no longer able to serve the individual, and the individual is not a required population to be served.
- The time limit expires on a specific program.

- The LDSS is not able to maintain contact with the individual at least every quarter because the individual cannot be located or is not available.
- The individual relocates to another jurisdiction. Entering a long-term care facility may be considered a relocation.
- The individual dies.

3.21 Relocation

If a relocation is temporary, the original jurisdiction keeps the case, and depending on the distance, provides any needed services or requests the new jurisdiction to assist. Service payments are the responsibility of the original jurisdiction in this situation.

A permanent relocation means the individual will be residing in a new locality. The LDSS previously providing services may close the case. The case is opened by the LDSS serving the jurisdiction where the individual now resides. The case may also be transferred by the supervisor in the original jurisdiction to a designated worker in the new jurisdiction. [ASAPS-Robo Help](#) provides information on transferring a case from one locality to another. See the guidance under the heading "Supervisors Tasks in ASAPS."

When an individual plans a permanent relocation to a facility in another jurisdiction and the individual will need services in the new jurisdiction, the LDSS involved should assist each other with needs concerning the individual's admission. If services will be needed, the sending LDSS should:

- Notify the receiving LDSS of the expected date of the admission, the facility selected, and the services needed.
- If only ALF Reassessment is needed, the sending LDSS shall notify the receiving LDSS of the admission date and the name of the facility.
- Offer to assist in completing an application if needed.
- If the individual requests it, send a copy of the record and a brief summary to the receiving LDSS before the individual arrives.

For case type Guardian Report follow the procedures in Chapter 7, Guardianship and Conservatorship.

3.22 Notice of action

Proper procedures regarding notice to the individual and documentation shall be followed regarding a decision on an application or when closing a case. Proper notice is

also required for all purchase of services. The form [Notice of Action for Service Programs](#) may be used to inform an individual about actions taken on his or her case and is available on the VDSS internal website.

3.22.1 Notice of action/application

- LDSS shall notify the individual of its decision or lack of decision on an application promptly but no later than 45 days after application is received. **Note:** For PAS, the LDSS shall notify the individual of the decision no later than 30 days of the individual's request for a screening.
- If the application is approved, the notice may be oral. If approval includes a purchase of service payment, the notice shall be written.
- Written notice shall be sent for denial of application or if a decision has not been made.

3.22.2 Termination of application other than approval or denial

- The individual may withdraw the application. For special procedures on Adult Protective Services, see Chapter 2.
- If the withdrawal was done by letter, telephone call or personal visit, a Notice of Action or letter shall be sent to acknowledge the withdrawal in order to protect the department and individual from any misunderstanding.
- The individual should be told that he or she may reapply at any time.

3.22.3 Failure to follow through or disappearance

If an individual disappears or fails to follow through with an application, VDSS does not need to try to find the individual unless a valid Adult Protective Service report has been made. If there has been no valid APS report, a Notice of Action terminating the application is sent 45 days after the application was received.

3.22.4 Notice of action/case management requirements

- A Notice of Action or letter shall be mailed or given to the individual when a purchased service payment is approved, reduced, suspended, or terminated.
- When mailed, send the Notice of Action approximately **14 days before** the date the action is to become effective so that the individual has a 10-day notice. See Section 3.22.5 regarding early notification regarding home based services.

- Notices are not required for fluctuations in purchased service payments when the Purchase Order authorization remains the same.
- Use either a Notice of Action or a letter when written notice is required. If a letter is used, it shall specify:
 - The action taken or planned. If a service payment is involved, the letter must give the current amount, if any, and proposed amount.
 - The effective date.
 - The reason for the action.
 - Information on appeal procedures.

3.22.5 Early notice due to reduction in funding for home based services

If the adult appeals the action within 10 days of the effective date of the Notice of Action, services must continue. The LDSS is encouraged to provide notice earlier than the recommended 14 days before the action becomes effective, particularly when the action is due to lack of or reduction in funding to provide a particular service (e.g. companion services). Providing early notice of the intent to reduce or discontinue services due to funding constraints will provide sufficient time for services to continue during the appeal before funding is exhausted.

3.22.6 Notice of action/closure

A Notice of Action or letter shall be mailed or given to the individual or his/her representative when a case is closed.

3.23 Death of the adult

If the LDSS receives reliable information of an individual's death, the LDSS closes the case. A Notice of Action or letter may be sent to an appropriate relative or to the person(s) with whom applicant was living.

3.24 Appendix A: Forms

The following forms may be used for case management purposes. Unless otherwise indicated, these forms are located on the DARS Adult Services forms page on the VDSS internal website.

Notice of Action-Adult Services & Adult Protective Services Programs

This form is used to notify an individual about an action that has been taken or will be taken on his or her case. *This form is also available in Spanish.*

Purchase of Services Order

This form is used to order services from vendors. This form is also used for unscheduled termination of, or change to, an existing POS Order.

Application for Adult Services

This form should be used by an individual to apply for adult services and adult protective services. *This form is also available in Spanish.*

3.25 Appendix B: Income eligibility determination

Income, not resources, is counted in determining if an individual meets the category of Eligibility Based on Income. All income, except items listed below, is to be counted.

Net income from self-employment, farm or non-farm, is to be counted. This is gross receipts minus expenses. The value of goods consumed by the client and his/her family is not to be counted.

The gross amount in wages or salary received is the figure to be used. However, if the wage earner voluntarily has additional amounts taken out for savings such as bonds, these amounts shall be counted as income.

Do count income from Social Security, but do not count income from Supplemental Security Income (SSI).

Income to be excluded

- Per capita payments to or funds held in trust for any individual in satisfaction of a judgment of the Indian Claims Commission or the Court of Claims.
- Money received from sale of property, such as stock, bonds, a house, or a car (unless the person was engaged in the business of selling such property in which case the net proceeds would be counted as income from self-employment).
- Earnings of less than \$25.00 a month.
- Withdrawals of bank deposits.
- Money borrowed.
- Tax refunds.
- Gifts.
- Lump sum insurance payments.
- Capital gains.
- The value of Supplemental Nutritional Assistance Program (SNAP) benefits.
- The value of USDA donated foods.

- The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food service program for children under the National School Lunch Act as amended.
- Earnings of a child under 14 years of age.
- Any benefits received under Title III, Nutrition Program, of the Older Americans Act, as amended.
- Any grant or loan to any undergraduate for educational purposes made or insured under any program administered by the Commissioner of Education.
- Any other scholarship loan or grant obtained and used under conditions that preclude its use for current living costs.
- Home produce used for household consumption.
- Earnings received by any youth under the Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973 (CETA).
- Payment to Americorp/VISTA volunteers.
- Payment to vendors for services to recipients. These are not to be considered income for the recipient.
- Garnished wages.
- The portion of income paid for child support, if being paid, whether court-ordered or not. The child support payment is income for the person receiving it.
- SSI.

3.26 Appendix C: Expenditures for services

3.26.1 Funding allocations

Each LDSS receives funding to purchase services needed by an adult to meet the goals of the adult's service plan. LDSS are encouraged to make maximum use of this funding in providing services to adults and shall be aware of the number of cases their allocations will support throughout the year. During the course of the fiscal year, if the LDSS realizes that it has been allocated more funds than are needed to serve its adults, the LDSS should return the surplus funds in a timely manner to the state for reallocation to other LDSS. The LDSS should make an effort to spend all of their funding for necessary services for the elderly and adults with impairments in their communities.

3.26.2 LASER

LASER (Locality Automated System for Expenditure Reimbursement) is an automated system used *to allocate funding*.

3.26.3 Budget lines, cost codes descriptions

Budget lines and cost code descriptions including examples of reimbursable expenses are available on [SPARK](#).

21704 GUARDIANSHIP PETITIONS

Provides for the costs of petitioning the court for appointment of a guardian for a Medicaid applicant who is unable to apply for himself or herself.

Note: VDSS does not provide a local budget allocation for this cost code, all expenditures entered in 21704 will be funded using 100% state General Funds.

LDSS should complete page two of the [Response to Medicaid Referral form](#) located on the VDSS internal website. Expenses shall be itemized, attached to the form, and retained by the LDSS as documentation for reimbursement.

Localities should submit a BRS to request funds to cover the expenditures. The request will be reviewed and acted on by the APSD Director.

Reimbursable examples

Expenses incurred during a guardianship proceeding for a Medicaid applicant who is unable to apply for himself or herself:

- Evaluation.
- Guardian ad litem legal fees.

- Attorney legal fees.
- Court filing fees.
- Other costs (itemized).

ADULT SERVICES (833)

83304 Adult Services- Home-Based Companion (State Supplement)

Companion services are performed by an individual or an agency provider who assists adults unable to care for themselves without assistance and where there is no one available to provide the needed services without cost. Services may include dressing, bathing, toileting, feeding, household and financial management, meal preparation, and shopping. Companion services shall only be provided to an eligible adult who lives in his or her own home.

83301 Adult Services – Home-Based Care -- Chore (State Supplement)

Chore services are the performance of non-routine, heavy home maintenance for adults unable to perform such tasks themselves. Chore services are provided only to adults living in an independent situation who are responsible for maintenance of their own home or apartment and have no one available to provide this service without cost. Chore services include yard maintenance, painting, chopping wood, carrying wood and water, snow removal, and minor repair work in the home.

83303 Adult Services – Home-Based Homemaker (State Supplement)

Homemaker services are provided by an individual or agency provider who gives instruction in, or where appropriate, performs activities to maintain a household. The activities may include personal care, home management, household maintenance, nutrition, consumer education, and hygiene education.

83302 Adult Day Services

Program funds are used to purchase adult day services from approved/licensed providers for a portion of a 24-hour day. Adult day services assess the needs of participants and offer services to meet those needs. Participants attend on a planned basis. Services include: personal supervision of the adult and activities that promote physical and emotional well-being through socialization.

ADULT PROTECTIVE SERVICES (895)

89501 Adult Protective Services

This budget line is used to fund the APS program. This funding may be used for reimbursable expenses of the Adult Protective Services Program at the local level. A base amount is provided to each locality. Additional APS funding is distributed using a need-based formula.

Protective services to adults consist of the receipt and thorough investigation of reports of abuse, neglect or exploitation of adults and of reports that adults are at risk of abuse, neglect or exploitation. APS provides services to elders and to incapacitated adults.

The purchase of goods or services is appropriate under the following circumstances:

- An APS report has been taken and the investigation has determined that an elder or an incapacitated adult needs protective services and the service to be purchased is part of the service plan to protect the adult from ongoing abuse, neglect or exploitation; or
- An APS report has been taken and the protective services investigation has found an elder or an incapacitated adult to be at risk of abuse, neglect or exploitation and the service to be purchased is part of the service plan to prevent abuse, neglect or exploitation from occurring.

Guardianship Fees

Section [64.2-2020](#) of the Code of Virginia requires a guardian to complete and submit an annual report, on the incapacitated adult for whom a guardian has been appointed, to the LDSS in the jurisdiction in which the adult resides. Section [64.2-2020](#) requires that the annual report, when filed, be accompanied by a filing fee of \$5.00. The \$5.00 filing fee that accompanies annual guardianship report shall be used in the provision of services to protect vulnerable adults and prevent abuse, neglect or exploitation of vulnerable adults.

To record the receipt of guardianship fees, the LDSS should enter the amount collected as a credit, using Account Code 40895 Receipt of Guardianship Fees.

Admin Adult Protective Services

Administrative costs of operating the APS program are included in Services Staff and Operations or Services Staff and Operations Pass-Thru (budget lines 855 and 857). Reimbursable examples include on-call coverage for staff who provide coverage for APS on nights, holidays, weekends, and other times outside of regular office hours; costs of staff travel for investigating, for ongoing service delivery, for training/education purposes, or other travel costs related to the APS program; office supplies and equipment dedicated to the operation of the APS program; and costs of community outreach to increase awareness of the problem of adult abuse.

*At any point in the budget year, LDSS may request that 895 funding be transferred to BL 855. The two part request must be entered into the LASER system and approved by the APS Division Director and a DSS budget analyst. **Note:** Though the \$5.00 guardianship fees are entered into BL 895, these fees can't be transferred to 855. The filing fee is considered a credit to the LDSS and credits may not be transferred. The filing fee must remain in BL 895 to support victims of adult abuse, neglect, and exploitation.*

REIMBURSEMENT THROUGH RANDOM MOMENT SAMPLING (RMS)

Preadmission Screenings

Individuals who are Medicaid eligible or will be Medicaid eligible within 180 days of placement and who are seeking Medicaid coverage for nursing facility care *or community-based services* shall be screened to determine their need for the service ([§ 32.1-330 of the Code of Virginia](#)). LDSS are reimbursed for PAS through the RMS process.

Assisted Living Facility (ALF) Assessments

LDSS assess individuals receiving Auxiliary Grant (AG) in ALFs using the UAI to determine the level of care (residential or assisted living). A short or full assessment is completed depending on the adult's condition or level of assistance he needs. LDSS also reassess individuals receiving AG annually to determine if the adult continues to meet the level of care that is required in an ALF. LDSS are reimbursed for ALF assessments and reassessments through the RMS process.