

# 4

## LONG-TERM CARE SERVICES

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# 4

## LONG-TERM CARE SERVICES

### 4.1 Introduction

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It is the responsibility of the service worker working with the adult and/or his or her representative to determine the most appropriate method of service delivery such as direct services, purchased services, or referral to another agency. This chapter identifies the primary services provided by local Adult Services programs and describes the responsibilities of the local department of social services (LDSS) in relation to other agencies.

### 4.2 Home-Based Care Services to adults

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#### 4.2.1 Home-Based Care Services defined

Home-Based Care Services consist of three components: Companion, Chore, and Homemaker services.

Each local board shall provide for the delivery of at least one of these services to the extent that federal and/or state matching funds are made available. The local board shall determine which of the three services is mandated ([§ 63.2-1600](#) of the Code of Virginia).

The local board shall develop policy addressing all aspects of home-based care provided in the locality, including criteria for receiving home-based services, financial eligibility criteria, which home-based service(s) will be provided, and how an assessment will be conducted to determine the number of approved hours. The policy shall be reviewed and approved by an AS/APS Regional Program Consultant prior to board approval.

#### 4.2.2 Purpose of Home-Based Care Services

Home-Based Care Services are used for the following purposes:

- To provide protection to adults or prevent abuse, neglect, or exploitation.

- To assist adults in attaining or retaining self-care, self-sufficiency, and independence.
- To prevent inappropriate institutionalization.

#### **4.2.3 Eligibility for Home-Based Care Services**

##### **4.2.3.1 Financial eligibility**

Eligible individuals are adults who meet financial eligibility criteria contained in Chapter 3, Adult Services Case Management and local board policy, and who are assessed to need the service.

##### **4.2.3.2 Living arrangements**

An adult is eligible to receive Home-Based Care Services if one of the following conditions is met:

- The home is owned in full or in part by the adult; or
- The rent or mortgage and utilities, etc. are paid in the adult's name; or
- The rent or mortgage, utilities, household expenses, etc., are shared between the adult and others; or
- The adult lives in the home of a relative, friend, roommate, or other housing situation; or
- The adult does not live in a residential care setting such as a nursing facility, assisted living facility, or a hospital.

##### **4.2.3.3 Prioritizing need for Home-Based Services/waiting lists**

When funds are inadequate to maintain the level of services or to increase service delivery as needed, the LDSS shall develop criteria for prioritizing need and/or establish a waiting list. Waiting list criteria shall be uniformly applied to all adults requesting the service. Waiting lists should be updated at least annually. Service by date of request is an acceptable means of administering a waiting list. The LDSS may adopt additional criteria regarding the adult's living situation if diminished funding has reduced the availability of the service. Acceptable examples of additional criteria include providing the service only to adults who live alone or who are at risk of institutionalization. Any other proposed policy shall be sent to the appropriate AS/APS Regional Program Consultant for approval prior to local board approval. Documentation of local board approval shall be submitted to the appropriate AS/APS Regional Program Consultant.

#### 4.2.3.4 Temporary reduction or termination of SSI

In cases where the Social Security Administration (SSA), the Virginia Department of Social Services (VDSS), or the LDSS has made an error that requires a temporary reduction or temporary termination of an individual's SSI payment due to an overpayment, the adult may continue to be eligible for service as an SSI recipient. The case record shall identify error(s) resulting in overpayment, who was responsible for the error(s), and what affect the error(s) had on the adult's SSI benefits.

#### 4.2.4 Criteria for Companion Services

##### 4.2.4.1 Definition

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. Companion Services shall be provided only to an individual who meets the eligibility requirements in [Section 4.2.3](#). Activities include, but are not limited to:

- Bathing.
- Dressing.
- Toileting.
- Eating/feeding.
- Transportation.
- Meal preparation.
- Shopping.
- Supervision.
- Light housekeeping.
- Companionship.
- Household/financial management.

##### 4.2.4.2 Provision of Companion Services

- A parent, spouse, or other relative of an eligible adult may be approved as a companion provider if the written documentation shows that:

- He or she is the most available and/or qualified person to provide the service.
  - He or she is unable or unwilling to provide these services free of charge.
  - In the professional judgment of the worker, this would be the best plan of care for the adult.
- An LDSS shall not establish policy that prohibits the utilization of a relative as a companion provider.

#### **4.2.5 Criteria for Chore Services**

##### **4.2.5.1 Definition**

Chore Services are the performance of non-routine, heavy home maintenance for adults unable to perform such tasks. Chore Services shall be provided for adults living in an independent situation who are responsible for maintenance of their residence and have no one available to provide this service without cost. Heavy home maintenance activities include but are not limited to:

- Performing minor repair work on furniture and appliances in the home.
- Carrying coal, wood, and water.
- Chopping wood.
- Removing snow.
- Yard maintenance.
- Painting.

##### **4.2.5.2 Eligible persons - Chore Services**

To qualify for Chore Services, the following information shall be documented in the case record:

- The adult is living in an independent situation and is responsible for maintenance of his or her residence.
- The adult is unable to perform the necessary heavy home maintenance task(s).

#### 4.2.5.3 Provision of Chore Services

Chore Services shall not be purchased from a relative who is a member of the household; however, chore services may be purchased from a relative who is not a member of the household.

#### 4.2.6 Criteria for Homemaker Services

##### 4.2.6.1 Definition

Homemaker Services are performed by an individual or an agency provider who provides instruction in (or, where appropriate, performs) activities to maintain a household. The activities include:

- Personal care.
- Home management.
- Household maintenance.
- Nutrition.
- Consumer education.
- Hygiene education.

##### 4.2.6.2 Provision of Homemaker Services

- Homemaker Services may be provided directly by staff of the LDSS.
- Services provided by all homemaker providers shall be supervised and monitored by the service worker or supervisor.
- The adult receiving care shall meet the requirements of [Section 4.2.3](#).

#### 4.2.7 Assessment required for Home-Based Care Services

##### 4.2.7.1 Use of Virginia Uniform Assessment Instrument

The LDSS shall use the Virginia Uniform Assessment Instrument (UAI) to assess the need for home-based services. The UAI may be found in ASAPS and may be printed as needed.

##### 4.2.7.2 Assessment procedure

Each LDSS shall establish a procedure for conducting a home-based care assessment to determine the required number of service hours. The method

used to determine the amount of services to be provided shall be approved by the local board and uniformly applied within each LDSS. Services should not be authorized prior to the date of assessed need. Any change in authorized hours shall be documented on an assessment form. The home-based care assessment shall be completed as needed, but at least annually for each adult receiving home-based services.

#### **4.2.7.3 Types of services**

As part of the assessment, informal services (e.g., family, friends, community groups) and formal services shall be explored that could help meet the adult's needs. Home-based services may be used to complement informal and/or formal service providers, or they may be the only service provided to the individual.

#### **4.2.7.4 Duplication of service activities**

An adult receiving home-based services may be assessed by the nursing facility preadmission screening team for nursing facility admission or community-based care when he or she is at risk of institutionalization. Although an adult may receive services from both home-based services and Waiver personal care simultaneously in order to meet his or her needs, duplication of service activities shall be avoided. Documentation in the service plan should demonstrate services provided by the LDSS and other providers. Service plans should be developed in coordination with other providers when possible.

### **4.2.8 Service delivery – Home-Based Care Services**

#### **4.2.8.1 Maximum hours**

Each LDSS shall establish local board policy to specify the maximum number of hours of home-based services that may be provided per adult per week.

#### **4.2.8.2 Provider pay rate**

Each LDSS shall establish local board policy to specify the rate of pay for providers. Home-based providers shall be paid at least minimum wage.

#### **4.2.8.3 Methods of service delivery**

Social services are provided directly, by referral, or by purchase as required to ensure appropriate service delivery and resource utilization necessary for the implementation of the service plan.

#### **4.2.8.4 Sliding-fee system**

The LDSS may develop a sliding-fee system for services. The LDSS fee system shall be approved by the appropriate AS/APS Regional Program Consultant prior to local board approval.

#### **4.2.8.5 LDSS responsibility**

When home-based services are contracted out to other agencies (i.e., not managed directly by the LDSS), the LDSS continues to be responsible for ensuring that the UAI and any needed reassessments are completed as well as ensuring compliance with other requirements noted in this section.

#### **4.2.8.6 Licensing standards**

Home-based services shall be purchased from providers who are approved as meeting the standards established by the State Board of Social Services as set forth in [22 VAC 40-771](#) and Chapter 5 Adult Services Providers or by demonstration of appropriate licensure through a licensing authority.

#### **4.2.8.7 Minimal safety standards**

If the adult's living situation does not meet minimal standards of safety (such as is required for the provision of Medicaid-funded personal care), the LDSS cannot deny services to the adult. However, the situation may preclude a provider from entering the home.

### **4.2.9 Receiving Home-Based Care Services and Medicaid Waiver Personal Care Services**

Eligibility for one service does not necessarily preclude an adult's eligibility for another service.

The LDSS shall not deny or terminate home-based services solely because the adult is eligible for or receiving Medicaid Waiver services. Before home-based services are terminated, the Medicaid Waiver hours necessary to meet the individual's needs shall be approved or recommended by the Medicaid Waiver provider and/or the preadmission screening team; the Medicaid Waiver program hours shall be ready to be implemented. This does not prohibit the LDSS from terminating home-based services if the combination of support systems and Medicaid Waiver can meet the adult's assessed needs.

Home-based services cannot be denied based on the home-based services provider's level of training, education, or professional credentials as long as the provider can meet the needs of the adult and meets standards established in [22 VAC 40-771](#) and Chapter 5.

If an adult is eligible for other services (such as Medicaid Waiver services), but cannot afford the co-payment or chooses companion services in lieu of Medicaid Waiver services, the LDSS cannot deny services to that adult if he or she meets eligibility requirements for the requested service(s).

#### **4.2.10 The LDSS as the adult's fiscal agent**

See Chapter 5 for information on the relationship between department-approved providers of home-based services and the adult receiving care. Neither the state nor the LDSS is the provider's employer.

### **4.3 Adult Day Services**

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#### **4.3.1 Definition – Adult Day Services**

Adult Day Services is the purchase of day services from approved providers or licensed providers for a portion of a 24-hour day. Adult Day Services include personal supervision of the adult and promotion of social, physical, and emotional well-being through companionship, self-education, and leisure activities.

#### **4.3.2 Eligible individuals - Adult Day Services**

Eligible individuals are those adults who meet financial eligibility criteria contained in Chapter 3 and local board policy, and who fall within all of the following categories:

- The adult has been assessed using the Virginia UAI as needing assistance with ADLs, IADLs, and/or supervision.
- The adult is in a family situation where the people normally responsible for his or her care are not available to provide such care.
- The adult does not live in an assisted living facility, nursing facility, hospital, or other public institution.

#### **4.3.3 Purchase components - Adult Day Services**

The following are purchase components for Adult Day Services:

- Registration required by facilities when not a part of unit cost.
- Transportation to and from center or home.
- Day services provided by a licensed or an approved provider.

#### 4.3.4 Providers - Adult Day Services

Adult Day Services providers are either:

- Licensed by the VDSS, Division of Licensing Programs; or
- Approved by the LDSS. The provider and home shall meet the standards found in Chapter 5, Adult Services Providers.

#### 4.3.5 Rates of payment - Adult Day Services

Rates of payment for services shall be negotiated by the LDSS on an individual basis with each vendor according to guidance regarding governing purchase of services or by the rate-setting process for department-approved providers by the local board.

#### 4.3.6 Service requirements - Adult Day Services

The entire UAI shall be completed to begin this service and shall be updated at least annually.

### 4.4 Adult Foster Care (AFC)

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#### 4.4.1 Definition – AFC

AFC is a locally optional program that provides room and board, supervision, and special services to an adult who has a physical or mental health need ([§ 63.2-1601](#) of the Code of Virginia). The adult shall be assessed prior to admission to the program using the Virginia UAI and determined to be incapable of independent living or unable to remain safely in his or her own home. AFC may be provided for up to three adults by any one provider. Care provided for more than three adults requires licensure by the VDSS as an assisted living facility.

The provision of an AFC program shall be approved by the local board of social services. Placements are made in homes approved by the LDSS. There shall be local board policy addressing AFC when this option is chosen. The LDSS is responsible for approving AFC homes in which adult placements are made. If an AFC provider is approved by the LDSS, the provider is bound by the department-approved provider standards located in Chapter 5 and regulations ([22 VAC 40-771](#)).

The LDSS may only approve AFC homes in which it will make placements. The LDSS may not approve AFC homes for placements by other agencies that are not part of the VDSS system.

*Additional guidance about AFC is available in the AFC Program Manual on [SPARK](#).*

## 4.4.2 Eligible individuals/payment sources - AFC

### 4.4.2.1 Local-only funding eligibility

Eligible individuals are those adults who meet financial eligibility criteria contained in Chapter 3 and local board policy, and who are assessed to need the service.

### 4.4.2.2 Auxiliary Grant (AG) eligibility

Eligible individuals are those adults who meet the criteria for a monetary payment under the AG Program (to be determined by the eligibility worker), and local board policy, and who are assessed to need the service.

### 4.4.2.3 Private pay

Eligible individuals are those adults who are incapable of independent living or unable to remain safely in their own homes and have the resources to pay for a private placement in an approved AFC home. This option should be outlined in the LDSS's AFC local policy and approved by the local board of social services.

## 4.4.3 LDSS services - AFC

Services that the LDSS shall provide as part of AFC are:

### 4.4.3.1 Recruitment, screening, and approval of AFC homes

The intent of the AFC program is to keep the adult in his or her own community. The recruitment of AFC homes and the placement of adults are limited to bordering city/county jurisdictions, so long as the adult's specified needs can be met in the AFC home.

Prior to the recruitment and approval of AFC homes and the placement of an adult in another bordering jurisdiction, there shall be a written agreement between the placing and receiving jurisdictions. The appropriate AS/APS Regional Program Consultant shall receive a copy of the agreement prior to the placement. A sample [interagency agreement](#) is available on the DSS internal website.

Refer to Chapter 5 for additional information on recruitment, screening, and approval.

#### 4.4.3.2 Assessment using the Virginia UAI

The entire UAI shall be completed for each individual applying for AFC prior to the beginning of the service and shall be updated at least annually. Each individual applying for AFC is assessed to determine his or her need for AFC and special services. The worker shall evaluate the adult's ability to perform activities of daily living, instrumental activities of daily living, manage medications, the adult's behavior pattern and orientation, and assess the availability of the informal support systems (e.g., family, friends, neighbors, community groups, etc.) to assist in meeting the adult's needs. Based on the results of the UAI assessment, the LDSS will determine if the adult's needs:

- Can be met by independent living with supportive services;
- Can be met by a placement in AFC; or
- Require a higher level of care such as an assisted living facility or nursing facility.

#### 4.4.3.3 Assistance with placement

Assistance with placement arrangements is provided to match the adult to an approved provider. This is based on:

- The adult's assessed need(s).
- Compatibility with the provider and other individuals residing in the AFC home.
- Ability of the AFC provider to provide any needed special services as identified by the assessment.

The LDSS shall arrange for any needed services from other community agencies prior to the individual's admission to the AFC home.

#### 4.4.3.4 Monitoring

The LDSS shall monitor the services that are provided to the adult and the provider for ongoing compliance. LDSS staff shall visit the home of the provider as often as necessary, but at least every six (6) months. The purpose of the monitoring visit is to determine the provider's compliance with applicable requirements and the progress and well-being of the adult. The provider monitoring visits shall be documented on the [Compliance Form for Department Approved Providers](#), which is available on the DSS internal website.

The LDSS will reapprove the provider prior to the end of the 24-month approval period if the provider continues to meet requirements. The LDSS shall determine and document that the provider is qualified to provide the special services required by the adult. For example, if the physician has instructed the provider on the correct procedure for dressing changes or medication management, and the provider is able to and does provide the services, then this is to be documented in the provider's record.

#### **4.4.3.5 Ongoing contact**

The placing LDSS will maintain contact with the adult residing in AFC and the provider as required by Adult Services manual guidance. The placing department maintains responsibility for the provision of direct services, case management, ongoing supervision of the adult, and monitoring of services provided in the AFC home. The adult's case shall remain open as long as services are provided, and the service plan shall be evaluated and updated in accordance with Chapter 3, Adult Services Case Management.

#### **4.4.3.6 AG**

The LDSS where an individual resided prior to entering an institution or AFC is responsible for determining the individual's eligibility for AG and issuing the AG payment.

#### **4.4.4 Medical examination - AFC**

Each adult in an AFC home shall submit a medical statement from a licensed physician or a local health department that contains the following information:

- Date of last physical examination (must have been within 60 days of admission in AFC).
- Diagnoses of significant problems.
- Documentation that the adult is believed to be free from tuberculosis in a communicable form.
- Recommendation for care including medication, diet, and therapy(ies).

#### **4.4.5 Monthly Rate- AFC**

The following services are included in the monthly rate paid to the AFC provider for a publicly funded adult residing in AFC:

#### **4.4.5.1 Room and board**

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

#### **4.4.5.2 Maintenance and care**

- Assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.
- Medication monitoring.
- Provision of generic personal toiletries including soap and toilet paper.
- Assistance with the following: care of personal possessions; care of personal funds if requested by the adult and the home's policy permits it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; and correspondence.
- Securing health care and transportation when needed for medical treatment.
- Providing social and recreational activities as required by provider standards.
- General supervision for safety.

#### **4.4.6 AG - Adult Foster Care**

##### **4.4.6.1 Maximum rate to be paid to AFC providers**

Individuals eligible for an AG payment and approved for AFC shall pay the provider a rate not to exceed the established AG rate. The LDSS shall not use local or local-only payments to reimburse the provider more than the established AG rate.

The AFC home may not request or require the receipt of any money, gift, donation, or other consideration from or on behalf of an adult as a condition of admission or continued stay. AG checks shall be provided directly to the adult or his responsible party who then pays the provider. The AFC home is required to provide each adult residing in the home, a monthly statement or itemized receipt of the adult's expenses not covered by the AG payment. Unless a guardian or conservator has been appointed by the court, the adult is free to manage his or her personal finances.

#### **4.4.6.2 Room, board, supervision, and special services**

An agreement stating the amount to be paid by the adult shall be reduced to writing and fully explained to the adult. The service worker, AFC provider, and the adult residing in AFC shall sign this agreement. A sample [agreement for AFC](#) is available on the VDSS internal website.

Any modifications in the amount to be paid shall be indicated on the signed agreement and initialed and dated by the service worker, the AFC provider, and the adult residing in AFC. Appropriate notification to the eligibility worker shall be made.

The adult shall retain a personal needs allowance for personal use. The amount retained shall not be less than what is allowable under the AG program.

#### **4.4.6.3 Coordinating eligibility for an AG**

For an adult to be eligible for an AG payment in AFC, the following shall occur:

- Both the service worker and the eligibility worker shall determine the adult's eligibility. Whoever has contact with the adult first shall refer the adult to the other.
- The service and financial eligibility determination processes shall occur simultaneously when possible. The service worker shall assess the adult's needs and arrange for the potential placement. The eligibility worker shall determine financial eligibility and shall notify the service worker of the adult's eligibility for AG.
- Upon notification that the adult is eligible for AG, the service worker shall assist with the placement. The service worker shall provide verification to the eligibility worker of the placement. The eligibility worker shall approve the case and determine the amount of the AG payment. The LDSS shall ensure that there is coordination of information between the service worker and the eligibility worker.

#### **4.4.7 Coordination with local Community Services Boards (CSB) – AFC**

LDSS are encouraged to coordinate with CSBs in the provision of AFC to adults with mental illness and/or mental retardation/intellectual disability. Prior to assisting individuals who receive services from the local CSB, the LDSS shall enter into an administrative support agreement with the local CSB concerning AFC. This agreement should specify which agency will be responsible for assessment, monitoring of services, placement, and discharge services provided to an adult with mental illness and/or mental retardation/intellectual disability in the AFC home.

The LDSS is responsible to approve the AFC home and follow the requirements of this chapter when the adult's assessment and residence in AFC is funded by the LDSS.

The LDSS has no responsibility for approving AFC homes when placement and services are provided and funded by the CSB or any other agency.

### **4.5 Assisted Living Facility (ALF) assessment**

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#### **4.5.1 Introduction to ALF assessment**

The following is a brief overview of the assessment process for individuals residing in an ALF. Please refer to the [Assisted Living Facility Assessment Manual](#), which is located on the DSS internal website, for complete information.

For information on assessment of private pay individuals, see the [Assisted Living Facility Private Pay Assessment Manual](#) on the DSS internal website.

#### **4.5.2 Definition of ALFs**

ALFs are licensed by the VDSS Division of Licensing Programs to provide care and maintenance to four or more adults. ALF placement is appropriate when the adult is assessed to need assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), administration of medication, and/or supervision due to behavioral problems, but does not require the level of care provided in a nursing facility.

#### **4.5.3 Persons to be assessed in ALFs**

Individuals applying to reside in or residing in ALFs, regardless of payment status or anticipated length of stay, shall be assessed using the Virginia UAI to determine the individual's need for residential or assisted living. Except in the case of a documented emergency, no one can be admitted to an ALF prior to an assessment.

#### **4.5.4 Assessors for public pay individuals in ALFs**

Employees of the following agencies can conduct ALF assessments:

- LDSS.
- Area agencies on aging.
- Local departments of health.
- Community services boards.
- Centers for independent living.
- State facility staff of the Department of Behavioral Health and Developmental Services (DBHDS). *Note: initial assessments only.*
- Designated staff of the Department of Corrections. *Note: initial assessments only.*
- Entities contracting with DMAS to perform nursing home preadmission screening (NHPAS) or to complete the UAI for a home- and community-based waiver program, including an independent physician contracting with DMAS to complete the UAI for individuals in ALFs, or any hospital that has contracted with DMAS to perform NHPAS. An independent physician is a physician chosen by the individual and who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence.

By statute, the LDSS is the assessor of last resort if there is no other assessor willing or able to perform the assessment or reassessment.

#### **4.5.5 Assessors for private pay individuals in ALFs**

Unless a private pay (i.e., non-AG) individual requests that an assessment be completed by a public assessor, qualified staff of the ALF or an independent private physician may complete the UAI for private pay individuals. Qualified staff of the ALF is an employee with documented training in the completion of the UAI. The administrator or the administrator's designated representative shall approve and sign the completed assessment.

#### **4.5.6 Assessment and determination of services to be provided in ALFs**

The [User's Manual: Virginia Uniform Assessment Instrument](#), available on the DSS internal website, provides thorough instructions regarding completion of the assessment. Information gathered on the UAI will allow the assessor to determine whether the individual meets the level of care criteria for ALF placement. An individual shall meet these criteria to be considered for public-funded ALF placement.

The UAI for ALFs is comprised of a short assessment or a full assessment. The short assessment may be used when the intake information indicates that the adult will need only residential level of care. The short assessment (Part A or pages 1-4) plus an assessment of the individual's medication management ("How do you take your medicine?" question on page 5 of the UAI) and behavior ("Behavior Pattern" section on page 8 of the UAI) is designed to briefly assess the individual's need for services and to determine if a full assessment (Parts A+B or entire UAI) is needed. The [UAI and the short form attachment](#) are available on the DSS internal website. The assessment focuses on the individual's ability to function while documenting functional dependencies and other needs. Emphasis shall be on assessing the total individual to determine activities he or she is able to safely perform in his or her usual environment.

For public pay individuals, the short assessment shall be completed. (Note: DMAS will reimburse the assessor only at the short-form rate if that is all that is needed even if the full assessment is completed.) If, upon completing the short assessment, it is noted that the individual is rated dependent in two or more ADLs or is rated dependent in behavior pattern, then a full assessment is completed. DMAS will monitor assessments to ensure that the appropriate version (i.e., short vs. full) is completed.

#### **4.5.7 When to complete a UAI for individuals residing in an ALF**

- The UAI shall be completed or updated within 90 days prior to the date of admission to the ALF. No one can be admitted to an ALF without having been assessed prior to admission except in the case of a documented emergency admission.
- An assessment using either the short-form or full UAI, as appropriate, shall be completed or updated at least once every 12 months on all individuals residing in an ALF.
- The UAI shall be completed or updated as needed whenever there is a change in the individual's condition that appears to warrant a change in the individual's approved level of care.

#### **4.5.8 Criteria for placement in an ALF**

##### **4.5.8.1 Criteria for residential living**

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

- Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding) (page 4 of UAI).

- Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management) (page 4 of UAI).
- Rated dependent in medication administration (page 5 of UAI).

#### **4.5.8.2 Criteria for assisted living**

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their functional capacity:

- Rated dependent in two or more of seven ADLs (page 4 of UAI).
- Rated dependent in behavior pattern (i.e., abusive, aggressive, or disruptive) (page 8 of UAI).

#### **4.5.8.3 Prohibited conditions**

Assessors shall also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions are present, the assessor shall document that they are present on the UAI and the individual is not eligible for ALF placement. Please refer to the Assisted Living Facilities Assessment Manual for more specific information on prohibited conditions.

State law prohibits admission or retention of individuals in an ALF when they have any of the following conditions or care needs:

- Ventilator dependency.
- Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing and care is provided by a licensed health care professional under a physician's treatment plan.
- Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia.
- Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease.
- Psychotropic medications without appropriate diagnosis and treatment plans.

- Nasogastric tubes.
- Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.
- Individuals presenting an imminent physical threat or danger to self or others.
- Individuals requiring continuous licensed nursing care (seven days a week, 24 hours a day).
- Individuals whose physician certifies that placement is no longer appropriate.
- Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance.
- Individuals whose health care needs cannot be met in the specific assisted living facility as determined by the ALF.

#### **4.5.8.4 Private pay individuals only - exceptions to the above**

At the request of the private pay individual, care for the conditions or care needs specified in the third and seventh bullet above may be provided to an individual in an ALF by a physician licensed in Virginia, a nurse licensed in Virginia under a physician's treatment plan, or by a home care organization licensed in Virginia when the resident's independent physician determines that such care is appropriate for the individual residing in the ALF. **This exception does not apply to individuals receiving AG.**

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

#### **4.5.9 Possible results from an ALF assessment**

- A recommendation for ALF care;
- Referral to a Nursing Facility Preadmission Screening (PAS) Team to determine if the individual is appropriate for Medicaid-funded community-based care or nursing facility care;

- Referrals to other community resources (non-Medicaid-funded) such as home-based care services, health services, adult day care centers, home-delivered meals, etc.; or
- Referral for services not required.

#### 4.5.10 Case typing for ALF assessments

Cases should be opened following all usual adult services assessment and case management procedures. Case typing will depend upon the adult's situation at the time of the initial assessment. For individuals needing ALF services, only the assessment requirements for completing the designated sections of the UAI shall be followed. Once placement has been made and the case management agency has been designated, if applicable, the case may be closed if the placement is outside of the LDSS's jurisdiction. If no other case management agency has been designated, the LDSS making the placement shall notify the LDSS where the placement is made that an individual receiving AG is residing in an ALF in its jurisdiction. The receiving LDSS will open the case with a case type of ALF Reassessment if the annual reassessment is the only case management service needed.

For case management, the case type would normally be AS (Adult Services). However, depending on the intensity of the needed case management services, case type AS – Intensive Services may be appropriate for Medicaid-funded ALF targeted assessment.

Case type APS is used in all cases where an individual residing in an ALF has been a victim of abuse, neglect, or exploitation, or is at risk of abuse, neglect, or exploitation, and all APS procedures found in Chapter 2, Adult Protective Services shall be followed if the individual is receiving protective services. If the adult remains in the LDSS jurisdiction and no other services are being offered to the individual who is receiving AG in the ALF, the worker should change the case type to ALF Reassessment, keep the case open and complete the required annual reassessment one year from the date of the placement assessment.

When an LDSS has been notified that an individual who is receiving AG is residing in an ALF in its jurisdiction and no other services are needed, the receiving department should open the case in case type ALF Reassessment and follow procedures for completing the required annual reassessment. If the individual needs other services, the worker should follow procedures in the [ASAPS-Robo Help](#) to determine the proper case type and to document the need for the required annual reassessment.

## 4.6 Nursing facility preadmission screening

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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 shall be screened to determine their need for the service (§ 32.1-330 of the Code of Virginia). See the [Preadmission Screening Manual](#) on the DMAS website for details on policies and procedures.

### 4.6.1 Community-Based Preadmission Screening (PAS) team

#### 4.6.1.1 Composition of the team

The team shall consist of a physician, a nurse, and a service worker who are employees of either the local department of health or LDSS.

#### 4.6.1.2 Responsibilities and procedures of the team

- The team determines:
  - If the adult meets nursing facility criteria upon completion of the UAI.
  - If the adult has a condition of mental illness, intellectual disability, or a related condition, the team shall determine whether an additional screening for active treatment needs is necessary.
  - If the adult's needs can best be provided in a nursing facility or in the community.
- The service worker and/or the nurse on the team shall collaborate with the adult and the adult's family to identify resources to meet the adult's needs. All community-based services are to be considered.
- The team shall notify the adult by letter of its decision to approve or deny the requested services.

### 4.6.2 LDSS responsibilities

- The LDSS has screening responsibilities for adults who:
  - Are residing in the community and desire a preadmission screening.
  - Move or plan to move into the LDSS' jurisdiction and request services (see the Pre-Admission Screening Manual for the requirements). [Medicaid Manuals](#) are available on the DMAS website.

- Are being paroled or otherwise released from a correctional facility and need a determination of Medicaid eligibility for admission to a nursing facility. LDSS are to accept these Medicaid applications even though the individual may be an inmate in a public institution at the time of application. The purpose of these applications is to determine eligibility for the individual at the time of release from prison. The parole officer will complete the Medicaid application and, if needed, the Medicaid History and Disability Report, and will send the application to the locality of residence prior to the inmate's incarceration. Preadmission screening will be completed by the local department of health or LDSS. Applications are subject to regular processing time frames.
- LDSS do not have nursing facility preadmission screening responsibilities for individuals who are:
  - **In acute-care hospitals.** Adults seeking nursing facility preadmission screening when in an acute-care hospital should be referred to the hospital-based preadmission screening team. For adults being discharged from military or Veterans' Administration hospitals, refer to the Medicaid Nursing Home Preadmission Screening Manual.
  - **Discharged from state mental health/intellectual disability/substance abuse facilities.** Adults seeking nursing facility preadmission screening prior to discharge from a state mental health/mental retardation or substance abuse facility should be referred to DMAS for screening.
  - **Transferred between nursing facilities within the state.** Adults transferred between nursing facilities within the state are not required to be screened by local screening teams. The nursing facility from which the individual is transferring sends a copy of all screening material to the receiving facility; the receiving facility initiates appropriate documentation for admission certification purposes.
  - **Transferred from out-of-state nursing facilities entering in-state nursing facilities.** Direct transfers from an out-of-state nursing facility should be referred to the receiving nursing facility.
  - **Currently receiving Medicaid-funded community-based care waivers.** The local preadmission screening team is not responsible for screenings for individuals who are in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and who are transferring to a nursing facility.

- **Currently receiving nursing facility services and transferred to a Medicaid-funded community-based waiver.** The local preadmission screening team is not responsible to screen individuals who currently are in a nursing facility and are transferring to a Medicaid-funded community-based waiver program.

#### **4.6.3 Procedures for adults residing in the community**

- Adults or their representatives should be referred to the local health department and/or LDSS for screening in the jurisdiction in which the adult is living at the time of application.
- If the adult is not already Medicaid-eligible, the adult should also be referred to the LDSS so that eligibility for Medicaid can be determined. Screening may occur either before or after determination of financial eligibility for Medicaid. DMAS will reimburse for screenings of individuals who are currently financially Medicaid-eligible or are expected to be financially eligible within 180 days of receipt of nursing facility care.
- Decisions of the screening committees may be appealed. If an individual wishes to appeal, he or she must submit a written request within 30 days of the PAS team's action. The request must be sent to the Client Appeals Unit, Virginia Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

### **4.7 The Department of Behavioral Health and Developmental Services (DBHDS) and Community Services Boards (CSB)**

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#### **4.7.1 Case management**

The local community services board (CSB) shall be contacted for information regarding the availability of case management services in the locality that it serves. CSB case management services include assessing the need for services, planning for service delivery, linking the adult to the needed services, and monitoring the provision of services to the individual. The LDSS may participate in the case management process.

#### **4.7.2 Case review by a prescription team**

The local CSB should be contacted for information regarding the specific activities and services of the local CSB prescription team.

The LDSS is identified in the Code of Virginia as a member of the prescription team established by the CSB. The team, under the direction of the CSB, shall be responsible for integrating the community services necessary to accomplish effective

prescreening and pre-discharge planning for adults referred to the CSB (§§ [37.2-505](#) and [37.2-837](#) of the Code of Virginia).

#### **4.7.3 Admission to a state facility operated by DBHDS**

The LDSS shall refer adults to the local CSB for preadmission screening for admission into state psychiatric and intellectual disability facilities. When admission to a state facility operated by DBHDS is being sought, the LDSS may be requested to assist in preparing portions of the comprehensive evaluation.

#### **4.7.4 Convalescent leave and discharge planning**

When an adult returns to the community from a DBHDS facility, an LDSS may be requested to participate in the facility's pre-discharge planning process (§§ [37.2-505](#) and [37.2-837](#) of the Code of Virginia). Adults released on convalescent status or expected to be discharged from DBHDS facilities who will be in need of social services are the responsibility of the LDSS of:

- First, the county or city where the adult was residing at the time of admission; or
- Second, the locality where the adult has chosen to reside, if the locality where the adult previously resided has not maintained service responsibility for the case; or
- Third, in the absence of such a place, the jurisdiction of the institution from which the adult is being released.

### **4.8 Long-term care coordinating committees**

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The Code of Virginia requires the establishment of a local long-term care coordinating committee in each city or county or combination thereof. The LDSS is a member of the committee. The purpose of the committee is to guide the coordination and administration of public long-term care services in the locality.

The governing body of each county or city, or combination thereof, shall designate a lead agency and member agencies to accomplish the coordination of local long-term care services. The agencies shall establish a long-term care coordinating committee composed of, but not limited to, representatives of each agency. The membership of the coordinating committee shall be comprised of, but not limited to, representatives of the local department of public health, the LDSS, the community services board or community mental health clinic, the area agency on aging, and the local NHPAS team. A plan shall be implemented that ensures the cost-effective utilization of all funds available for long-term care services in the locality. Localities are encouraged to provide services within each category of service in the continuum and to allow one person or

agency to deliver multiple services, when possible (§§ [63.2-1602](#) and [2.2-708](#) of the Code of Virginia).

## 4.9 Appendix A: Forms

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The following forms may be used during the provision of Adult Services. Unless otherwise indicated, these forms are located on the [Adult Services forms page](#) of the DSS internal website.

### **Adult Foster Care Agreement**

This form is used as an agreement among the individual receiving foster care services, the LDSS and the foster care provider.

### **Adult Foster Care Interagency Agreement**

This form is used when an LDSS is placing an adult in an AFC home in a neighboring jurisdiction.

### **Short Form Attachment**

This form is used when it is determined that an individual will only need residential level of care in an ALF setting. The attachment is used in conjunction with pages 1-4 of the UAI.

### **Uniform Assessment Instrument (UAI)**

This form is used to assess an individual's need for services including assisted living, home-based services, and Medicaid funded services.