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SECTION 1

INTRODUCTION

1.1 Introduction

Adult Family Care Homes are placement settings for adults that provide support, protection and security in a family setting. This may be an appropriate option for individuals who are no longer able to safely remain in their own homes due to physical, cognitive, and/or emotional deficits. Although an individual may be experiencing deficits in one or more of these domains, the deficits are not significant enough to warrant the level of care provided in an assisted living facility or nursing home. The Adult Family Care provider must be certified by the Department of Health and Human Resources, Bureau for Children and Families. Once certified, the provider may provide care for up to three (3) adults. The provider receives payment for the care provided. This payment may come from the client placed in the home, the Department, or a combination of these two (2) sources. Even though the potential provider has adequate bedroom space for up to three (3) individuals, the final decision as to the number of clients the provider can be certified to keep rests with the homefinder and their supervisor.

1.2 Definitions

Abuse: Infliction of or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or resident of a nursing home or other residential facility (As defined by [WV Code §9-6-1](#) and a similar definition is contained in [§61-2-29](#) that addresses penalties for abuse or neglect of incapacitated adult or elder person).

Adult Emergency Shelter Care Home: A home that is available on a short-term, emergency basis for residential care type clients for whom no other appropriate alternatives currently exist, agreeing to accept placement on a twenty-four (24) hour basis.

Adult Emergency Shelter Care Provider: An individual or family unit that has been certified by the Department of Health and Human Resources to provide support, supervision and assistance to adults placed in their home at any time on short notice.

Adult Family Care Home: A placement setting within a family unit that provides support, protection and security for up to three (3) individuals over the age of eighteen (18).

Adult Family Care Provider: An individual or family unit that has been certified by the Department of Health and Human Resources to provide support, supervision and assistance to adults placed in their home for which they receive payment.

Assisted Living Facility: Any living facility, residence or place of accommodation available for four (4) or more residents, which is advertised, offered, maintained or operated by the ownership or management, for the express or implied purpose of having personal assistance or supervision, or both, provided to any residents therein who are dependent upon the services of others by reason of physical or mental impairment and who may also require nursing care at a level that is not greater than limited and intermittent nursing care.

Note: Previously defined Personal Care Homes and Residential Board and Care Homes are now defined in WV Code and Policy as Assisted Living Facilities.

Cognitive Deficit: Impairment of an individual's thought processes.

EFT (Electronic Funds Transfer): An electronic transfer of provider payment, commonly known as Direct Deposit, into the provider's designated bank account.

Emancipated Minor: A child over the age of sixteen (16) who has been emancipated by 1) order of the court based on a determination that the child can provide for his/her physical well-being and has the ability to make decisions for him/herself or 2) marriage of the child. An emancipated minor has all the privileges, rights and duties of an adult including the right to contract. (Refer to WV State Code [§49-7-27](#)).

Emergency or Emergency Situation: A situation or set of circumstances which present a substantial and immediate risk of death or serious injury to an incapacitated adult.

FACTS: Acronym for the Family and Children's Tracking System and is the automated client information system used by the West Virginia Department of Health and Human Resources, Bureau for Children and Families.

FACTS PLUS: The Family and Children's Tracking System Provider Look-Up and Update System which allows registered providers to view details of their payments and individuals served on a secured site. Information is available twenty-four (24) hours a day.

Incapacitated Adult: Any person, by means of physical, mental or other infirmity is unable to physically carry on the daily activities of life necessary to sustaining life and reasonable health. (**NOTE::** Incompetence of an adult is determined by a legal proceeding and is not the same as a determination of incapacity. Similar definition "incapacitated adult" is contained in WV State Code §61-2-29, abuse or neglect of incapacitated adult or elder person regarding criminal penalties).

Legal Representative: A person lawfully invested with the power and charged with the duty of taking care of another person or with managing the property and rights of another person, including, but not limited to, a guardian, conservator, medical power of attorney, trustee, or other duly appointed person.

Neglect: Means A) The unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult; or B) the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or facility resident. (Similar definition is contained in §61-2-29 abuse or neglect of incapacitated adult or elder person regarding criminal penalties).

Physical Deficit: Impairment of an individual's physical abilities.

SECTION 2

INTAKE

2.1 Eligibility Criteria

In order for an applicant to be approved as an Adult Family Care Provider they must meet all following criteria:

- a) Be age twenty-one (21) years of age or older;
- b) Submit a completed application packet;
- c) Meet all applicable standards for this type of setting; and,
- d) Be a US citizen and WV Resident.

2.2 Recruitment of Adult Family Care Providers

With the ever increasing need for supportive living placement options for vulnerable adults, it is important that the Department continue with recruitment efforts to locate new Adult Family Care Homes. This is one of the primary responsibilities of the Adult Family Care homefinder. Generally, when the regional homefinder receives an inquiry from someone in the community who is interested in becoming an Adult Family Care provider, the Adult Family Care homefinder will give/send the prospective provider an application packet which is to be completed and returned within thirty (30) days.

When additional Adult Family Care Homes are needed, the following steps are to be taken to develop a successful recruitment campaign.

- a) Identify number and type of homes needed;
- b) Plan/develop information to be disseminated within the community to create an interest in the program; and,
- c) Implement recruitment campaign.

There is a great variation from one community to the next; therefore, these unique characteristics must be considered when developing a recruitment campaign. Some basic principles which apply generally have been identified and may be helpful in developing local programs. Individuals within the community must be made aware of the Adult Family Care Program and encouraged to seek more information. A variety of methods may be applied. The following are suggested approaches that have proven to be effective.

Note: In any recruitment initiative, staff must follow the local protocol for this activity and must coordinate efforts with the Department's Office of Communications. All written material (brochures, news releases, posters, etc.) must be approved by this office in advance.

2.2.1 Newspaper Articles

a) Classified Advertising

This approach has not been commonly used because: (1) it tends to emphasize the potential for financial gain and (2) there is generally a cost associated with this option. This option may be useful in those areas where other forms of newspaper publicity have been exhausted. An example of an ad would be: "Are you looking for a new meaning and purpose for your life? Why not open your home to a person who is looking for the care and support of a family? Call the local Department of Health and Human Resources and ask about Adult Family Care Home Opportunities."

b) News Release

This type of article simply announces the existence of a program and tells a little about it, including pertinent information such as the program name, the name of the agency, the name and phone number of contact person, etc. Also included in this advertisement would be news coverage of presentations to community groups and agencies.

c) Regular Columns

Many newspapers have regular columns on subjects of interest. The columnist usually becomes well-known and develops a following of readers. If the interest of a well-known columnist can be stimulated, he/she can be of tremendous help in developing community interest, as his/her approach to the subject will add the human interest touch which is usually lacking in a regular news article. Personal endorsement of the Adult Family Care Home program by the columnist/newspaper will often cause the regular readers to consider it more seriously than they might otherwise.

d) Letters to the Editor

Letters written by local supporters of the program for publication on the editorial page of a local newspaper can be effective. This approach is most effective if it is written by a person who is well known in the community, but not associated with the Department. A local physician, attorney, politician or judge who has an interest in the program would be excellent. The AFC homefinder, or homefinding supervisor, responsible for recruitment may have to seek out and educate these individuals about the program. Often they will agree to have an agency representative draft the letter for their signature.

e) Feature Article

This is by far the most effective form of newspaper publicity, but it is also the most difficult to obtain. These articles often appear in "Sunday

Supplement" or family sections of the newspapers and almost always include human interest items and pictures. They go into a considerable amount of detail and local Adult Service staff which are fortunate enough to be given this type of publicity must co-ordinate efforts with Department's Office of Communication. This type of article is most effective in locations where some active Adult Family Care Homes are already in operation. Written permission must be obtained in advance and a copy of this filed in the appropriate client and/or provider record. A copy of the authorization must be filed in the client/provider record, as applicable, and the location of the authorization is to be noted in Document Tracking in FACTS.

2.2.2 Radio

Radio exposure can be a useful tool for getting the Adult Family Care story to the community.

a) Spot Announcement

This approach probably reaches the greatest number of people, but often does not stimulate as much interest as is needed. It involves preparing a 30 - second spot announcement designed to encourage listeners to call for additional information. Radio stations will usually donate time several times a day for several days, as well as help with wording the announcement, if requested. The tape can be cut by an agency representative, but usually a professional announcer will be available for this, if needed.

b) Interview or Discussion Program

Most radio stations have time periods set aside during which they interview individuals concerning items of local interest. An agency representative or even a client and or provider in the Adult Family Care Home Program may be interviewed with questions designed to cover important points. A panel discussion is another possibility, using a group of sponsors or community leaders and professionals. The possibilities are endless, but the radio station will not approach the agency. The local agency representatives must contact the station manager.

2.2.3 Television

Television time is often difficult to obtain, but Federal regulations require stations to give some time for community service announcements. Since this time is usually already allocated to particular organizations, it is sometimes easier to enlist the cooperation of the organizations and use the television spots allocated to them. These spots are usually equivalent in content to radio spots, but a poster of some kind will be needed to display on the screen during the announcement.

Many local television stations have daytime interview programs similar to

those on radio. The educational television stations are particularly good for this type of presentation. Local television stations are sometimes willing to put together a special, filmed program on subjects of general interest. Spot announcements on cable TV may be another option.

2.2.4 Church Groups

Religious organizations of all denominations provide an excellent pool of prospective Adult Family Care Homes. Exploration of this area is to begin by interviewing local religious officials to inform them of the program and enlist their help in finding ways to present it to the members of their churches. In some churches, the minister may be willing to discuss the program from the pulpit or he can usually recommend specific groups within the church organization who might be interested in knowing more about the program.

2.2.5 Civic Groups

There are local organizations around the State that are frequently looking for luncheon speakers and community service projects. The various women's clubs, garden clubs and service organizations (i.e. Ministerial Association, Community Round Table, Civitan, Lions' Club, Moose Lodge, Eagles and etc.) are an excellent place to start. Some of these have newsletters and most will welcome agency representatives as luncheon or dinner speakers.

2.2.6 Existing Adult Family Care Homes

Many times the Adult Family Care Home Program will recruit for itself once a number of good homes have been established and placements made. Providers are considered one of the best sources for new Adult Family Care Homes. This resource is an important one to cultivate when working with providers from day to day.

2.2.7 Adult Family Care Promotional Material

Promotional materials must be available in every DHHR county office. It is not intended to tell the whole story, but it can stimulate interest if properly used. Any location where people gather can be considered for distribution of promotional material. Many ministers will allow them to be placed in church lobbies. Local social service agencies and associations may also display this material, such as the local Behavioral Health Center, Home Health Agencies, Social Security, physicians, dentists, etc. A little imagination may produce any number of possibilities.

Workers may contact the Bureau for Children and Families if additional assistance is needed in recruitment. Publicity is an ongoing process and is to be continued even though the program may be well established in a county.

Note: It is recommended that an evaluation of the campaign be completed to look at things such as: 1) overall effectiveness 2) most effective strategies 3) least effective strategies, etc.

2.3 Application Process

When an inquiry is received from a person expressing interest in becoming an Adult Family Care provider, information about the Adult Family Care Program, along with an application packet, shall be provided. All inquiries are to be documented in FACTS as a Request to Provide Intake. The completed application packet must be returned within thirty (30) days or the intake is to be closed. The application packet includes:

- a) Application;
- b) Physician's Letter (applicant);
- c) Personal Reference Letters (two);
- d) Credit Reference Letter (one);
- e) Fire Safety Checklist;
- f) Provider Tax Information Reporting Form (W - 9); and,
- g) Application for EFT and FACTS PLUS.

Note: In addition to being available in the Reports section of this policy, the AFC application packet is available through the internet at the DHHR Bureau for Children and Families web site. Forms may be downloaded, completed, and submitted directly to the local DHHR office. When an application is received this way, it must be entered into FACTS as a Request to Provide Intake upon receipt and the thirty (30) days for completion of the application packet begins on the date received.

Upon receipt of the application by the Regional Homefinder, a home study is to be initiated and completed within ninety (90) days. The study is very extensive and will involve the following at a minimum:

- a) Site visits;
- b) Interviews;
- c) Review of supporting documentation (physician's letter, reference letters, fire safety checklist, etc.);
- d) Completion of required background checks for all household members over the age of eighteen (18), (Nurse Aid Abuse Registry, substantiated CPS/APS, State Police Sexual Abuse Registry, and local court system); and,

- e) CIB (Crime Information Bureau) and NCIC (National Crime Information Center) check.

SECTION 3

ASSESSMENT

3.1 Introduction

Upon receipt of the completed application packet the homefinder is to begin the assessment process. The assessment is the process the homefinder goes through to determine if the provider and the provider's home meet all required criteria. A thorough evaluation of the home and family must be completed within ninety (90) days of receipt of the application. Only in very extenuating circumstances will requests be considered for extensions granted beyond the original ninety (90) days in which the home study was to have been completed. The regional homefinding supervisor may grant an extension of an additional thirty (30) days. An extension must only be considered if the applicant has demonstrated active progress toward meeting the application requirements. Some examples of situations where it may be appropriate to request an extension are as follows:

- a) The CIB has been requested, but the results have not been received;
- b) Due to circumstances beyond their control, the applicant could not schedule the required medical exam within the time frame; and,
- c) A minor emergency home repair cannot be completed within the ninety (90) days.

Receipt of required documentation is to be recorded in FACTS. This will include, but is not limited to, documents provided to the applicant, including the application form, physician's letter, reference letters, etc. The assessment process must include: interviews of household members, record check, reference check, CIB, evaluation of the home, etc. The assessment process must be completed before the home can be approved. In addition, required pre-service training must be completed before any placements may be made in the home.

All contacts with the provider must be documented in FACTS as soon as possible after the contact is made. Documentation is to be pertinent and relevant to activities necessary to complete the application/assessment process.

3.2 Initial Interview

Upon receipt of the completed application, the homefinder will arrange an appointment to meet with the applicant. This initial interview is to be conducted in the applicant's home with only the applicant, the applicant's spouse and the homefinder present. This interview shall involve an intense discussion of all of the items contained in the outline for the AFC Home Study Summary and the standards for Adult Family Care Homes as outlined in this policy. The homefinder

must make a thorough inspection of the home and its" grounds during this visit. This inspection shall include, but not be limited to, all areas that are required for completion of the Annual Fire and Safety Review and all required physical standards for Adult Family Care Homes. It is the homefinder's responsibility to bring to the applicant's attention, at this time, the obligations which he/she will be assuming in caring for adults who require care, supervision and/or protection. The homefinder must also explain to the applicant the agency's standards and requirements for all Adult Family Care Homes in regard to the care of clients placed in their home. The homefinder must inform the potential provider about what he/she can expect from the agency. The homefinder must explain the agency's responsibilities with regard to the client and the provider. Because of the amount of information to be covered, it may be necessary to complete the interview in more than one (1) visit.

3.3 Interviews with Individual Family Members

Upon completion of the initial interview with the applicant and inspection of the physical facilities of the home, the homefinder will make arrangements to interview all other household members individually. Because Adult Family Care involves all household members and not just one member of the household, it is essential that the homefinder evaluate each individual member. A thorough description of each member is to be documented in the Adult Family Care Home Study Summary focusing on appearance, interests, attitudes, occupation, temperament, physical/mental health and the relationship with other household members and attitudes about the family caring for Adult Family Care clients.

If, on the Application to Provide Adult Family Care, it is indicated that "someone in the immediate family has ever been arrested for or ever been involved in any criminal activities", this must be explored thoroughly when interviewing this particular household member. This exploration must include determining:

- a) What the person was arrested for;
- b) What criminal activities he/she was involved in; and,
- c) The reason(s) for this person's action(s).

If the behavior was violent in nature, constituting harm to another person, the homefinder will give careful consideration as to whether the behavior is likely to occur again. If a strong possibility of reoccurrence exists, the application to become an Adult Family Care provider must be denied and written notification of the denial sent.

3.4 Record Check

The homefinder must complete a record check in FACTS and any existing paper files to insure that there is no prior CPS or APS involvement. The record check must be completed for every adult household member excluding DHHR clients. If any of the adult household members, who are or would be responsible for

providing care, had prior employment in a nursing facility, the homefinder must also check the Nurse Aide Abuse Registry by contacting or checking the OHFLAC website at www.wvdhhr.org/ohflac/. If the applicant, or any adult household member who is going to be providing care, is listed on the Nurse Aide Abuse Registry, the applicant shall not be approved to provide Adult Family Care services. If a record check reveals a history of substantiated APS or CPS, the application may not be approved, unless a policy exception is granted. Any exception must first be recommended by the AFC homefinder and then approved by the homefinding supervisor. Upon approval by the homefinding supervisor, the waiver request is to be forwarded to the appropriate person for final approval/denial. Exceptions to the above policy may be considered based on the following criteria:

- a) The specifics of the APS/CPS case, including the relationship of the allegations to the individual's ability to provide services to adults;
- b) The number of allegations which were substantiated against the individual, including an exploration of repetitive occurrences that may indicate a pattern of abuse and neglect;
- c) Circumstances surrounding the allegations, (i.e., age of the individual, family circumstances or financial problems, etc.); and,
- d) Evidence that would indicate whether, or not, the individual is currently able to provide care to aged and incapacitated adults.

3.5 Criminal Identification Bureau Check (CIB)

A Criminal Identification Bureau (CIB) check shall be completed on all adult members of the household and all individuals who provide direct care to adult clients for two (2) or more hours per week. Included are: care givers, adult household members, and private pay clients placed in the home prior to receipt of the request to become an AFC provider, regular volunteers, substitutes, respite providers, and transportation providers. A records check is not required for transportation providers who are relatives of the client. Providers are required to notify the agency within twenty-four (24) hours when the household composition changes, (i.e., new adult household members added, excluding clients, or when any household member has been charged and/or convicted of a criminal offense). The CIB check shall be submitted on all new adult household members within five (5) working days of notification by the provider. A statement of criminal record and subsequent CIB and NCIC checks must be completed in accordance with the time frames outlined in the current CIB policy. (See Criminal History Background Check, Chapter 18).

CIB and NCIC checks must be made on new applicants prior to final approval of the home. When a CIB and NCIC report reveals convictions for any adult household member, the following apply:

- a) The applicant/household member or anyone that provides any type of service to AFC clients, shall not be approved, employed, or utilized nor considered for a waiver, if ever convicted of murder/homicide, felonious physical assault or felonious battery;
- b) Child/adult abuse or neglect, crimes which involved the exploitation of a child or an incapacitated adult, domestic battery or domestic assault, felony arson, felony or misdemeanor crime or incapacitated adult which causes harm, felony drug related offenses within the last ten (10) years, felony DUI within the last ten (10) years, hate crimes, neglect or abuse by a caregiver, pornography crimes involving children or incapacitated adults, including but not limited to, the use of minors in filming sexually explicit conduct or sending distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian, or custodian, depicting a child engaged in sexually explicit conduct, purchase or sale of a child, abduction; kidnapping; sexual offenses, including, but not limited to incest, sexual abuse or indecent exposure;
- c) The applicant/household member or anyone that provides any type of service to AFC clients, shall not be approved, employed or utilized nor considered for a waiver if they are on parole or probation for a felony conviction;
- d) Any applicant/household member or anyone that provides any type of service to AFC clients, shall not be approved, employed or utilized if convicted of a felony not listed above, unless a waiver is requested and approved;
- e) Any applicant/household member or anyone that provides any type of service to AFC clients, with two (2) or more misdemeanors shall not be approved, employed or utilized unless a waiver is granted; and/or,
- f) An applicant/household member or anyone that provides any type of service to AFC clients, shall not be approved, employed nor utilized if he/she fails to report convictions to the Department or agency, unless a waiver is requested and approved.

Waivers to the above policy may be considered based on the factors listed below. Any waiver must first be approved by the local Waiver Committee prior to being submitted to the appropriate person for final approval/denial.

- a) There is satisfactory evidence that the individual has been successfully rehabilitated;
- b) The length of time since the last conviction;
- c) The type of crime(s) for which the individual was convicted, would not impair their ability to provide services to adults (i.e., shoplifting, disorderly conduct, etc.);

- d) The number of crimes for which the individual was convicted, including an exploration of repetitive offenses that may indicate a pattern of criminal activity; and,
- e) The circumstances surrounding the commission of the crime, such as the age of victim; physical, financial or other losses by victim; age of the individual when crime(s) were committed; family or financial problems of the individual when crimes were committed.

3.6 References

Reference letters are to be sent to the Adult Family Care homefinder from the reference source in the Adult Family Care Provider Application Packet. The applicant is responsible for requesting that all reference letters be completed and are sent to the appropriate parties for that purpose. Three (3) references are required:

- a) Two (2) personal references must be completed, one of which must be completed by a person unrelated to the applicant;
- b) One (1) credit reference, to be completed by a current utility provider or bank/lending institution.
- c) The homefinder must conduct a face to face interview with at least one (1) of the personal references.

Section I of the outline for the Summary Recording of the Home Evaluation describes the information required concerning references. Documentation and summarization of all reference contacts must be made within the Summary Recording in Section I. All references received in written form shall be attached to the completed Adult Family Care Home Study Summary and shall be filed in the provider's record and documented in FACTS.

Note: If the homefinder feels the need for additional references to determine if an applicant qualifies to be an Adult Family Care provider, it is permissible for the homefinder to request additional references. It is not permissible to ask for additional references to replace references that may have given **negative feedback**. The only time that the additional references may replace one of the original references is when the original references refuse to respond.

3.7 Group Interview

A group interview is required as the final step in the home study process. All members of the applicant's household must be present for this final interview. This session will provide the homefinder with the opportunity to observe interactions between family members and to discuss questions, problems, and/or assurances that the homefinder has in relation to approval of the home. Improvement and/or changes in the home that are required to bring the home into compliance with agency standards will also be discussed at this time.

3.8 Required Medical Statements

3.8.1 Designated Provider

The family member who will be known as the Adult Family Care provider must obtain, from a physician, a statement that he/she is physically and mentally able to care for incapacitated adults and is free of communicable diseases to the best of the physician's knowledge. The medical statement must be received and reviewed by the homefinder before the final approval can be given for their home to begin operating. The statement must not be dated later than ninety (90) days from the date of the application. The cost of the initial medical statement is at the provider's expense.

3.8.2 Other Household Members

If the homefinder believes it is likely that the home and all household members will meet agency standards and that approval of this home is likely, the homefinder must request a medical statement for all household members. Medical statements for household members eighteen (18) years and older must include a statement that they are physically and mentally able to care for incapacitated adults if they are to provide any direct care to clients. These statements shall be prepared by a practicing physician who knows the family member and can state that they are free from communicable diseases to the best of the physician's knowledge. The statement must be dated not more than ninety days (90) prior to the application date.

Note: If a household member has ever been committed to a mental institution or been treated for severe mental or emotional disturbances, the homefinder must obtain information to determine the nature of that illness and a statement from an attending physician and/or other involved behavioral health professionals documenting that person's current status. The homefinder must consider all characteristics of each household member in determining the family's ability to care for vulnerable adults in their home.

3.9 Adult Family Care Home Study Summary

The results of the homefinder's evaluation of an applicant, his/her home and all household members must be documented on the "AFC Home Study Summary" which is available as a DDE in the reports section of FACTS. At a minimum the homefinder must document findings/information as outlined in the following sections. The completed Summary must be filed, the date of completion entered in FACTS, and the location of the completed form noted in Document Tracking. The completed document must be saved to the file cabinet in the provider's record in FACTS.

3.9.1 Identifying Information

- a) Name of potential applicant

- b) Physical Address
- c) Mailing Address
- d) Phone Number
- e) Other

3.9.2 Neighborhood

- a) Describe the general location
- b) Specify whether the area is rural/urban
- c) Specify if in a congested city area
- d) Is the location in a business, factory or residential section?
- e) Evidence of pollution
- f) Evidence of crime in this community
- g) Other

3.9.3 Accessibility

- a) Is the home located where it is accessible to necessary resources (i.e. recreational facilities, stores, the local Department of Health and Human Resources, the local mental health center, physician and pharmacy)?
- b) By what means are these facilities accessible (car, bus, walking, etc.)?
- c) Describe the community's strengths and limitations
- d) Other

3.9.4 Physical Structure

- a) Exterior
 - 1) Describe the house and all other buildings associated with it.
 - 2) Do premises appear to be well-cared for?
 - 3) Are there areas or objects that could be dangerous to persons who are mentally or physically incapacitated?
 - 4) Is there yard space for recreation?
 - 5) Are outside stairways adapted for use by handicapped individuals?
 - 6) Are there animals in the home and/or on the grounds and, if so, do they appear to be healthy and friendly? Are all vaccinations current and documented? If the homefinder is uncertain of the vaccination schedule for the particular type of animal/pet the provider owns, contact with a veterinarian is necessary to determine compliance by
 - 7) schedule for the particular type of animal/pet the provider owns, contact with a veterinarian is necessary to determine compliance by

the provider

- 8) Other
- b) Interior
 - 1) Number of rooms, number of bedrooms and their location
 - 2) Number of bathrooms
 - 3) Adequate furnishings in all rooms.
 - 4) Is there running water in bathrooms and kitchen?
 - 5) Is there an approved water source?
 - 6) Are wastes disposed of in a sanitary manner?
 - 7) Is there clutter in hallways and rooms?
 - 8) Are rooms and passageways free from obstructions?
 - 9) Describe the general upkeep of the house
 - 10) Is there adequate storage space for client's personal items in bathrooms and bedrooms?
 - 11) Are clients' beds firm, clean, and adequately supplied?
- c) Give clear description of room or rooms to be used for the Adult Family Care client:
 - 1) Is lighting adequate for reading, handiwork, and other activities?
 - 2) Does the home have a basement? If so, what is it used for?
 - 3) Does this home meet all fire safety and sanitary standards as determined on the Adult Family Care Fire and Safety Report and the Annual Sanitary Inspection of Adult Family Care Home? (These forms are available as DDE's in the Reports section of FACTS.)
 - 4) Other

3.9.5 Arrangements for Adult Family Care Clients

a) Recreational and Educational Outlets

What activities will clients encouraged to engage in? (Household chores, family vacations, reading, playing games, hobbies, and social activities in the community, etc.).

b) Areas Accessible to Clients

What rooms in the house will the clients be allowed in? What rooms, if any, will be off limits and why?

c) Furnishings in Client's Rooms

Describe furnishings provided. Are they comfortable, usable, clean, adequate and attractive? If no, describe what changes are needed. Is client permitted to bring personal furnishings?

d) Client's Place in the Family Structure

Will client be considered a part of the family? Describe.

e) Type of Client Preferred by Family

Does any family member have certain qualities he/she cannot tolerate? Describe. Does the family understand that most clients placed have mental and/or physical limitations and usually require medication and sometimes treatment?

f) Care and Welfare of Clients

Does it appear that the home will be able to meet all care and welfare, social and nutritional standards as outlined in this policy? If no, explain.

3.9.6 Finances and Resources of the Provider

a) Income

Indicate amount and source(s) of income within the household. Also give occupation/employment history.

b) Property

Is the home rented, owned or mortgaged? If rented, has/can applicant obtain written authorization from the landlord that it is acceptable for them to operate an Adult Family Care Home on the premises? If the landlord will not approve rental property for use as an Adult Family Care Home and provide a written statement to the effect, the home cannot be approved.

c) Insurance

General statement regarding medical insurance carried on each member of the household and real estate insurance (homeowner or rental).

d) Transportation

What is the provider's means of transportation? Is this transportation dependable? Is this transportation available at all times? If no, explain.

e) Other Resources

Other Resources that are Pertinent to the Family (i.e., livestock, farm products, board paid by members of the household).

f) Financial Security

Does the family appear to be secure financially? Will there be other income in the home besides that paid for the care of the Adult Family Care clients? Will this income cover all of the expenses (utility bills, rent, groceries, etc.) that the family itself incurs each month? If no, explain. If the household does not have

sufficient income to meet the household expenses, the application as an Adult Family Care provider must be denied. The Adult Family Care or private pay client's income must not be used in determining if the household has sufficient income to pay household expenses.

3.9.7 The Applicant's Family

a) Household Members

Describe each household member thoroughly. Include name, age, appearance, interests and attitudes, achievements in employment, education/training and community and social activities. Is there any evidence of unfounded prejudices, over sensitiveness, irritability, explosiveness, peculiarities or unusual activities? Describe this member's medical history including illnesses, operations, history of communicable disease, mental illnesses, alcoholism/substance abuse, etc.

b) Family Relationships

Describe early life experiences of the family and its members that shed light on how they function. Is the relationship between family/household members a good one? If married or residing as a couple, does each partner appear to be happy and satisfied with the other partner? Has either one been married previously? If so, are there stepchildren from these marriages? Does the couple have a good relationship with their children and other relatives? If there are conflicts, what are the reasons for them? Are there any agency records (provider or client) that give us information about this family?

c) Family Attitudes

How do the household members of this family feel about having Adult Family Care clients in their home to live on a full time basis? How do relatives of the family who do not live with them feel about this?

d) Relationship of Provider to Client

Is this home being evaluated for the provider to care for a relative? Does the situation meet the criteria for a provider to care for a relative according to policy?

e) Health Standards

Are the applicant and all family members free from communicable diseases? Is the applicant physically and mentally able to care for an adult(s) placed in their home? Will all household members be conducive to the health and welfare of clients placed there? Does any household member have a debilitating disease or illness? Do all household members receive adequate medical care?

3.9.8 Reasons for Wishing to be an Adult Family Care Provider

Relate reasons for becoming a provider as expressed by the applicant and the homefinder's impression.

3.9.9 Ability to Care for Incapacitated Adults

- a) Have the potential providers anticipated how an adult may react when he/she is brought to a new home and meeting new people? Explain.
- b) What are their ideas and practices in relation to sex education, physical care, responsibilities for a resident, recreation and socialization? Explain.
- c) Do they recognize the problems and disappointments involved with caring for incapacitated adults as well as the satisfactions? Explain.
- d) How do they accept the possibility of disturbances and difficulties in their home? Are there members of the home who already create disturbances and difficulties? If yes, explain.
- e) How will the provider encourage the client's cooperation for health and safety sake, as well as contributing to a normal household atmosphere? Will they encourage the client to become as independent as possible? Explain.
- f) What constitutes a problem to this family? If such would arise, how would the family deal with and bring it to a satisfactory conclusion? Explain.
- g) Will the family assume responsibility for maintaining adequate clothing (mending, laundry, ironing, purchasing, etc.) for the client, providing transportation for medical care, providing care during temporary illnesses and providing supervision at all times, if necessary? Describe.
- h) How will the client be introduced in the community? Does the provider feel that his/her neighbors will have any strong objections to an incapacitated adult being close by? Describe.
- i) Will the provider be able to recognize and handle emergencies?

3.9.10 Results of CIB

Summarize the results of the CIB check for each household member. If a waiver is being requested, justification for the waiver is to be documented. (See the CIB Manual Chapter 18).

3.9.11 References

Summarize details of all references received and the required face to face contacts with at least one (1) personal reference.

3.9.12 Evaluation of Home and Recommendations

- a) Specify the strengths and weaknesses the family exhibits. Do the

strengths greatly outweigh the weaknesses?

- b) Are there certain types of adults the homefinder feels this family could handle better than others? Explain.
- c) Are there certain types of adults that could definitely not be placed in this home? Explain.
- d) Are there racial or nationality factors that need to be taken into consideration? Explain.
- e) Does this home meet all standards for Adult Family Care Homes? If not, what are the deficiencies and their effect on the homes' approval?
- f) If the home is being recommended for approval, how many adults will the provider be able to adequately care for?

3.10 Approval Process for Adult Family Care Provider

Approval of a home to provide Adult Family Care is based upon the evaluation of the home by the homefinder and the review by the homefinding supervisor of the Adult Family Care Home Study Summary recording as well as a determination as to whether all standards for an Adult Family Care Home have been met. No standards for Adult Family Care may be waived by the homefinding staff. If the provider requests a waiver, a recommendation for a waiver must be submitted to the appropriate person per regional protocol for approval/denial.

3.11 Written Notification of Decision on Application

- a) Written notification of the decision on an application must be prepared by the homefinder and sent to the applicant within five (5) working days from the date of the decision.
- b) If the application is denied, the homefinder must send the Negative Action Letter within five (5) working days advising the applicant of the denial, stating the reason(s) for the denial. The Notification of Application for Social Services is available as a DDE and may be accessed through the Reports area of FACTS. This negative action letter is a two (2) part letter and serves as written notification of the grievance procedure which is available to the applicant and is to be added to the file cabinet and Document Tracking by using the "Save to FACTS" functionality. This functionality may be found in Microsoft Word under the "Add – Ins" menu and then selecting "Save to FACTS"; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and save a copy of the letter into the Investigation filing cabinet by using the import functionality. It also is to be added to

the file cabinet for the provider record in FACTS. (See [Common Chapters Manual](#) for detailed information about the grievance procedure).

- c) If the application is approved, the Adult Family Care Approval Letter and Certificate of Approval must be sent to the applicant. These documents are available as DDE's and may be accessed through the Reports area of FACTS.

Copies of any approval or denial letters and Certificate of Approval sent to an AFC Home applicant must be filed in the file cabinet in FACTS and entered in Document Tracking.

3.12 Procedures Once the Home is Approved

When the homefinder has received all of the required forms, completed all steps required in the home study process, and has approved the home to provide Adult Family Care, the homefinder must explain the Agreement for Participation (this form is available as a DDE and may be accessed through the Reports area of FACTS) and secure the required signatures. The signed original of the Agreement for Participation must be filed in the file cabinet in FACTS and entered in Document Tracking. A copy must be given to the provider.

In addition, the homefinder must explain the EFT option to the provider (Detailed information may be found at the State Auditor's web site at www.wvsao.gov). Also, the homefinder must explain FACTS PLUS to the provider (Detailed information may be found at www.wvfacts.org).

SECTION 4

CASE PLAN

4.1 Standards for Selection of Adult Family Care Home

In order to safeguard the health, comfort and well-being of clients in Adult Family Care, the Department of Health and Human Resources has established certain standards and requirements which must be met before a home will be approved for Adult Family Care.

The local office of the Department of Health and Human Resources is responsible for conducting a study of prospective Adult Family Care Homes and providers to determine if they meet agency standards. In conducting the family home study, the local office shall give careful consideration to each of the standards described in the following sections.

4.1.1 Fire Safety Standards

The applicant will be provided with a copy of the "Home Fire Safety Checklist" as part of the initial application packet. In addition, the worker shall complete the Annual Fire and Safety Review initially as part of the home study process and annually thereafter. If there are areas of concern identified during the worker's inspection they may request the Annual Fire and Safety Review be completed by the local fire department or authority. The installation of a smoke detectors and fire extinguishers, which may reduce the cost of homeowners insurance, is required. The State Fire Marshall's Code requires certain types of homes, including Adult Family Care, to have smoke detectors installed at the entrance to every bedroom in the home. Additionally, the provider must develop fire evacuation routes and be certain that clients are aware of escape procedures in the event of an emergency. It is recommended the provider hold two (2) fire drills a year.

The following fire safety standards apply to all Adult Family Care Homes:

- a) Installation of smoke detectors at the entrance of every bedroom is required. (It is recommended that batteries be replaced every six months);
- b) Carbon Monoxide Detectors are required if natural fuels (any heating source except electric or solar) are used in the home;
- c) The home must have at least one (1) fire extinguisher capable of extinguishing all types of fires (ABC certification), located in the kitchen. It is recommended that an additional fire extinguisher be placed near the heating source, particularly if a fireplace or wood burning stove is used as a source of heat;

- d) The provider must develop fire evacuation routes and be sure that clients are aware of escape procedures in the event of an emergency; and,
- e) Portable heaters are not to be used as the primary source of heat (vented or unvented.)

Section 87-1-3 of the State Fire Marshall Code says: "All unvented fuel fire heaters are prohibited for all occupancies except one (1) and two (2) family dwellings." According to the Fire Marshall's office, this statement means that a family can have three (3) outsiders in addition to their own family and use an unvented heater. Since AFC Homes are only allowed up to three (3) residents at a time they would be within the regulations in using unvented heaters. Use of any portable unvented heater, (i.e., kerosene, electric, propane, etc.), may be permitted only in a short-term emergent situation. All portable unvented heaters must be approved by the home finder. In addition to approval by the home finder for use of portable unvented heaters, the manufacturer's instructions, restrictions, etc. must be followed. The Fire Marshall recommended that if portable unvented heaters are used, they need to be equipped with an automatic shut off in the event the heater tips over. Stationery unvented heaters are permitted, with the approval of the home finder.

4.1.2 Mobile Homes

If a mobile home is the family residence, it will only be considered for approval if manufactured after 1976 and meets all fire safety standards. It is further recommended that the mobile home be inspected by the Fire Department.

4.2 Sanitation Standards

The sanitation inspection is to be completed by the homefinder. He/she may request that the County Health Department make the inspection in those situations where He/she feels unable to make this determination.

The "Annual Sanitation Review," must be completed to document the inspection. The form is designed so that it can be used either by the homefinder or by the County Health Department.

4.2.1 Water Supply

If the water supply is other than a municipal water supply, the water must be approved by the Department of Health or an approved independent laboratory prior to approval of a new provider. If the water is determined to be unsafe, this does not automatically disqualify the home but appropriate action must be taken to correct these conditions to assure a safe water supply is available for drinking, cooking and bathing. While the water supply typically should not need to be re-tested on a routine schedule, if something should occur that could compromise the water quality, the provider must have the water tested and take actions necessary to ensure a safe source of water. The provider is responsible for

payment for any water testing that is needed.

4.2.2 Toilet and Bathing Facilities

Toilet and bathing facilities shall be in working condition. Homes without indoor toilets shall not be disqualified solely for this reason unless the use of such a facility would be hazardous or unsafe for a client.

4.2.3 Liquid and Solid Waste Disposal

Liquid waste shall be disposed of in a sanitary manner into a public sewage system where available or, if none is available, into a system that is approved by the Department of Health.

4.2.4 Garbage Disposal

All garbage, refuse, trash and litter shall be collected and disposed of in compliance with established requirements of applicable state and local authorities. Garbage containers shall be made of metal or other impervious material and shall be water tight, rodent proof and have tight-fitting covers.

4.3 Health Standards

The health status of each household member, particularly related to their ability to provide care to adults in their home, shall be assessed by the homefinder. To do so, the homefinder must consider information reported on the Physician's Statement as well as information obtained during individual/group interviews with household members.

Providers and members of the household must meet the following:

- a) Providers and household members shall be free from communicable diseases such as TB and hepatitis;
- b) Providers and household members who will be providing direct care to clients shall be free from disabling conditions which render them unable to properly supervise and care for clients;
- c) The health and physical abilities of the provider must be such that quality and protective care can be given to a resident placed there;
- d) Household members shall not have an illness or condition which would have a negative impact on the care of the clients; and,
- e) Household members shall not have exhibited behavior patterns that would be physically harmful or emotional damaging to clients placed in the home.

Information must be documented on the Home Study Summary.

4.4 Nutritional Standards

Worker must assess the provider's ability to meet the nutritional needs of adults placed in their home. Providers must be able to comply with all the following requirements;

4.4.1 Meal Preparation

Diets prescribed by physicians shall be in writing, dated and kept on file and meals carefully planned to adhere to the prescribed diet. (Training in preparing special diets, if needed, may be obtained from County Extension offices, the local Health Department, etc.).

- a) Food preferences shall be taken into consideration without sacrificing good nutrition;
- b) At least three (3) nutritionally balanced meals per day shall be served with not more than a fourteen (14)-hour span between the evening meal and breakfast;
- c) Nutritional between-meal snacks must be available to residents except when conflicting with special diets prescribed by a licensed physician; and,
- d) All salt used in preparing and serving shall be iodized salt.

4.4.2 Food Handling/Sanitation

- a) All food shall be stored in a safe and sanitary manner;
- b) Refrigerators shall be kept clean and in proper working condition;
- c) Kitchen floors, walls, sinks, ceilings, light fixtures, storage areas and equipment shall be kept clean and in good repair; and,
- d) Open kitchen windows and doors shall be screened and maintained.

4.5 Social Standards

The worker must assess the availability of social and recreational resources as well as the provider's ability to meet the social and supportive needs of adults placed in their home. Providers must be able to comply with all of the following requirements:

- a) The location of a home must be accessible by automobile, preferably near churches, stores, community facilities and public transportation;
- b) The atmosphere within the home is to be supportive of the emotional needs of the clients;
- c) The clients must be allowed to dine with other members of the family, utilize the normal facilities of the home, and generally share in the life of the family;

- d) Appropriate health care services will be utilized when needed;
- e) An approved Adult Family Care home **shall not accept** any private placement except with prior approval by the Department;
- f) The number of residents placed in an Adult Family Care Home shall not exceed three (3);
- g) Excluding clients, there should be no more than six (6) individuals in the provider household. Homes with more than six (6) members will require a policy exception prior to approval;
- h) Clients shall be encouraged by the family to engage in those activities and functions (in and outside of the home) to support and enhance their physical, mental, emotional and/or spiritual well-being;
- i) Clients will be afforded the opportunity for participation in religious services of their choice; and,
- j) Telephone services must be available in the home and made reasonably available to the client. Clients will be responsible for the cost of their long distance calls.

4.6 Home and Housekeeping Standards

Worker must assess the provider's home in order to assure that it is adequate in providing care to adults. Provider must be able to comply with the following requirements:

4.6.1 Appearance of Home

- a) Each home shall provide an attractive, homelike and comfortable atmosphere and shall be maintained in a clean, hazard free, orderly manner; and,
- b) The exterior of the home and surrounding yard shall be attractive in appearance, well-maintained and free of clutter and present a respectable appearance in the community.

4.6.2 Sleeping Facilities

- a) A bedroom shall not be used as a common passageway to other rooms;
- b) Single occupancy in a room should be encouraged. More than double occupancy is not permissible;
- c) With the exception of a husband and wife placed in an Adult Family Care Home, no more than one (1) resident may sleep in a double bed;
- d) There must be at least three (3) feet between beds in multiple occupancy rooms;
- e) Beds shall be equipped with substantial springs and a clean comfortable

mattress;

- f) Bed linens, which must consist of two (2) sheets, a pillow, and a covering as required, to keep the clients comfortable, shall be provided and must be changed at least weekly;
- g) Rubber impervious sheets shall be placed over the mattress when necessary;
- h) Folding cots and portable beds are not permitted;
- i) No double-decker beds are permitted for residents;
- j) Each client is to be provided a separate comfortable bed with adequate unobstructed space between the beds;
- k) Beds shall be placed so that no resident may experience discomfort because of proximity to radiators, heat outlets, air conditioners or by exposure to drafts;
- l) Closet space shall be available for each client either in the client's bedroom or immediately adjacent to it;
- m) Each resident shall have space for storage of clothing and personal belongings.
- n) Sleeping room for clients shall not be used for any purpose by any other member of the family's household;
- o) Furniture and accessories shall be in good condition and attractive as well as comfortable;
- p) Each bedroom should contain a comfortable chair for the resident;
- q) The client is to be encouraged to bring some personal furnishing of his/her own when feasible/practical;
- r) Each bedroom shall have at least one (1) outside window;
- s) Each single occupancy bedroom shall have, at a minimum, one hundred (100) square feet of floor space (10X10); and,
- t) Each double occupancy bedroom shall have, at a minimum, 80 square feet of floor space per occupant, total of 160 square feet.

4.6.3 Accessibility

- a) Clients shall be housed in the provider's residence;
- b) This residence must have a common entrance;
- c) Rooms shall be easily accessible to clients and should not be more than one (1) flight above street level;
- d) The use of an upstairs bedroom for Adult Family Care clients is

discouraged if the clients placed are mentally or physically incapacitated to the point that quick emergency exiting would not be possible;

- e) The bedroom shall not be entirely below ground level but if partially below ground level the bedroom must have direct access from the bedroom to the outside. Direct access shall mean that the room has a window/door which is large enough to allow emergency exit to the outside without going through an adjoining room; and,
- f) Bathroom(s) shall be situated where they are easily accessible to clients and shall be equipped to meet their needs.

4.6.4 Lighting and Ventilation

- a) There shall be sufficient artificial and/or natural light and ventilation available in bathrooms. Ventilation means a window that opens to the outside atmosphere or an exhaust fan;
- b) Open windows and doors must be screened; and,
- c) House must have metered electricity service.

4.6.5 Safety

- a) Devices/measures necessary to ensure the safety of clients must be used. For example:
 - 1. Handrails for stairs;
 - 2. Handgrips for tubs, showers and toilets;
 - 3. Nonslip stools and mats and bath seat for tub;
 - 4. Nonskid floor surfaces;
 - 5. Nonskid rugs;
 - 6. Firearms and ammunition must be stored in a locked storage area (cabinet, room, etc.) and/secured at all times; and,
 - 7. Special equipment prescribed by a physician is to be available and readily accessible to the resident for whom it is prescribed. Determination of what "readily accessible" means is to be based on the type of special equipment and the capabilities/needs of the resident.

4.7 Care and Welfare Standards

Worker must assess the applicant's ability to provide necessary care, support and assistance to adults placed in their home. Provider must be able to comply with the following requirements:

4.7.1 Personal Care/Grooming

- a) Clients shall be suitably dressed at all times;
- b) Assistance must be provided when needed in maintaining personal hygiene and good grooming;
- c) Toilet articles, such as towel, toothpaste, toothbrushes, brushes and combs, etc. shall not be used in common;
- d) The client shall be provided with soap, clean towels, wash cloths, individual mouthwash cups, toothbrushes, denture containers and cleaner; and,
- e) Assistance in laundry and minor repair of clothing will be provided when necessary.

4.7.2 Rights of the Resident

- a) Client shall not be detained in a home against their will unless they have been determined to be incompetent by a court of law to make decisions concerning their own welfare;
- b) Physical restraints are not to be used;
- c) Client shall not be denied the right of rest periods in their beds;
- d) Visitation will be encouraged so as to maintain relationships with family and others. Visitation is to be in accordance with established house rules;
- e) A client's right to privacy will be respected;
- f) A client's correspondence shall not be opened except as authorized by the client or his/her legal representative;
- g) No form of physical punishment shall be permitted;
- h) Adequate clothing shall be maintained for each client. (A clothing allowance is available from the Department to assist with clothing costs); and,
- i) The client may use his/her personal expense allowance to purchase any item(s) they choose so long as the purchases do not conflict with established house rules or regulations applicable to operation as an Adult Family Care Home.

4.7.3 Inclusion in the Family

- a) Clients shall be encouraged to use all common areas in the home and to take part in social activities within their capacity; and,
- b) Depending upon the client's physical condition or the advice of the physician, the client will be encouraged to perform certain tasks around the home, such as caring for his room or occasionally assisting with meal

preparation (and/or cleanup) as long as he/she is not exploited.

4.7.4 Emergency/Special Needs

- a) During periods of temporary illness clients may be given more intense assistance with (ADL) activities of daily living by the provider not to exceed six (6) months without a policy exception. The intent of providing this additional assistance on a short term basis is to prevent movement to a higher level of care. Title XIX Medicaid Waiver services for the AFC client are not to be provided in an AFC Home;
- b) Home Health Services may be provided on a short term basis not to exceed ninety (90) days per episode. Services provided in the home by another agency must be in addition to care furnished by the Adult Family Care provider, not instead of;
- c) Hospice care may be provided in the home by a licensed hospice provider as needed. Services provided in the home by the hospice agency must be in addition to care furnished by the Adult Family Care provider, not instead of;
- d) If the client has special equipment, such as walkers and wheelchairs, it shall be made available to them at all times. (If a client placed in the home requires special equipment, the physical structure must be able to accommodate its use); and,
- e) The provider must have established procedures for obtaining assistance in an emergency situation.

4.7.5 Personal Characteristics

Providers shall be persons who are:

- a) Mature in judgment;
- b) Interested in adults and able to recognize the importance of rehabilitative services;
- c) Free of personal problems which would consistently take priority over the care of residents;
- d) Able to work with agencies and relatives in helping clients in the home;
- e) Willing to consult with the worker regarding the client's adjustment to the home and to cooperate in maintaining the standards and necessary records;
- f) Physically, mentally and emotionally capable of meeting all applicable responsibilities;
- g) Clean and neat in appearance;
- h) In possession of financial resources adequate to provide a reasonable

standard of living for the immediate family. This means that the provider must have sufficient income to meet all of the families expenses (not including those incurred by the Adult Family Care clients placed there) without depending on the Adult Family Care supplement or the resources (check and food stamps) of the client. Any exception to this requirement must be authorized via policy exception; and,

- i) Has an understanding of their responsibility to see that each client gets that portion of his or her check designated for personal expense allowance.

4.7.6 Relative Placements

Adult Family Care payments shall not be made to a provider for the care of a spouse. When considering payment to a relative for provision of Adult Family Care, the following will be considered in order for the Department to make a supplemental payment. If the relative has provided these services to the client for any period of time prior to requesting payment, it must be determined why he is requesting payment for these services now.

- a) The provider must be willing to accept other clients unless the home does not have adequate space to accommodate additional clients;
- b) The degree of burden placed on the provider in furnishing care to the relative in placement will be considered, such as amount of time spent and cost involved. For example, the provider's presence may be required in the home on a twenty-four (24) hour basis;
- c) If the relative is giving up employment to care for the client, an Adult Family Care payment may be necessary to enable the person to continue to provide the service. However, the client's resources and the Adult Family Care payment cannot be the only income in the household. If a relative is giving up employment to care for a disabled relative and that relative has been providing the household's sole source of income, an Adult Family Care payment cannot be approved without a policy exception. If no recent changes have occurred and the request for payment is being made because the client or relative has only recently become aware of the Adult Family Care Program, a social service supplement may be made if it can be demonstrated that the circumstances of burden or hardship have existed for a period of time and that the home meets all standards for Adult Family Care Homes; and,
- d) Adult Family Care Homes shall not be approved to care for more than three (3) adults. Relatives to whom care is provided and private paying residents must be included in this number. The Adult Family Care Home Study Summary and the annual AFC Approval Letter will reflect how many adults the provider has been approved to care for, and this will be

made clear to the provider.

4.7.7 Dual Providers

In general, providers are discouraged from providing services to more than one (1) program at a time (i.e. Foster Care, Day Care, Specialized Family Care, Private Agencies, Adult Family Care, etc.) due to the amount of time and effort each of the programs require. When a person is approved to provide more than one (1) service, the demands placed on providers who serve dual client populations often become excessive, reducing the level of service to all clients and disrupting the provider's household. Therefore, requests to become a dual provider must be given careful consideration. Before a provider may offer dual services, the worker(s) and the supervisor (s) of both programs must evaluate all aspects of the situation to determine that this is, indeed, the best possible arrangement in view of the ages, needs and circumstances of the children and adults.

There are a few rare instances where a provider may be delivering services to more than one (1) program simultaneously. One example of a situation where approval as a dual provider may be considered is a foster family that has provided care for two (2) or more children for an extended period of time, one of which is nearing the age of eighteen(18) and is not capable of independent living due to a mental or physical incapacity. In such an instance an exception may be considered to allow an existing foster parent to also become an Adult Family Care provider for that child when they reach the age of eighteen (18). Under no circumstances can a foster child automatically become an Adult Family Care client on his eighteenth (18th) or twenty-first (21st) birthdays.

To work out the best plan for this client, it is necessary for staff from both units to begin planning at least six (6) months prior to requesting approval for a provider to offer dual services. Staffing and joint involvement is also necessary if a foster child appears appropriate for any Adult Services that will be needed following Foster Care placement, including the need for Adult Family Care to be provided in a home other than the Foster Care Home. The Service Plan must document definite goals, specific tasks and time frames to accomplish the goals. The ultimate goal must be placement in the least restrictive living arrangement that is appropriate to meet the individual's needs.

When it is determined that this arrangement is appropriate an exception must be requested. If an exception is to be requested, all the following criteria must be met:

- a) The client wishes to remain in the home;
- b) The provider wishes to continue to provide services;
- c) The client meets all AFC eligibility requirements; and,
- d) The provider meets all applicable standards to be an AFC provider.

The client, provider, worker from the other program, Adult Service worker, and the homefinder(s) must have discussed this thoroughly and deemed this to be the best plan for the client. The exception request must be submitted to the District Waiver Committee (comprised of the Community Service Manager, or designee, Adult Services Supervisor, the Day Care Supervisor and/or the Foster Care Supervisor, etc.) for approval. Accompanying the exception request must be documentation showing why this person is not capable of independent living, steps taken to prepare the person for independent living and how removal from this home would be detrimental to this person's well-being. If the request is approved by this committee, final approval of a request to become a dual provider must be granted as a policy exception through FACTS. For all other dual provider types, the above process must be followed and a policy exception requested in FACTS.

If the client receives services from Title XIX Waiver program, the client is not eligible for a Supplemental Adult Family Care payment and the client's AFC case may be closed. In addition, the Adult Family Care Home must be evaluated for closure. If the Adult Family Care Home provider is certified as a Title XIX Waiver provider or employed as a Personal Care provider, the provider must decide if they want to continue being a provider with that program or if they want to be a provider through the AFC program. If the decision is to continue as a provider with the Title XIX Waiver program or as a Personal Care provider, the AFC provider record must be closed in FACTS. If the client receives services from any other agency that provides supervision or care for the client, this must be evaluated to determine if the client remains eligible to receive a supplemental payment from DHHR or remains eligible for AFC placement.

An Adult Family Care provider cannot accept care for an Aged and Disabled Waiver client. The qualified Aged and Disabled recipient requires more advanced care than Adult Family Care.

4.8 Provider Records (AFC and Respite Providers)

An individual paper record shall be established for each Adult Family Care Home provider/respice provider, as well as those applicants not approved. The homefinder must complete the check list in FACTS to indicate the date required documentation is received. In addition receipt of other information must be entered in document tracking.

Provider records shall be organized as follow:

4.8.1 Application / Home Study Block

The following information is to be dated and filed in chronological order in this block. All items that are part of the home study process and that are used to determine whether a home will be approved, re-approved or denied shall be filed in this block. The completed Application to Provide Adult Family Care shall be

filed at the front of this block to facilitate easy access. Documentation of the annual re-evaluation shall also be documented in FACTS. Since respite providers complete an abbreviated application process, the documents that are required for respite providers will be filed in the appropriate blocks as applicable.

- a) Completed Application form;
- b) Fire and Safety Checklist;
- c) Annual Fire and Safety Review;
- d) Annual Sanitation Review;
- e) Personal Reference Letters;
- f) Credit Reference Letters;
- g) Adult Family Care Home Study Summary;
- h) Annual Re-evaluation Summary;
- i) Corrective Action Plans;
- j) Appropriate correspondence;
- k) Approval/Re-certification Letters; and,
- l) Other.

4.8.2 Legal Block

This block shall contain all legal documents, dated and filed in chronological order.

- a) W-9;
- b) Adult Family Care Provider Agreement for Participation;
- c) Original of all Payment Agreements;
- d) CIB check results;
- e) Appropriate correspondence; and,
- f) Any other legal documents.

4.8.3 Medical Block

This block shall contain any medical information regarding the provider or any of the provider's family members. Information is to be dated and filed in chronological order.

- a) Initial Physician's Statement for provider;
- b) Initial Physician's Statement for household members;
- c) Physician's Statement for provider;
- d) Appropriate correspondence, and,

- e) Other medical reports.

4.8.4 Payment Block

This block shall contain all information related to payments made to or requested by the provider. Information is to be dated and filed in chronological order.

- a) Receipts for authorized expenditures;
- b) Appropriate correspondence;
- c) Other payment related information; and,
- d) If a respite provider, invoice for respite payment.

Note: The Service Plans are to be filed in the client's record.

4.8.5 Training Block

This block shall contain all information related to provider training. Examples of documentation include: sign in sheets, certificates of completion, agenda, course syllabus, etc. Information is to be dated and filed in chronological order.

- a) Documentation of completion of pre-service training;
- b) Documentation of completion of required quarterly training;
- c) Required documentation when requesting a training incentive payment must be filed in this block;
- d) Appropriate correspondence; and,
- e) Other training related information.

SECTION 5

CASE MANAGEMENT

5.1 Introduction

Once an individual has been approved as an Adult Family Care Home Provider, various case management activities must occur. These activities may include: identification of available homes based on the characteristics of individual needing placement, monitoring of the placement setting, follow-up on complaints related to compliance with program standards, providing and/or arranging needed training, and completion of annual provider reviews.

5.2 Responsibilities of Agency, Provider and Client

5.2.1 Agency Responsibilities

a) Homefinder Responsibilities:

1. The homefinder is responsible for providing or arranging appropriate training for Adult Family Care Providers;
2. The homefinder will work in collaboration with the Adult Services worker to identify suitable homes for clients needing placement;
3. The homefinder will provide ongoing support for the provider as needed and develop evacuation/disaster plans with the provider;
4. The homefinder will complete regularly scheduled reviews of the home (see Case Review) and have at least one face to face contact with the provider in the provider's home every six (6) months;
5. The homefinder will provide the Adult Family Care Home a "Certificate of Approval/Re-certification Letter" upon approval of the home and annually thereafter. This form is available as a DDE and may be accessed through the reports area of FACTS; and,
6. The homefinder will follow-up on all complaints about the provider and respite provider related to compliance with program standards. When a complaint is received against an Adult Family Care provider or respite provider relating to non-compliance with program standards or regulations, an I & R Intake must be entered in FACTS.

In addition, the homefinder must explain the EFT option to the provider. (Detailed information may be found at the State Auditor's web site at www.wvsao.gov). Also, the homefinder must explain FACTS PLUS to the provider. (Detailed information may be found at www.wvfacts.org).

On the Outcome Screen, if the referral is going to be accepted for investigation,

the worker/supervisor must select 'Progress to Investigation' to get the investigative screens to open. A variety of information must be gathered by conducting a series of interviews with the provider, client (if applicable), witnesses, and others having knowledge of the situation. In addition to conducting interviews the homefinder may need to make observations as applicable to determine if the complaint(s) can be substantiated. All information gathered during the investigation must be documented in the Investigation Screens in FACTS.

If the complaint(s) is/are substantiated, the homefinder must provide written notification to the Adult Family Care Provider/respite provider of the non-compliance issues and what changes must be made to bring the home/provider back into compliance with agency standards. The form letter titled AFC/ESC Corrective Action Letter has been developed for this purpose. (This form is available as a DDE in the Reports area of FACTS. It is also available for informational purposes in the REPORTS section of this policy).

Written notification must be sent to the provider within seven (7) calendar days of the conclusion of the non-compliance investigation notifying the provider of the deficiencies found. The provider must submit a Corrective Action Plan within fifteen (15) days of the written notification. The worker must follow-up as needed to determine that the non-compliance issues have been corrected within thirty (30) days. Anything beyond this thirty (30) day time frame a policy exception needs requested. This may include obtaining written documentation, physical observation of the home, etc. If the required changes have not been made within the time frame set by the homefinder in conjunction with the provider, the provider shall be notified in writing advising them of the Department's intention to close the home. The homefinder must notify the social worker that the home/respite provider is going to be closed so any clients currently in the provider's home/care can be moved. Clients are not to be placed with the provider or respite provider once the home/provider is closed. In addition, if circumstances warrant, the homefinder/social worker may decide the clients must be removed pending the investigation. The Negative Action Letter is to be used for closure. (This form is available as a DDE in the Reports area of FACTS).

Documentation of all contacts made with the provider concerning deficiencies is required and is to be documented in FACTS. Merging and associating must be done as appropriate in FACTS. The investigation must be connected to the provider on the Case Connect Screen. If the adult service social worker notices non-compliance issues during a visit to the home, this must be entered as an I & R Intake with follow-up as outlined above.

b) Social Worker Responsibilities:

1. The Adult Service social worker shall furnish the provider with a copy of the Adult Family Care Payment Agreement for each individual client placed in the Adult Family Care Home. The Department is responsible to

make payment to the provider in accordance with the terms of the payment agreement;

2. The Adult Service social worker will discuss with the provider the care required by the individual;
3. The Adult Service social worker will discuss the preparation of the individual for placement, including the signing of the Resident Agreement for Participation Form. This form is available as a DDE and may be accessed through the reports area of FACTS;
4. The Adult Service social worker will provide basic identifying information regarding the person being placed in the home. This information must be kept on file by the provider at all times during the stay of the client;
5. The Adult Service social worker shall monitor the client's placement to determine if the home is meeting the client's needs;
6. The Adult Service social worker will give at least thirty (30) days' notice before the termination of placement in a home, unless an emergency transfer is necessary and then notify the homefinder of the pending changes;
7. The Adult Service social worker will routinely monitor the use of the client's personal expense allowance. If the provider manages the personal expense allowance, a written record of expenses must be maintained by the provider. Should the worker suspect misuse of a client's personal expense allowance, a formal accounting of expenses must be requested and the homefinder notified about the concerns; and,
8. All contacts by the homefinder and Adult Service social worker with the provider should be documented in FACTS as soon as possible after the contact is made. Documentation is to be pertinent and relevant to activities related to case management.

c) Homefinder/Social Worker Collaboration for Placement:

When placement of an adult in an Adult Family Care Home is being considered, it is important to consider both the needs of the client and the characteristics of the Adult Family Care Home. How successful the placement is often depends on how good a match there is between the client, the provider and other members of the Adult Family Care household, including other clients in placement. Careful consideration of these factors prior to placement can facilitate a successful placement and minimize placement disruptions later. The Adult Service social worker is to work in collaboration with the Adult Family Care homefinder to identify potential homes.

The successful placement of a client in an Adult Family Care Home will depend

largely on assuring a good “match” between the client being placed and the provider. In order to ensure as good a match as possible, the social worker must evaluate the client in the following areas:

1. Current physical health status and medical history;
 2. Current mental/emotional/cognitive status and history;
 3. Current medications and ability to self-administer medication;
 4. Individual or special needs as viewed by the client, the physician and the social worker;
 5. The client’s expressed wishes regarding his/her living arrangements;
 6. Family, friends and community ties, who and where these are located and assistance they are willing to provide to the client;
 7. Family experiences of the client such as the kind of home life he/she had and attitude toward any remaining family;
 8. Educational and employment history;
 9. Religious preferences, interests, hobbies, likes and dislikes, and personal habits;
 10. Household possessions or pets and plans for what will be done with these;
 11. Physical appearance and personal characteristics (i.e., neat/untidy, withdrawn/outgoing);
 12. Behavior problems that are currently present or that have been present in the past;
 13. Problems with any prior placement;
 14. Unusual habits that could be problematic for a provider; and,
 15. Financial resources such as income, medical insurance and assets.
- d) Provider Responsibilities
1. The provider shall notify the DHHR social worker promptly if a client, or their legal representative, fails to pay for their portion of the cost of care as per the payment agreement;
 2. When requesting removal of a client, the provider must give the Department thirty (30) days’ notice;
 3. The provider must notify the Department of Health and Human Resources immediately in case of a client’s death;
 4. The provider must notify the Department of Health and Human Resources immediately of any accidents, injuries, unusual occurrences, etc.;
 5. The provider **shall not** serve as legally appointed Guardian, Conservator,

Health Care Surrogate, Power of Attorney or Medical Power of Attorney for any Adult Family Care client, whether the client is in their home or in another Adult Family Care provider's home, unless the Adult Family Care provider is the biological or legally adoptive parent of the adult child. In addition, other household members **are not** permitted to serve as Guardian, Conservator, Health Care Surrogate, Power of Attorney or Medical Power of Attorney for any Adult Family Care client; whether the client is in the home they are residing in or in another Adult Family Care provider's home;

6. The provider may be appointed as a representative payee when appropriate;
7. The provider shall allow representatives of the Department of Health and Human Resources to conduct site visit, investigate any complaints and visit the AFC client in the home as required;
8. The provider shall notify the social worker of any changes in the client's circumstances including financial situation, unplanned discharge from the home, etc.;
9. The provider shall discuss established/applicable house rules and regulations with the client prior to or upon placement. This may include such things as smoking regulations, use of the kitchen, mealtimes, bedtime, entertainment and dress;
10. The provider must notify the homefinder, **in advance**, of their intent to accept placement of a private paying resident or a person being placed by someone other than the Department. The Department does not provide case management services to private paid clients, unless they are involved with Adult Protective Services. Actual placement may only occur after the homefinder has granted approval. If the Adult Service worker is notified prior to the homefinder concerning placement the Adult Service worker needs to coordinate the placement with the homefinder;
11. The provider is responsible for maintaining appropriate liability insurance. **(Private pay clients are not covered by the Department);**
12. The provider shall maintain all personal information pertaining to the client in a confidential manner. (See [Records Maintained by the Provider](#));
13. The provider is responsible for assuring that the client receives the designated personal allowance each month. If the provider handles the client's money, they must maintain documentation of all expenses incurred on the client's behalf. This documentation is to be filed in the client's record maintained by the provider;
14. The provider shall not use any form of corporal punishment or physical restraints;

15. The provider is responsible for obtaining any necessary medical care for the clients placed in their home and for notifying the social worker of any significant changes in the client's physical, emotional or mental health;
16. The provider is responsible for insuring that a suitable/approved backup system is in place for those times they are absent from the home;
17. Prescription medication shall not be provided to any client except on written order of a licensed physician. When medication requires administration by a trained person, arrangements are to be made to procure the services of such a person. If the client is capable of self-administration of medication as determined by his physician, then he/she should be permitted and encouraged to do so;
18. All prescription medicines must be labeled with the client's name, prescription number and directions for dosage, and stored in a secure place;
19. No Over the Counter Medications (OTC) will be administered without written physician's orders;
20. The provider is responsible for providing/arranging transportation to meet all of the client's medical needs (obtaining prescriptions, going to doctor's appointments or mental health appointments, attending day programs and etc.);
21. The provider is responsible for providing necessary documentation to the social worker (i.e., copies of client's prescriptions, supporting documentation for requested demand payments, receipts, etc.);
22. The provider must repay the Department of Health and Human Resources when an overpayment occurs. The time frame for the repayment will usually be within thirty (30) days; however, the Adult Service social worker may grant additional time. The Adult Service social worker must notify the provider in writing of the amount owed and the repayment plan; and,
23. The provider should not take or be recipient/beneficiary of any life insurance plan/policy for Adult Services client.
24. The provider must develop in conjunction with the homefinder an appropriate evacuation/disaster plan for the home. This plan should be reviewed on an annual basis.

Note: Providers must notify the AFC homefinder **before** accepting any new private pay and/or DHHR clients in their home. If the provider fails to notify homefinder a Corrective Action may be issued. When accepting private pay clients, the provider will not receive Departmental Case Management services.

5.2.2 Client Responsibilities:

1. The client or his/her legal representative is responsible to make payment

- to the provider in accordance with the terms of the payment agreement;
2. The client shall inform the provider before inviting friends or relatives to the home;
 3. It is the responsibility of the client, or his/her legal representative, to immediately inform the social worker and the provider of changes in his income and/or living arrangements;
 4. The client, or his/her legal representative, will be responsible to make restitution in the event there is an error in payment as a result of his/her failure to immediately inform the social worker and the provider of any changes;
 5. The client is to respect the rights of others in the home, including the provider; and,
 6. The client is to become familiar with and abide by the provider's house rules and regulations.

5.3 Liability Insurance

The Department of Health and Human Resources and the State Board of Risk and Insurance Management have implemented an agreement to provide liability and property damage insurance protection for Adult Family Care providers. The insurance afforded Adult Family Care providers by this program is not intended to replace any of their existing property or liability insurance (comprehensive personal liability insurance, homeowners insurance, etc.), as only acts of Adult Family Care clients are covered. Instead, it seeks to reduce the cost of the providers' existing coverage and ensure quality care for disadvantaged adults. This insurance protection does not provide coverage for any injury or property damage resulting from a client's operation of the provider's automobile or other licensed motor vehicle. The provider must not permit a client to operate any licensed motor vehicle that is not owned by the client. The liability and property insurance protection coverage includes the following through the State Board of Risk Management:

5.3.1 General Liability Insurance

This insurance protects the Department of Health and Human Resources, including its employees and the Adult Family Care providers in the event of negligent acts of the client that cause injury or damage to persons other than the Adult Family Care provider. The limits of liability are one million per each occurrence. There is no deductible required for general liability claims.

5.3.2 Property Insurance

This insurance protects the Adult Family Care provider in the event of property damage caused by the client to the care provider's own property. Losses will be adjusted on an actual cash value basis (replacement cost, less physical

depreciation). Each loss will be subject to a \$2,000.00 deductible with the care provider responsible for the first \$300.00 of the deductible and the Department of Health and Human Resources assuming the remaining \$1,700.00. Adult Family Care providers are to immediately notify the homefinder of any property damage caused by the client in excess of \$300.00 or any negligent act of a client that causes injury or damage to a person. When needed, the homefinder may assist the Adult Family Care provider with completing the appropriate claim form ([Form #RMI-3](#)) and describing the losses incurred or damage and file with [Board of Risk and Insurance Management](#) (BRIM).

When a homefinder is informed of a loss suffered by an Adult Family Care provider, the following procedures apply:

1. The provider and/or the homefinder complete the claim form (Insurance Loss Notice Form [#RMI-3](#)). The form is used to report general liability losses (negligent acts of the client that cause injury or damage to persons other than the provider). It is also used to report property damage caused by the client to the provider's own property;
2. The completed form must be co-signed by the CSM or their designee;
3. Submit the completed form to the Director, Division of Assets and Project Management (Building 3, Room 232, Capitol Complex, Charleston, WV 25305);
4. Retain a copy of the completed form in the client's record and the provider's record and document the location of the form in FACTS, Document Tracking;
5. Send a copy of the completed form to the Commissioner of the Bureau for Children and Families; and,
6. Document all contacts related to this in FACTS.

Upon receipt of the necessary information by the Division of Assets and Project Management, an insurance adjuster will complete their investigation directly with the care provider.

Note: Private pay clients would not be covered under the Department's insurance.

5.4 Taxes

An interpretation by the Internal Revenue Service ([Revenue Ruling 1952-1-13737, CB 1952 - 1, p. 7](#)) indicates that Adult Family Care Homes are considered in the same classification as Foster Care Homes for children and are subject to the regulations as stated in [Revenue Ruling 77-280](#). Also according to [Letter Ruling 8025214](#), payments made to a host family pursuant to an Adult Family Care Program adopted by a Department of Public Welfare to delay or prevent the admission of certain persons into nursing homes are

excludable from gross

income except to the extent the payments exceed the expenses incurred by the host in supporting the participant (from [CCH A:9.171](#)).

Payments received from the Department of Health and Human Resources for the support of an adult in an Adult Family Care Home are not to be included in the gross income of the provider for income tax purposes except to the extent that the payments exceed the expense incurred by the provider in supporting the adult. If the payments to the provider do not exceed the expenses incurred, the provider is not required to report the transaction on his Income Tax Return. It is the provider's responsibility to maintain sufficient records of income and expense to make this determination and it is suggested that providers develop a system of record keeping which would document income expenditures. (Homes that have been established as a business venture, such as Assisted Living facilities, are not included in this ruling).

Note: For Adult Family Care providers who are also Emergency Shelter Care providers, the monthly subsidy amount paid to insure the availability of the emergency shelter care beds is considered taxable since it is not tied to a specific client. Conversely the daily boarding and care rate paid for a client placed in the Emergency Shelter Care Home is not considered taxable income to the extent that it does not exceed actual expenses. (For further information regarding income taxes, it is recommended the provider contact their tax preparer, the [Internal Revenue Service](#) and/or the [West Virginia Tax Department](#)).

5.5 West Virginia Business License

The Bureau for Children and Families has been advised by the Tax Division of the State of West Virginia Department of Tax and Revenue that Adult Family Care Home providers are required to register with the state to do business and pay business registration tax if they have a gross income of more than \$4,000.00 for income purposes during the preceding tax year. ([Legal Log #98-372](#)) According to the Tax Division, there is no doubt that the Adult Family Care Program services are within the definition of "business activity", which includes "all purposeful revenue generating activity engaged in or caused to be engaged in with the object of gain or economic benefit, either direct or indirect" and none of the listed exclusions from the definition, appear to be applicable. (See W. Va. [Code 11-12-2 \(b\)\(2\)](#)).

While "gross income" is not defined in the Business Registration Tax statutes, that term as commonly used and understood in the field of taxation would include all amounts which the client pays the provider, any payments from DHHR to the provider for his/her services, as well as income from other source. Thus, the \$4,000.00 gross income exception would not be available to the Adult Family Care Home provider except possibly in the first year of operation. Accordingly, the Adult Family Care Home providers are required to register and pay the

Business Registration Tax if they had gross income of more than \$4,000.00 for income tax purposes during the provider's personal income tax year immediately preceding the registration period. (For further information regarding West Virginia Business license, it is recommended that the provider contact the [West Virginia State Tax Department](#)).

5.6 Training Requirements

An Adult Family Care Home provider must participate in at least six (6) hours of face to face pre-service training prior to accepting clients in their home. Three (3) hours of this may be provided by the homefinder during the home study process. Suggested topics include:

- a) Program guidelines-Define Adult Family Care Homes and prospective clients;
- b) Legal rights and responsibilities of the client and provider (provider liability, provider's taxes, responsibilities to the agency);
- c) Role of the provider in interdisciplinary team approach;
- d) Utilization of DHHR resources;
- e) Utilization of community resources;
- f) Overview of human needs (resident and provider–motivation, sexuality, communications, etc.);
- g) Crisis intervention (overview);
- h) Record keeping; and,
- i) Confidentiality.

The remaining three (3) hours of pre-service training must address specialized topics related to caring for adults. Suggested topics include, but are not limited to:

- a) Crisis intervention - detailed techniques for dealing with persons experiencing emotional turmoil such as depression, anxiety, and general fear of placement;
- b) Behavior management;
- c) Basic First Aid;
- d) CPR;
- e) Nutrition;
- f) Characteristics of aging and information about special handicaps;
- g) Medication (Importance of medication, side effects, over the counter drugs (OTC) etc.);

- h) Effects of being institutionalized; and,
- i) Signs of abuse and neglect and mandatory training; and
- j) End of life.

Respite providers are required to receive the abuse and neglect training prior to providing care. However, respite providers are not required to have in-service training because they are not eligible for training incentive payment.

5.7 Combination Adult Family Care/Emergency Shelter Care Homes

“Combination” Emergency Shelter Care/Adult Family Care Homes may be approved with the following stipulations:

- a) An existing Adult Family Care provider would be eligible to participate as a “combination” home after they have provided services for six (6) months and have demonstrated the ability to care for clients. A „combination” home must have a separate room for the Emergency Shelter Care client to accommodate placements of either sex. (An exception is permitted if the provider has both a male and a female Adult Family Care client already housed in separate rooms, each of the rooms must be large enough to accommodate another person of the same sex). The total number of clients in the home cannot exceed three (3) at any one time;
- b) The monthly stipend applies only to the Emergency Shelter Care bed and not to the “regular” Adult Family Care beds; and,
- c) The placement will not be disruptive to clients already residing in Adult Family Care.

The homefinder must carefully evaluate the capacity of the Adult Family Care Home provider for assuming the additional responsibility of also providing Emergency Shelter Care.

5.8 Respite Care

Household members will not be paid as respite providers. An Adult Family Care provider is entitled to use up to seven (7) days of respite care per calendar year. Respite is determined within the calendar year from January 1 through December 31 of each year. During these seven (7) days, the Adult Family Care provider will continue to receive the regular AFC payment uninterrupted. Respite care can be arranged to provide temporary care to elderly or disabled adults in order to offer short term relief to regular Adult Family Care providers. The purpose is to allow these full-time providers to have planned times for vacations or other activities and to provide emergency care in the event of illness of the provider or a provider’s family member. Although providers are encouraged to take their residents with them on vacations, it is also recognized that sometimes families may need to spend some time by themselves. Under no circumstances

is a client to be placed with an unapproved respite provider. Providers need to give a five (5) day notice before taking their respite. Providers need to notify the Adult Service social worker before using respite.

5.8.1 Determining the Need/Planning for Paid Respite Care

All paid respite is to be planned and approved by the worker in advance, with the exception of respite which is needed as a result of an emergency involving the provider or a member of the provider's household. When respite is needed in an emergency, verbal approval of the worker must be obtained prior to placement of the client with an approved respite provider. The need for paid respite is to be documented in the Service Plan and is not to exceed seven (7) days per calendar year per client for whom DHHR is making a supplemental payment. Respite care arrangements must be part of the Service Plan and all contacts regarding the arrangements must be documented.

Prior to payment for respite care, the respite provider must submit a written signed/dated statement or invoice, verifying dates respite care was provided and the client's name(s) that care was provided to, with the name of the respite provider and the regular AFC provider's name. Upon receipt of this written invoice/statement, the social worker is to request a demand payment for the appropriate amount. In the event respite care would continue beyond the allowed seven (7) days, the social worker is to discontinue respite payment for the client to the respite provider. The per diem rate paid to the respite provider will be based on the per diem rate for the regular AFC provider. Payment beyond the annual seven (7) days is the Adult Family Care provider's responsibility.

5.8.2 Approval as a Respite Provider

When a request is received for an individual to become a respite provider, a Request to Provide Services intake must be completed. Approval of a home to provide respite care is based upon the evaluation of the home if care is going to be provided in the respite provider's home as well as a determination as to whether all standards for a respite care provider have been met by the homefinder. If the provider is going to provide respite in the Adult Family Care provider's home or their home, all standards set forth for respite providers must be met. No standards for respite care may be waived by the homefinding staff. A recommendation for a waiver must be submitted to the appropriate person for approval or denial

5.8.3 Currently Approved AFC/ESC Provider Will Furnish Respite in Their AFC Home

Prior to provision of the respite, the respite provider must become familiar with the client(s) they will be providing care for (medications, allergies, primary physician, dietary requirements, legal representatives, etc.). They must meet all the following criteria in order to provide respite:

- a) Must be an active AFC/ESC provider with current certification; and,

- b) The home may not exceed the number of clients the home is approved for, including the respite clients (i.e., AFC Home is approved for three (3) clients. There are currently two (2) AFC clients in placement in the AFC Home. The AFC provider could furnish respite to only 1 (one) additional client).

5.8.4 Approved Respite Provider Will Furnish Respite in AFC Provider Home

Prior to provision of the respite, respite provider must become familiar with the client(s) they will be providing care for (medications, allergies, primary physician, dietary requirements, legal representatives, etc.). Approval of the respite provider must be based on receipt and satisfactory results of the following:

- a) Return of negative CIB and NCIC (see section titled [CIB Check](#) for details);
- b) Completion of a record check in FACTS to verify that there is no history of substantiated APS or CPS;
- c) Completion of a check of the Nurse Aid Abuse Registry (worker can check this on OHFLAC's website: [Office of Health Facility Licensure & Certification](#) - click on Abuse Registry [must have the individual's SSN]);
- d) Face to face interview in the potential provider's home;
- e) When deemed appropriate, request personal reference letter(s) and/or medical report;
Note: The initial medical report is at the respite provider's expense.
- f) Completion of W - 9;
- g) Completion of the mandatory abuse and neglect training; and
- h) Verification that the applicant is twenty-one (21) years of age or older.

5.8.5 Respite Will be Provided in Respite Provider's Home

Prior to provision of the respite, respite provider must become familiar with the client(s) they will be providing care for (medications, allergies, primary physician, dietary requirements, legal representatives, etc.). Approval as a respite provider must be based on receipt and satisfactory results of the following:

- a) Return of negative CIB and NCIC for all household members over the age of eighteen (18) (See section titled [CIB Check](#) for details);
- b) Completion of a record check in FACTS to verify that there is no history of substantiated APS or CPS for all household members over the age of eighteen (18);
- c) Completion of a check of the Nurse Aid Abuse registry for all household members over the age of eighteen(18) (worker can check this on

OHFLAC's website: www.wvdhhr.org/ohflac-click on Abuse Registry [must have the individual's SSN]);

- d) Face to face interview in the potential provider's home to assess the provider's ability to provide needed care and their ability to address emergency situations should they arise while the client is in their home;
- e) Completion of visual inspection of the home to ensure that the home has adequate space/sleeping areas to accommodate the client(s), meets fire, safety and sanitation requirements as required for AFC homes;
- f) When deemed appropriate, request personal reference letter(s) and/or medical report;
- g) Completion of W - 9;
- h) Completion of the mandatory abuse and neglect training; and,
- i) Verification that the applicant is twenty one (21) years of age or older;

Upon approval as a respite provider the individual must be set up as a Service Provider in FACTS and a paper record established. Requirements to be approved as a respite provider vary somewhat depending on the potential respite provider's circumstances.

In addition, the homefinder must explain the EFT option to the respite provider. (Detailed information may be found at the State Auditor's web site at www.wvsao.gov). Also, the homefinder must explain FACTS PLUS to the provider. (Detailed information may be found at www.wvfacts.org).

Note: A respite provider can live outside of the state of West Virginia, but they must provide the respite care service in the provider's home or in an approved home that is in West Virginia.

5.8.6 Unpaid Respite

Respite that is not reimbursed by DHHR (unpaid respite) must be addressed on the Service Plan and approved in advance by the worker. Though DHHR is not making payment in these instances, only respite providers approved by DHHR may furnish respite care. Unpaid respite may be provided by an adult household member, age eighteen (18) or older. All paid respite providers must be approved by DHHR in advance and must be at least twenty-one (21) years of age.

- a) Written Notification of Decision on Application for Respite Providers;
- b) Written notification of the decision on an application must be prepared by the homefinder and sent to the applicant within five (5) working days from the date of the decision;
- c) If the application is denied, the homefinder must send the Negative Action Letter (SS-13 form) within five (5) working days advising the applicant of the denial, stating the reason(s) for the denial. The Notification of

Application for Social Services is available as a DDE and may be accessed through the Reports area of FACTS. This Negative Action Letter also serves as written notification of the grievance procedure which is available to the applicant and must be added to the file cabinet and Document Tracking by using the "Save to FACTS" functionality. This functionality may be found in Microsoft Word under the "Add – Ins" menu and then selecting "Save to FACTS"; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality. (See [Common Chapters Manual](#) for detailed information about the grievance procedure); and,

- d) If the application is approved, Notification of Application for Social Services must be sent to the applicant. This document is available as a DDE Report and may be accessed through the Reports area of FACTS.

5.9 Annual Review

5.9.1 Adult Family Care Provider Review

The homefinder must complete a review of an Adult Family Care Home at least annually. This requires at least one (1) face to face interview in the home with the provider. The results of this review are then to be documented on the Annual Review Summary. This form is available as a DDE in the Reports area of FACTS. It is also available for informational purposes in the Reports section of this policy. In addition to the annual review, the homefinder must complete a face to face contact with the provider, at a minimum, at least every six (6) months. This face to face contact must be completed in the provider's home.

At a minimum the review must include a discussion of:

- a) Changes in family composition;
- b) Changes in financial resources;
- c) Changes in the health of the provider or his/her family members;
- d) Provider's description of being an Adult Family Care provider;
- e) Client's adjustment to the Adult Family Care Home;
- f) Provider's ability to adequately care for the client's needs;
- g) Provider's cooperation with the Department;
- h) Complaints received regarding the home;
- i) Changes in location of the home;
- j) Expectations and requirements of a provider (review of Provider Agreement for Participation);

- k) A discussion of EFT and FACTS PLUS, if the provider is not participating in EFT;
- l) Goals for the upcoming year; and,
- m) Recommendations for continued use.

A letter of re-certification shall be sent to the provider following satisfactory completion of all components of the Annual Review. This form is available as a DDE in the Reports area of FACTS. It is also available for informational purposes in the Reports section of this policy.

Also as part of the annual review process, the following forms are to be updated:

- a) Physician's Letter-provider is to arrange for completion, upon request (The medical statement is required every three (3) years, unless the homefinder requests one prior to that time). The cost of the initial medical statement is the provider's responsibility; however, after approval, if the provider does not have insurance or sufficient resources to cover the statement, this can be paid by a demand payment at Medicaid Rates;
- b) Annual Sanitation Review - social worker is to complete;
- c) Annual Fire and Safety Review - social worker is to complete; and,
- d) Others required due to change in circumstances (CIB, medicals on new household members, etc.).

Also the homefinder must do a record check in FACTS of APS/CPS history for all household members over the age of eighteen (18).

The Status Screen must be updated, reflecting the homefinders recommendation for the continued use of this home. Also, the homefinder must thoroughly document the above information on the appropriate screens in FACTS, in addition to any other pertinent information gathered during the review process.

5.9.2 Notification of Adult Family Care Provider Review

If the provider is going to be certified for an additional year, notification must be sent using the AFC Recertification Letter in the Reports area of FACTS, and a new certificate sent to the provider. If the provider is not going to be certified to continue providing care, the form letter Notification of Application for Social Services is to be used and is available in the Reports area in facts. This is a two (2) part form with the second part containing information about the provider's right to a fair hearing. The provider must be closed in FACTS if the provider is not going to be certified to continue providing AFC care.

5.9.3 Respite Provider Review

The social worker must complete a review of the respite provider at least annually. This requires at least one (1) face to face interview in the respite provider's home if respite care is provided in their home. If respite care is

provided in the Adult Family Care provider's home, it is at the discretion of the homefinder whether the interview will be conducted in the Adult Family Care provider's home or the respite provider's home.

At a minimum the review must include a discussion of the following:

- a) Changes in family/household composition;
- b) Changes in health of the respite provider and/or other household members;
- c) Respite provider's ability to adequately care for the needs of clients placed in their home;
- d) Provider's cooperation with the Department;
- e) Complaints received regarding the home;
- f) Changes in location of the home;
- g) Review of expectations and requirements of respite providers and how these are/are not met;
- h) A discussion of EFT and FACTS PLUS, if the respite provider is not participating in EFT; and,
- i) Recommendations for continued use.

The annual review process is to also include the following:

- a) Record check in FACTS of APS/CPS history;
- b) Other changes in circumstances (CIB, NCIC, medicals on new household members, updated medical on provider, when appropriate, etc.) The Department does not reimburse respite providers for medical statements regarding their ability to care for clients, unless the medical statement is deemed necessary by the homefinder. If the respite provider has no other resources to pay for this report, they may request reimbursement by the Department for this expense. To request reimbursement, the respite provider must submit a receipt, along with the completed medical report, to the Department and indicate that reimbursement is being requested. Reimbursement for completion of the medical report by the physician may not exceed the current Medicaid rate for a medical report. This will be paid via a demand payment. (For detailed information refer to the [Demand Payment](#) section of this policy).
- c) The homefinder must thoroughly document the above information as applicable on the Contact Screen, in addition to any other pertinent information gathered during the review process. The Status Screen must be updated, reflecting the homefinder's recommendation for continued use.

Respite provider furnishes respite in the Adult Family Care provider's home

At a minimum the review must include a discussion of the following:

- a) Changes in health of the respite provider;
- b) Respite provider's ability to adequately care for the needs of clients;
- c) Provider's cooperation with the Department;
- d) Complaints received regarding the respite provider;
- e) Review of expectations and requirements of respite providers and how these are/are not met;
- f) A discussion of EFT and FACTS PLUS, if the respite provider is not participating in EFT; and,
- g) Recommendation for continued use.

The annual review process is to also include the following:

- a) Record check in FACTS of APS/CPS history;
- b) Other changes in circumstances (CIB, NCIC, updated medical on provider, when appropriate, etc.) The Department does not reimburse respite providers for medical statements regarding their ability to care for clients, unless the medical statement is deemed necessary by the homefinder. (Refer to the section above titled [Respite Provides Respite](#) in their home for information on payment of this medical statement).

The homefinder must thoroughly document the above information on the Contact Screen, in addition to any other pertinent information gathered during the review process.

5.9.4 Notification of Respite Provider Review

If the respite provider is going to be certified for an additional year, notification must be sent using the AFC Recertification Letter in the Reports area of FACTS. This form letter is to be modified as needed. If the provider is not going to be certified to continue providing respite care, the form letter Notification of Application for Social Services is to be used and is available in the Reports area in facts. This is a two (2) part form with the second part containing information about the provider's right to a fair hearing. The provider record must be closed in FACTS if the provider is not going to be certified to continue providing respite care.

5.10 Adult Residential Services Corrective Action Letter

Homes that are found to be substandard as a result of a re-evaluation or investigation of non-compliance complaint will be notified in writing of the deficient areas and what changes must be made to bring the home back into

compliance with agency standards. A form letter titled AFC/ESC Corrective Action Letter has been developed for this purpose. (This form is available as a DDE in the Reports area of FACTS. It is also available for informational purposes in the Reports section of this policy). Written notification must be sent to the provider within seven (7) calendar days of the completion of the review or the conclusion of the non-compliance investigation notifying the provider of the deficiencies found. The provider must submit a Corrective Action Plan within fifteen (15) days. The worker must follow-up as needed to determine that the non-compliance issues have been corrected within thirty (30) days. Anything beyond this thirty (30) day time frame a policy exception needs requested. Documentation of all contacts made with the provider concerning deficiencies is required and is to be documented in FACTS. If the required changes have not been made within the time frame set by the homefinder in conjunction with the provider, the provider shall be notified in writing advising them of the Department's intention to close the home. The Negative Action Letter is to be used. (This form is available as a DDE in the Reports area of FACTS. It is also available for informational purposes in the Reports section of this policy).

5.11 Adult Protective Services and Adult Family Care Homes

The Department of Health and Human Resources has a dual responsibility when supervising the care provided in Adult Family Care Homes. For this reason a clear distinction must be made between abuse/neglect and compliance issues related to certification as an AFC provider. Abuse/neglect allegations are to be investigated by Adult Protective Services staff while issues related to compliance with AFC standards are to be addressed by the homefinder. The Adult Family Care Program policy requires that the homes meet specified standards to ensure that quality care is provided to clients placed in these homes. The Adult Protective Services law addresses those situations in which there are allegations of abuse/neglect in an Adult Family Care setting.

In addition to the requirements set forth in Department policy, State Code also specifically addresses the potential penalties if a caregiver is found to have abused or neglected an incapacitated adult or elderly person. This section of the Code [§61-2-29](#) states:

- a) [§61-2-29-b](#) Any person care giver, guardian or custodian who neglects an incapacitated adult, or elder person or who knowingly permits another person to neglect said adult, is guilty of a misdemeanor and, upon conviction thereof, shall be fined not less than five hundred dollars nor more than fifteen hundred dollars, or imprisoned in the county or regional jail for not less than ninety days nor more than one year, or both fined and imprisoned and
- b) [§61-2-29-c](#) Any person, care giver, guardian or custodian who intentionally abuses or neglects an incapacitated adult or elder person is guilty of a felony and, upon conviction thereof, shall, in the discretion of

the court, be confined in a state correctional facility for not less than two nor more than ten years.

Situations constituting the abuse, neglect or creation of an emergency situation involving an incapacitated adult requires investigation and intervention by the Department to protect the adult. Indications of potential abuse/neglect cannot be ignored by an Adult Family Care worker/homefinder and must be addressed with the provider involved as well as documented in the appropriate client and provider records. In such situations a referral to Adult Protective Services must be made.

When a situation is determined to be so severe that removal from the home is necessary to protect the client, immediate action must be taken. In addition, if abuse or neglect of an incapacitated adult by a household member is substantiated, and the perpetrator remains in the home, the client(s) must be removed from the home in order to ensure their safety. Court action may be required if the client refuses to leave or if a provider refuses to allow the client to leave. It is very important that if removal of one client is deemed necessary, a thorough investigation must be made to determine if other Adult Family Care clients in that home are to be removed. (See Adult Protective Service Policy for detailed information regarding handling reports of abuse and neglect).

5.12 Supervision and Support of the Adult Family Care Home

The purpose of supervising an Adult Family Care Home is to insure the best possible care for clients and to provide guidance and support to the provider. Supervising an Adult Family Care Home involves building a cooperative relationship between the social worker, homefinder, client and provider. The homefinder is to have ongoing regular contact with the provider. This includes, but is not limited to, a formal review of the provider conducted in the home at least once annually and a face to face contact with the provider in the provider's home at least once every six (6) months.

The discussion during the initial application process and reviews with the provider must focus upon the following types of issues:

- a) Integrating clients into the family of the Adult Family Care provider;
- b) Provider's role and responsibility in helping the client to adjust to the home;
- c) Provider's attitudes toward the clients placed in their home;
- d) Service planning (long-range, as well as short-range);
- e) Obtaining appropriate medical care;
- f) Resources to cover medical costs (Medicaid, Medicare, Private Insurance, Special Medical Authorization, etc.);
- g) Documentation of use of clients resources (i.e. personal expense

- allowance or as representative payee);
- h) Emergency procedures - provider and/or client;
- i) Behavioral health, medical and other needs;
- j) How to recognize and address behavioral changes;
- k) Resources to meet behavioral needs;
- l) Conflict resolution;
- m) Transportation needs (Social worker is not to provide routine transportation);
- n) Transportation resources (i.e., Non-Emergency Medical Transportation, Senior Services, Veteran's Association and other community resources);
- o) Eligibility for other benefits (i.e., Food Stamps, NEMT, Trip, Medicaid, etc.), and,
- p) Ensure that the provider has received all relevant information about the clients placed in their home and that an individual file is maintained by the provider for each client placed.

5.13 Use of Volunteers

Volunteers can be valuable resources for the Adult Family Care Home Program. Some examples of volunteer assignments might include: regular visitation, telephone assurance, exercises and even transportation to community events or non-emergency medical appointments. If the volunteer is going to have direct unsupervised contact with the clients two (2) or more hours per week, the following must be completed before the volunteer can be used:

- a) CIB (See CIB Check and CIB Policy for details);
- b) Completion of a record check in FACTS to verify that there is no APS/CPS history;
- c) Check of the Nurse Aid Abuse Registry (OHFLAC) to ensure that there is no history of abuse/neglect while employed as a CNA;
- d) Interview by the Department's homefinder; and,
- e) Approval by the Department.

The use of volunteers in the AFC Home must again be discussed with the provider at the scheduled reviews as appropriate.

5.14 Ongoing Training Requirements

All providers, (excluding respite providers) must participate in at least eight (8) hours of ongoing training annually and of which, four (4) hours must be face to face with the homefinder. The homefinder must provide on-going training

to address abuse and neglect allegations in that face to face training. The provider can receive two (2) hours of ongoing training each quarter, and each homefinder is responsible for the development and implementation of the ongoing training for providers. It is recommended that other community agencies be involved in providing this training as appropriate (i.e., mental health centers, health departments, senior centers, etc.).

The following topics may be included as the basis of an ongoing training curriculum:

- a) Nutrition;
- b) First Aid;
- c) CPR;
- d) Safety in the home;
- e) Basic health care;
- f) Medication;
- g) Behavior management;
- h) Meal planning and budgeting;
- i) Fire prevention and safety;
- j) Client activities, recreational and therapeutic;
- k) Sanitation;
- l) Utilizing community resources;
- m) Use of volunteers;
- n) Topics to address specific needs/concerns; and,
- o) Topics of interest identified by the DHHR staff or the provider.

Providers who participate in more than the required two (2) hours of ongoing training per quarter may be eligible to receive a training incentive payment. (See [Demand Payments](#) for detailed information).

Respite providers are not required to participate in training, but are to be encouraged to participate. Respite providers are NOT eligible for the training incentive payment.

5.15 Payment by the Bureau for Children and Families

Providers of Adult Family Care services may receive reimbursement from the Department in one (1) of two (2) ways, automatic payment and demand payment. Reimbursement to the provider for the care and supervision furnished to the client will be done by automatic payment. Demand payments are available for a very limited and specific set of expenses that may occur in an Adult Family Care setting. Payment for respite care is accomplished via a demand payment.

The provider may opt to receive their payment via the EFT method as opposed to the paper check method. (Detailed information may be found at the State Auditor's web site at www.wvsao.gov). The provider may also enroll in FACTS PLUS so they can view secure information about payment details and the individuals they serve. (Detailed information may be found at www.wvfacts.org).

If an overpayment is received by the provider regardless of whether it is social worker, homefinder or provider error, the Adult Service social worker must notify the provider in writing of the overpayment amount and the month(s) the overpayment(s) covers. If the overpayment is client specific, the social worker must pursue repayment. If the overpayment is provider specific, the repayment must be pursued by the homefinder. The provider must negotiate an agreement with the Adult Service social worker to repay either in a lump sum payment or monthly payments. The time frame for the repayment will usually be within thirty (30) days; however, the Adult Service social worker may grant additional time.

After all reasonable attempts, if the provider does not agree to repay or defaults on monthly payments, if the repayment agreement was negotiated by the social worker, the social worker must contact the homefinder to consider Corrective Action. If the homefinder negotiated the repayment agreement, the homefinder must consider Corrective Action and/or closure of the home.

5.16 Determination of Rate of Payment

Determination of the rate of payment due to an Adult Family Care provider is done automatically by FACTS and is based on a variety of client information entered in the system by the social worker. Key areas used in calculating the rate of payment include employment information including sheltered employment, income and asset information, and debts and expense information. Complete and accurate documentation in each of these areas is essential in determining the rate of payment. This calculation must be completed before the Payment Agreement can be created.

5.16.1 Personal Expense Allowance

The personal expense allowance is the amount a client placed in an Adult Family Care home is permitted to retain from the total income they receive in order to meet their personal expenses. The amount of the personal expense allowance is established by the Bureau for Children and Families and may be adjusted periodically. All clients placed by the Department in an Adult Family Care Home shall receive the full personal expense allowance amount each month or have this amount readily available for their use. An exception to this would be when the client enters placement after the first day of the month. In this situation, the personal expense allowance is to be pro-rated. When the client moves from one provider to another provider in the middle of the month, any personal expense allowance remaining must be given either to the client or the new provider, if the new provider is going to handle the client's personal expense allowance.

Whenever the provider has responsibility for managing the client's funds (i.e., representative payee or handling the client's personal expense allowance) the provider must maintain a record of funds received and expenditures made on the client's behalf.

The client may use his/her personal expense allowance to purchase any item(s) they choose so long as the purchases do not conflict with established house rules or regulations applicable to operation as an Adult Family Care Home. The allowance must be available to the client and used as he/she desires.

The personal expense allowance shall NOT be used to obtain basic necessities such as food, clothing, shelter costs, medication, transportation, or medical care unless it is the desire of the client to do so.

Examples of items that **may** be purchased:

- a) Tobacco products;
- b) Hair styling/permanents;
- c) Hair spray, cologne, aftershave;
- d) Extra clothing;
- e) Jewelry;
- f) Radio or television;
- g) Games, books and other recreational items of interest to the client;
- h) Postage stamps and stationary;
- i) Long distance telephone calls;
- j) Cosmetics;
- k) Pre-need burial trust fund; and,
- l) Hair care above and beyond the basic care that must be provided to maintain cleanliness and neatness of the client's hair.

Examples of items that **may not** be purchased:

- a) Basic personal hygiene articles (toothbrush, toothpaste, soap, deodorant, towels, wash cloths, etc.);
- b) Regular hair cut (applies to all clients, male and female);
- c) Basic recreational needs;
- d) Medications, including over the counter drugs prescribed by the client's physician; and,
- e) Co-pay on client's medication.

5.16.2 Sheltered Employment Income

Adults who have been placed in an Adult Family Care setting by the Department who receive income for sheltered employment are entitled to keep a portion of their income from this source. The adult is permitted to keep up to \$65.00 of their net income earned from this source. Individuals who receive \$65.00 or less per month from this source are entitled to keep the full amount earned while those who earn more than \$65.00 from this source are permitted to keep \$65.00 and the balance is to be applied to their monthly payment to their Adult Family Care provider.

Sheltered employment income is included in determining the amount of payment due from the Department and from the client, since the amount of sheltered employment income will vary monthly, a new payment agreement must be developed each month. The client's social worker must complete documentation in FACTS indicating sheltered workshop wages as the income type. Thereafter, on a monthly basis the social worker must update the amount of income received from this source. The amount entered is to be the full amount of monthly earnings from this source for the preceding month. FACTS will calculate payment amounts and disregard the appropriate amount up to the maximum allowed \$65.00.

Note: See Adult Family Care Request to Receive Services for detailed information about Sheltered Employment Income.

5.17 Payment Agreement

When placing a client in an Adult Family Care Home a supplemental payment by DHHR will NOT be made if there is any source available that will pay for the client's cost of care up to the current State rate. DHHR will supplement the cost of care as a last resort. (Refer to [Determination of Rate of Payment](#) for additional information).

If the client receives services from Title XIX Waiver program, the client is not eligible for a Supplemental Adult Family Care payment and the client's AFC case may be closed. In addition, the Adult Family Care Home must be evaluated for closure. If the Adult Family Care Home provider is certified as a Title XIX Waiver provider or employed as a Personal Care provider, the provider must decide if they want to continue being a provider with that program or if they want to be a provider through the AFC program. If the decision is to continue as a provider with the Title XIX Waiver program or as a Personal Care provider, the AFC Provider Record must be closed in FACTS. If the client receives services from any other agency that provides supervision or care for the client, this must be evaluated to determine if the client remains eligible to receive a supplemental payment from DHHR or remains eligible for AFC placement.

Immediately following placement of a client in an Adult Family Care Home, an agreement outlining the terms of payment to the provider must be completed. In no instance may completion of the Payment Agreement exceed five (5) working

days following placement of the client in the Adult Family Care Home. Once created and signed by all parties, this document is a legally binding agreement between the client, the provider, and the Department. It identifies all parties to the agreement and sets forth the terms and the amount of payment due to the provider and payable by the client and/or the Department. Specifically:

- a) The total monthly rate of payment due to the provider for a full month of care;
- b) The total daily rate due to the provider for a partial month's care;
- c) The portion of the monthly payment which is to be paid by the client for a full month of care;
- d) The portion of the daily rate that is to be paid by the client for a partial month's care;
- e) The portion of the monthly payment, if any, which is to be paid by the Department for a full month of care;
- f) The portion of the daily rate, if any, that is to be paid by the Department for a partial month's care; and,
- g) The amount, if any, the provider must furnish the client for their personal expense allowance.

The Payment Agreement also identifies the date on which the agreement becomes effective. Payment to the Adult Family Care provider will be an automatic payment and will be based on the amounts set forth in the Payment Agreement.

The Payment Agreement is created by FACTS based on a variety of information entered in FACTS by the social worker. Specifically, information from the following areas of FACTS is used in creating the Payment Agreement: 1) financial, 2) debt/expenses and 3) employment.

Therefore, it is essential that documentation in these areas is complete and accurate prior to creation of the Payment Agreement.

Based on information entered in these areas of FACTS, the appropriate amounts will be entered on the Payment Agreement when the document is printed. Upon completion of all documentation, the social worker must submit the payment agreement to the supervisor for review and approval. Prior to granting approval, the supervisor must review all the areas indicated above.

Entry or update of payment information and supervisory approval must be completed in a timely manner in order to avoid delay in payment to the provider. Due dates for entry of information necessary for creation of the payment agreement is as follows:

- a) For initial agreements (first time placement) information must be entered

and approved by the end of the business day on the third (3rd) working day of the month;

- b) For current agreements that are being terminated (i.e., discharge from the home) information must be entered and approved by the close of business on the last day of the month in which the change occurred; and,
- c) For situations that are to be updated effective on a future date (i.e., SSI increase becomes effective on the first (1st) day of following month) information must be entered and approved after the fifth (5th) working day of the month in which the change becomes effective but before noon on the last day of that month. For example, if the change in income becomes effective January 1st, the case information must be updated between the fifth (5th) working day of January and noon on January 31st.

Information must be entered and/or updated as outlined in order to prevent inaccurate or delayed automatic payment. Payment information that is not entered and approved by the specified date may require a demand payment for the purpose of doing a payment adjustment/correction.

Once the supervisor approves the payment agreement, the client's social worker must print the agreement. They must then check the printed document for accuracy. Finally, the client's social worker must review the Payment Agreement with the client and the provider and obtain the necessary signatures. The signed copy of the Payment Agreement is to be filed in the paper record with a notation made in Document Tracking. (See Adult Family Care Request to Receive Services for additional information).

Note: The Payment Agreement is available as a DDE in the reports area of FACTS. The per diem rate entered in certain sections of the payment agreement, are based on the following formula: (monthly rate x 12 months) 365 days = daily rate. Payment is made for the date of placement but payment IS NOT made for the date of discharge.

The Payment Agreement must be reviewed as part of the six (6) month client case review process. In addition, whenever there is a change in the client's needs or financial situation, the Payment Agreement must be reviewed. A new Payment Agreement must be completed any time this review reveals that there is a change in the resources available to the client to contribute to their cost of care.

5.18 Bed Hold

It is recognized that there will be times when it is necessary for the client to be absent from the Adult Family Care Home. In certain circumstances payments to the provider may continue uninterrupted.

These include absences from the home due to client inpatient hospitalization, provider respite and client social activities.

Specific time frames apply to each. There may be instances where an extension of established time frames may be required. In this event, the client's social worker must request a policy exception. It must be done through FACTS and must include thorough documentation and justification for the extension of the bed hold.

5.18.1 Medical

A bed may be held for a resident for up to fourteen (14) days per episode when it is necessary for the client to be absent from the home for inpatient hospitalization. Payment at the established rate will continue for up to fourteen (14) days, or until such time it is determined that the client will not be returning to the home not to exceed the fourteen (14) day limit. Payment by the Department and/or the client will continue in accordance with the terms of the Payment Agreement in effect. If it is determined that the resident will not be returning to the home, the client's social worker must end date the Payment Agreement and advise the provider.

5.18.2 Respite

An Adult Family Care provider is entitled to use up to seven (7) days of respite care per calendar year. During the seven (7) days the Adult Family Care provider will continue to receive the regular Adult Family Care payment uninterrupted. (See section on [Respite Care](#) under [Case Management](#) and [Demand Payments](#) for additional details).

5.18.3 Social

Providers are to encourage residents to engage in appropriate social and recreational activities. Examples include: natural family visitation, natural family vacations, specialized camps, overnight field trips, etc. A client may be absent from the home for these types of events for up to fourteen (14) days per calendar year. During the resident's absence the Adult Family Care provider will continue to receive payments uninterrupted.

Recreational and social activities must be reflected in the client's Service Plan. All overnight absences for this purpose must be approved in advance by the client's social worker.

5.19 Automatic Payments

The primary method used to make payment to AFC providers will be the automatic payment process. Specifically, payment to the provider for the care of each individual placed in their home is automatically created by FACTS and mailed or electronically transferred to the provider on a monthly basis. The amount of payment the provider will receive is based on information entered in FACTS regarding the provider and the client. Information that is taken into

Consideration by FACTS in generating the monthly automatic payment is as follows:

- a) Type of placement;
- b) Client's personal expense allowance;
- c) Client benefit income;
- d) Client employment income;
- e) Client sheltered employment income;
- f) Client assets; and,
- g) Client monthly expenses (in certain circumstances).

Based on all of these various pieces of information, FACTS will calculate the total rate of payment due to the provider.

In order to assure that payments to the provider are accurate and received by the provider without delay, it is essential that the social worker enter the required information in a timely manner. Due dates for entry of information necessary for creation of the payment agreement is as follows:

- a) For initial agreements (first time placement) information must be entered and approved by the end of the third (3rd) working day of the month following the month of placement;
- b) For current agreements that are being terminated (i.e., discharge from the home) information must be entered and approved by the close of business on the last day of the month in which the change occurred; and,
- c) For situations that are to be updated effective on a future date (i.e., SSI increase becomes effective on the first (1st) day of following month) information must be entered and approved after the fifth (5th) working day of the month in which the change becomes effective but before noon on the last day of that month. For example, if the change in income becomes effective January 1st, the case information must be updated between the fifth (5th) working day of January and noon on January 31st.

Information must be entered and/or updated as outlined in order to prevent inaccurate or delayed automatic payment. Payment information that is not entered and approved by the specified date may require a demand payment for the purpose of doing a payment adjustment/correction. Finally, prior to noon on the fourth (4th) working day of the month following the service month the social worker must review the monthly payment approvals screens in FACTS in order to verify that the payment information in the system and due for release during the next payment cycle is accurate. If there are corrections needed, the social worker must make the necessary changes by noon on the fourth (4th) working day of the month. If no errors are detected, the social worker must verify the payment

shown.

5.20 Demand Payments

Most costs associated with the care of an adult placed in an Adult Family Care Home will be included in the monthly reimbursement paid to the provider by automatic payment. There are, however, certain specific costs that may be incurred that are not included in the monthly reimbursement. The demand payment process may be used to request reimbursement for certain costs incurred for/on behalf of clients placed in an Adult Family Care Home by the Department or for specific expenses incurred by the Adult Family Care Home provider that are not client specific. Payments that are made on behalf of a specific client (i.e., co-pays, durable medical, etc.) are to be entered by the client's social worker. Payments to the provider that are not client specific (i.e., training incentive payment) are to be entered by the homefinder.

In order to generate demand payments for clients placed in Adult Family Care, the vendor would have to be set up in FACTS and entered on the Service Log in FACTS. The need for a demand payment of any type must be determined jointly by the client's social worker, social worker's supervisor, and or homefinder (if applicable), and the provider prior to any cost being incurred and cost associated with the client must be reflected in the client's Service Plan. Some demand payment types require a two-tiered approval meaning they must first be approved by the supervisor and then must also be approved by a second party. If the demand payment requires a two-tiered approval in FACTS, the appropriate individual(s) responsible for approving /denying the two-tiered payment must be contacted for approval/denial prior to any cost being incurred. In addition, all potential resources must be thoroughly explored before requesting a demand payment. Examples include, but are not limited to, family members, community/civic organizations, churches, drug company program assistance programs, samples from physicians, mental health agencies, health right clinics, etc. Efforts to locate alternate resources must be documented in FACTS.

Those payment types that require a two-tiered approval are marked with an (*) in the list below. When one of these types is to be used approvals must be obtained before services are provided. This approval must be requested by completion of the Demand Payment Screens in FACTS. In addition, the social worker must document justification/explanation for payment in FACTS in the Comments Text Box on the Demand Payment Screen. (See Documentation Requirements for the specific demand payment type being requested).The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. Only the following demand payment types are permitted.

Supervisory approval only:

- a) Respite care;

- b) Trial visit (when client does not have resources to pay this cost);
- c) Payment adjustment (to correct underpayment to provider);
- d) Specialized AFC payment (applies only to existing AFC providers of this type);
- e) Clothing allowance;
- f) Educational expenses for special education students;
- g) Annual client medical evaluation;
- h) Co-payment on prescription medications;
- i) Provider training incentive payment (not client specific); and,
- j) Provider medical report (not client specific).

Two tiered approval required:

- a) *Durable medical equipment and supplies;
- b) *Non-Medicaid covered services;
- c) *Food supplements;
- d) *Over-the-counter drugs/DESI drugs or prescriptions not covered by insurance/Medicaid;
- e) *\$1,000 incentive payment to provider for their efforts in clients return home; and,
- f) *Other demand payments.

Demand payments are done on a weekly basis, based on information entered in FACTS by the social worker/homefinder, including an explanation of why the payment is necessary.

When a demand payment is needed, the social worker/homefinder must enter the required information in FACTS. The payment information must then be forwarded to the supervisor for approval. Demand payments require supervisory approval. For certain demand payment types, approval by a second party is also required in addition to the supervisory approval.

Finally, after the required approval(s) is granted, the social worker/homefinder must review the payment on the Demand Payment Verification screen by the established deadline to ensure that the amount to be paid to the provider is accurate. If the payment is accurate, verify the payment. If not, identify and resolve the problem(s).

5.20.1 Respite Care

An Adult Family Care provider is entitled to use up to seven (7) days of respite care per calendar year. During these seven (7) days, the Adult Family Care

provider will continue to receive the regular AFC payment uninterrupted. To request payment to an approved respite care provider during this seven (7) day period, the social worker is to complete a demand payment, after the respite provider has submitted an invoice. Payment by the Department to the respite care provider shall not exceed seven (7) days. In the event respite care would need to continue beyond the allowed seven (7) days, the social worker must request a policy exception in order for payment to the regular provider to continue. The payment to the respite provider beyond seven (7) days is the responsibility of the regular AFC provider. Payment for respite care by the Department is to be reimbursed at the current per diem rate for the Adult Family Care client. (See [Case Management - Respite Care](#) in this policy for detailed information about respite care).

5.20.2 Trial Visit

If a client who is currently an active Adult Services client is planning to move to another home or a different type of setting, a trial placement is recommended to assure a good match between the prospective provider and the client. If an overnight stay is planned as part of a trial visit, the Department may reimburse the prospective provider. In order to generate this type of demand payment, the provider would have to be set up in FACTS and the trial placement reflected on the Service Log in FACTS. The current provider will continue to receive payment, with the trial visit provider being paid for the number of days for the trial visit. If the client is being discharged from an institutional setting or coming from the community and is not an active Adult Services client at the time of the trial visit, the client must be encouraged to use his/her resources to make payment to the prospective provider. If it is determined that the client does not have resources to pay the provider for the trial visit, the client's social worker is to request that payment to the provider be made by the Department as a demand payment. Reimbursement made by the Department for a trial visit is to be at the current daily rate for the type of provider involved in the trial visit. The social worker shall request payment for the days the client is in the trial home (i.e., if the client goes to trial home visit on Friday at 6:00 p.m. and comes back on Sunday at 12:00 p.m. the provider will be paid for three (3) full days.

5.20.3 Payment Adjustment

This demand payment type is to be used for the purpose of correcting an under payment to an Adult Family Care provider. As an example, an under payment may occur when the social worker is unable to complete the placement process, including all applicable documentation in FACTS, prior to the deadline for entering payment/placement information. A payment adjustment may be requested to reimburse the provider for any unpaid portion due.

5.20.4 Specialized AFC Payment

This demand payment type applies only to payments made to existing

Specialized Adult Family Care providers (Lewis County). The rate of payment for this type of provider is different from the rate of payment for a regular AFC Home, therefore, this demand payment type is to be used to reimburse Specialized AFC providers for the balance of payment due each month.

5.20.5 Clothing allowance

Clients who are placed in residential settings by the Department are to have adequate clothing. A clothing allowance is available for adults who are placed in a residential setting by the Department and for whom the Department is making a supplemental payment. Individuals who are in the home for whom the Department is not making a supplemental payment **ARE NOT** eligible for clothing allowance from the Department. The clothing allowance is available at the time of placement and on six (6) months intervals throughout the placement. Requirements related to the use a clothing allowance include the following:

- a) Must be based on the client's need for clothing;
- b) Placement allowance cannot exceed \$100 (one time only life time at the initial placement in an adult residential placement);
- c) Re-placement allowance cannot exceed \$75 during a six (6) month period;
- d) Need for placement or re-placement clothing must be planned in advance of purchase by the provider and the client's social worker; and,
- e) To receive reimbursement by the Department, the residential service provider must submit an itemized invoice for the clothing purchased (See Clothing Allowance, in the Request to Receive Services Policy for detailed information).

5.20.6 Educational Expenses for Special Education Students

Adults who are enrolled in special education programming may incur costs associated with their educational program. In order for the Department to reimburse the provider for these costs, the adult must be enrolled on a full-time basis in an educational program. In addition, the costs for which reimbursement is requested must not be reimbursable by any other source and must be related to enhancing or completing their educational program. Examples of costs that may be reimbursable include graduation fees and reasonable special fees for school trips/functions.

5.20.7 Annual Client Medical Evaluation

Each client placed by the Department in an Adult Family Care Home must receive an annual medical examination. The Adult Family Care provider is to arrange for this examination to be completed. If the Department is going to reimburse for this, the cost cannot not exceed Medicaid rates. A demand payment for this type of expense may be handled in one of two ways: 1) The Adult Family Care provider pays the costs, on the client's behalf, and submits all

receipts documenting the expense of the service to request reimbursement from the Department, and 2) The vendor of service provides the service and submits an invoice to the Department requesting payment. The client's social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. If the client has medical coverage, the cost for the exam must be billed to the medical provider.

5.20.8 Co-Payment on Prescription Medications

The cost required for medication co-payments may be reimbursed for adults who have been placed in an Adult Family Care Home by the Department and for whom the Department is making a supplemental payment. Reimbursement by the Department may only be considered after it has been determined by the client's social worker that there is no other personal or community resource that can meet this need. In addition, the medications to which the co-payment applies and for which payment is requested must:

- a) Be prescribed by the adult's physician;
- b) Be identified on the medications screen in FACTS;
- c) Meet an identified need on the adult's service plan; and,
- d) Be necessary to prevent the need for a higher level of care;

A demand payment for this type of expense may be handled in one of two ways. 1) The Adult Family Care provider pays the costs, on the clients behalf, and submits all receipts documenting the expense of the service to request reimbursement from the Department. 2) The vendor of service provides the medications and submits an invoice to the Department requesting payment for the co-payment. The social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. If this is an ongoing expense and the monthly amount is stable, the social worker may request a resource deduction to meet the cost.

5.20.9 Provider Training Incentive Payment

Adult Family Care providers who are currently receiving a supplemental payment for a client(s) placed in their home by the Department are entitled to receive reimbursement for approved training they receive. This reimbursement is offered as an incentive to encourage providers to participate in relevant training opportunities to enhance their skills and knowledge as Adult Family Care providers. Training that would be acceptable in order to qualify for this payment

would include training provided by the Department or training that is furnished by another agency/entity that has been approved **IN ADVANCE** by the Department.

Adult Family Care providers are required to attend a minimum of two (2) hours of training per quarter. However, in order to be eligible to receive this training allowance, the provider must attend a minimum of six (6) hours of approved training during the quarter for which reimbursement is being requested. The two (2) hours of required training may be included in the total hours required for the incentive payment. The quarters to be used for determining this allowance are based on the calendar year. Specifically, the quarters to be used are January - March; April - June; July - September; and October - December. Upon completion of the required hours of approved training, the provider may request payment of the training allowance by the Department. Verification of attendance of the approved training must be submitted at the time reimbursement is being requested. Without verification that training was attended, payment shall not be made.

Upon receipt of the required verification of attendance of at least six (6) hours of approved training during the quarter, the homefinder may then prepare a request for a demand payment in the amount of \$25.00. Upon completion of the demand payment request, the homefinder must forward the request to the supervisor for approval. The verification of attendance must be entered in Document Tracking and filed in the provider's paper record.

Note: The training allowance cannot be pro-rated. If a full six (6) hours of training is not completed within the quarter, the provider is not eligible for this payment. Also this demand payment type is not to be used for required training materials. Instead the "other demand payment" type is to be used. Respite providers are not eligible for the training incentive payment.

5.20.10 Provider Medical Report

After an Adult Family Care Home is approved, the person(s) in the household who is primarily responsible for furnishing care to the clients placed in the home is required to have a medical evaluation completed at a minimum of every three (3) years; however, the homefinder has the flexibility of requesting an updated medical prior to the expiration of the three (3) year time frame, if they question the provider's ability to care for the incapacitated adult(s). The purpose of this evaluation is to ensure that the person(s) who has responsibility for providing care remains in good health and able to provide the necessary care and support to adults placed in their home.

The provider is to arrange for completion of the medical report with their physician. When arranging for completion of this evaluation, providers are to be encouraged to request that their physician complete this evaluation during a regularly scheduled medical appointment whenever possible.

If the provider has no other resources or insurance to pay for the medical report,

they may request reimbursement by the Department for this expense. To request reimbursement, the provider must submit a receipt, along with the completed medical report, to the Department and indicate that reimbursement is being requested. Reimbursement for completion of the medical report by the physician may not exceed the current Medicaid rate for a medical report.

A demand payment for this type of expense may be handled in one of two ways. 1) The Adult Family Care provider pays the costs and submits all receipts documenting the expense of the service to request reimbursement from the Department. 2) The vendor of service provides the service and submits an invoice to the Department requesting payment. The homefinder must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. Upon completion of the demand payment request, the homefinder must forward the request to the supervisor for approval. The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

If the homefinder feels a medical statement is warranted for respite provider and requests an updated medical statement, the respite provider may request reimbursement by the Department for this expense if the respite provider does not have sufficient resources or insurance to pay for it. To request reimbursement, the steps outlined above for this type of demand payment are to be followed.

Note: If the homefinder has concerns with a provider's capacity to fulfill their duties, the homefinder may request that a psychological/physical evaluation be done on the provider. A demand payment may be requested for the payment. The psychological/physical evaluation must be paid at the current Medicaid rate.

5.20.11 Durable Medical Equipment and Supplies

In certain situations the cost of obtaining durable medical equipment or supplies may be reimbursed for adults who have been placed in an Adult Family Care Home by the Department and for whom the Department is making a supplemental payment. Reimbursement by the Department may only be considered after it has been determined by the client's social worker that there is no other personal or community resource that can meet this need. In addition, the durable medical equipment/supplies for which payment is requested must:

- a) Be prescribed by the adult's physician (written statement must be filed in the client's paper record);
- b) Meet an identified need on the adult's Service Plan;
- c) Be necessary to prevent the need for a higher level of care;
- d) Be a one (1) time only expense rather than a reoccurring cost; and,
- e) Not exceed the current Medicaid rate.

A demand payment for this type of expense may be handled in one of two ways. 1) The Adult Family Care provider pays the costs, on the client's behalf, and submits all receipts documenting the expense of the service to request reimbursement from the Department. 2) The vendor of service provides the equipment/supplies and submits an invoice to the Department requesting payment. The client's social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. This demand payment type requires approval by the appropriate party in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. If this is an ongoing expense, the social worker may request a resource deduction to meet the cost.

5.20.12 Non-Medicaid Covered Services

Clients placed in Adult Family Care by the Department may, at times, incur expenses that are medically necessary but are not reimbursable by Medicaid. Reimbursement by the Department for these costs may only be considered after it has been determined by the client's social worker that there is no other personal or community resource that can meet this need. In addition, the services for which payment is requested must:

- a) Be recommended/authorized by the adult's medical/mental health professional;
- b) Health professional (written statement of need required);
- c) Meet an identified need on the adult's service plan; and,
- d) Be necessary to prevent the need for a higher level of care.

A demand payment for this type of expense may be handled in one of two ways. 1) The Adult Family Care provider pays the costs, on the client's behalf, and submits all receipts documenting the expense of the service to request reimbursement from the Department. 2) The vendor of service provides the equipment/supplies and submits an invoice to the Department requesting payment. The client's social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. This demand payment type requires approval by the appropriate party in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. If this is an ongoing expense, the social worker may request a resource deduction to meet the cost.

5.20.13 Food Supplements

In unique situations, food supplements may be required by an adult placed by the Department in an Adult Family Care Home in order to maintain sound nutritional status. In certain situations the cost of obtaining these food supplements may be reimbursed by the Department. Reimbursement by the Department may only be considered after it has been determined by the client's social worker that there is no other personal or community resource that can meet this need. In addition, the food supplements for which payment is requested must:

- a) Have been deemed medically necessary by the adult's physician (written statement of need required);
- b) Meet an identified need on the adult's service plan; and,
- c) Be necessary to prevent the need for a higher level of care.
- d) A demand payment for this type of expense may be handled in one of two ways. 1) The Adult Family Care provider pays the costs, on the client's behalf, and submits all receipts documenting the expense of the service to request reimbursement from the Department. 2) The vendor of service provides the supplies and submits an invoice to the Department requesting payment. The client's social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. This demand payment type requires approval by the appropriate party in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. If this is an ongoing expense, the social worker may request a resource deduction to meet the cost.

5.20.14 Over-the-Counter Drugs/DESI Drugs or RX Not Covered

In certain situations medications may be required by an adult placed by the Department in an Adult Family Care Home that are not covered by Medicaid or other insurance. These include items such as over-the-counter medications, DESI drugs, or other prescription medications that are medically necessary but not covered by insurance. The cost of these medications may be reimbursed by the Department. Reimbursement by the Department may only be considered after it has been determined by the social worker that there is no other personal or community resource that can meet this need. In addition, the medications for which payment is requested must:

- a) Have been deemed medically necessary by the adult's physician (written statement of need required);
- b) Meet an identified need on the adult's service plan; and,

- c) Be necessary to prevent the need for a higher level of care.

A demand payment for this type of expense may be handled in one of two ways. 1) The Adult Family Care provider pays the costs, on the client's behalf, and submits all receipts documenting the expense of the service to request reimbursement from the Department. 2) The vendor of service provides the supplies and submits an invoice to the Department requesting payment. The client's social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the client's social worker must forward the request to the supervisor for approval.

This demand payment type requires approval by the appropriate party in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. If this is an ongoing expense, the social worker may request a resource deduction to meet the cost.

5.20.15 \$1,000 Incentive Payment

The intent of this incentive payment is to reward a provider who has been primarily responsible for a client improving to the point that they no longer require Adult Family Care services and consequently can return to their own home to live. This payment is not intended to provide additional compensation for providers who have provided short term care to clients with short term needs.

To qualify for this payment, a provider must be nominated by the client's social worker. When a client is first identified as a possible candidate for independent living, the social worker will need to consult with their supervisor. If it is agreed that the provider is a potential nominee, the social worker is to notify the Bureau for Children and Families of their intention to proceed. In order for a provider to be considered for nomination to receive this incentive payment, all the following criteria must be met:

- a) The client must have been income eligible and the provider having received a monthly supplemental payment from the Department for the service they rendered (private pay clients are not to be considered);
- b) The provider must have provided full time care to the client for a minimum of twelve (12) consecutive months;
- c) A multi-disciplinary team, such as a Community Planning Team (CPT) used with Guardianship cases, must have been involved in the establishment of the goal of independent living and the development/monitoring of the Service Plan that was implemented;
- d) Independent living must have been the planned objective on the client's Service Plan and progress toward the achievement of this goal must be well documented in the six (6) month case review;

- e) The provider must have been assigned, as part of the Service Plan, key/measurable tasks toward the achievement of the client's goal of independent living;
- f) The social worker must be able to demonstrate the client's return to the level of independence was primarily due to the efforts of the provider;
- g) An after care plan must be in place to identify the tasks to be accomplished, and by whom, during the six (6) month period the client is living in their own home; and,
- h) Once the client has returned to their home, they must remain there independently for at least six (6) months before the bonus can be given.

Close communication between the local staff and the Bureau for Children and Families is encouraged throughout this very involved procedure. An appropriate Service Plan must be developed with the goal of independent living and the specific tasks assigned to the provider in accomplishing this goal clearly identified. Regular monitoring of the progress being made by the client toward the achievement of the established goal of independent living is to be documented by the social worker. Upon completion of the six (6) month case review, an update regarding the status of progress must be forwarded to the Bureau for Children and Families. If, supportive services are required once the client goes home, an After Care Plan must be developed to identify what services are to be provided and who will be responsible for the provision of those services. The client's social worker must continue to provide Case Management services for at least six (6) months after the client's return to independent living. Follow-up during this period of time must include, at a minimum, monthly monitoring visits. If more frequent monitoring is required, this must be evaluated carefully as it may be an indication that the case may not be stable and the client may need to return to a more supportive type of setting.

Note: Placement in the AFC Home is to be end dated when discharge occurs. However, the Adult Residential Services case is to remain open until the end of the After Care period and the incentive payment has been made.

If, at the end of the six (6) month After Care period the client is able to continue to live independently, the client's worker must prepare a request for payment of the \$1000.00 provider bonus. Upon completion, the request must be submitted to the supervisor for approval. At a minimum, the request must include the following:

- a) The date the client went into placement with the provider; and,
- b) Adequate documentation/justification to support the provider's eligibility to receive the bonus, based upon each of the criteria listed above.

If the supervisor concurs with the worker's recommendation that the provider is eligible to receive this special compensation, the request is then to be forwarded

to the Bureau for Children and Families for consideration and approval. Once approval of both the supervisor and the Bureau for Children and Families has been obtained, a demand payment may be issued by the Department. In addition to the payment, the local office is encouraged to send a Letter of Commendation to the provider recognizing them for their efforts.

5.20.16 Other Demand Payment - Not Specified

In certain situations the cost of obtaining needed supplies or services may be reimbursed for the provider or for adults who have been placed in an Adult Family Care Home by the Department and for whom the Department is making a supplemental payment. Reimbursement by the Department may only be considered after it has been determined by the client's social worker/homefinder that there is no other personal or community resource that can meet this need. In order for the Department to reimburse the provider for these costs, the provider must submit receipts for the costs incurred. This demand payment type requires approval by the Bureau for Children and Families in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

5.21 Special Medical Authorization

Most clients who are placed in an Adult Family Care will be eligible for Medicaid or some other type of medical insurance to cover the cost of needed medical care. If a client currently receives Medicaid, the Special Medical Card must not be issued. The coverage for Medicaid and the Special Medical card are identical. If the client does not have coverage for necessary medical care, the social worker must thoroughly explore all potential options for securing appropriate medical coverage.

Examples include, but are not limited to, community/civic organizations, family members, churches, Medicare Part D, drug company assistance programs, samples from physicians, mental health agencies, health right clinics, etc. If, after this exploration, the client does not have the resources to pay for needed medical care, use of the Special Medical Authorization may be requested to pay for specific medical expenses. For clients that are eligible for Medicare, the Special Medical card will not cover any prescriptions that are covered under Medicare Part D, regardless of whether the client is enrolled in Medicare Part D or not; therefore, the Special Medical card must not be issued for any prescriptions covered by Medicare Part D for individuals eligible for Medicare. Eligibility for Medicare Part D is based upon the following:

The individual must be receiving either Medicare part A or B. To be eligible for either Medicare Part A or B, the individual must be sixty-five (65) years of age OR, if under sixty-five (65) years of age, the individual must be receiving disability Social Security benefits and must have been receiving disability Social Security benefits for two (2) years.

Lack of resources means that:

- a) The client does not have funds to pay for medical care;
- b) No other resources are available, such as family, friends, community/civic organizations, etc.;
- c) Is not eligible for any type of medical coverage; and,
- d) Is eligible for medical coverage but benefits are not currently available (recent application - not yet approved for coverage), with the exclusion of Medicare Part D.

(Refer to [Case Management Activities](#) section for additional information).

Regardless of the reason(s) resources are not available, use of the Special Medical Authorization may only be used to meet an emergent need or to prevent an emergency from occurring. When this is the case, the social worker may request use of the Special Medical Authorization to cover the cost of certain medical care or services. The Special Medical Authorization may only be issued for a period of up to six (6) months. At the end of the approved eligibility period, if continuation of services is necessary, a new authorization must be requested.

Note: In a situation where a client needs services from more than one vendor (i.e., an office visit with a physician and prescriptions from a pharmacy) a separate Special Medical Authorization request will be required for each vendor, with the appropriate eligibility period for each authorization. (Refer to [Case Management Activities](#) section for additional information).

5.21.1 Allowable Costs

Special Medical Authorization is available for use by adults placed by the Department in Adult Family Care in very limited situations. This authorization may only be used when all the following conditions exist:

- a) The client is currently a resident in an Adult Family Care Home;
- b) The client was placed by the Department or was placed by another party but the placement was approved by the Department;
- c) The treatment, service, or certain supplies for which authorization is being requested is deemed medically necessary by the client's physician;
- d) The medical treatment, service or certain supplies are needed to remedy an emergency medical situation or to prevent a medical emergency from developing; and,
- e) The Department is making a supplemental payment to the Adult Family Care (except for private pay clients that have approval of a policy exception for the Special Medical Card).

The Special Medical Authorization may be used to cover certain medical costs

however; all Medicaid eligible services are not necessarily covered by this authorization. The Special Medical card will not cover any prescription that is not on the Medicaid Drug Formulary. In addition if the client is in a category that should be eligible for Medicare Part D, the Special Medical card will not cover any prescription costs that are covered by Medicare Part D. Therefore the Special Medical card must not be issued for individuals in this category. The Special Medical Authorization is to be used to provide for medical care needed to treat an emergency or to prevent a medical emergency from occurring (limited to prescriptions and limited doctor visits).

Examples of costs that are typically covered:

- a) Medication (must be prescribed by a physician);
- b) Limited doctor visit;
- c) Pads/Chux only - 150/month;
- d) Adult disposable briefs only - 200/month; and,
- e) Combination of pads and adult disposable briefs - 250/month.

Examples of costs that are NOT covered (not all inclusive):

- a) Hospitalization;
- b) Nursing home placement;
- c) Psychiatric treatment;
- d) Behavioral health day treatment;
- e) Dental work;
- f) Glasses;
- g) Outpatient surgery; and,
- h) Diagnostic testing.

Note: The Special Medical Authorization may be used to cover costs; however, all Medicaid eligible services are not necessarily covered by this certain medical authorization (i.e., hospitalization IS NOT covered by the Special Medical Authorization; nor is Case Management services at behavioral health centers).

5.21.2 Required Procedures

If a client, who has been placed in an Adult Family Care Home by the Department, has no medical coverage, does not have the resources to pay for and is determined by their physician to be in need of medically necessary treatment or services, Special Medical Authorization may be requested to cover the cost. To request Special Medical Authorization, the social worker must complete the Special Medical Screen in FACTS. This request must be approved before a Special Medical Authorization can be generated by FACTS.

The approval process is slightly different dependent on whether or not the Department is making a supplemental payment for the Adult Family Care Home placement at the time of the request.

If the Department is making a supplemental payment for the Adult Family Care Home placement at the time of the request, the approval for use of a Special Medical Authorization must be done by the supervisor. If the Department is not making a supplemental payment for the AFC placement at the time of the request, the approval for use of a Special Medical Authorization requires a policy exception and approval by the supervisor and a second party.

When requesting a Special Medical Authorization the following information must be documented in FACTS:

- a) Client's goal related to providing the requested services;
- b) Explanation of how provision of the requested services will prevent movement the client to a higher level of care;
- c) List the specific service(s) payment is being requested for and associated cost (cannot exceed current Medicaid rate);
- d) Statement of verification that all potential resources have been explored and the amount of resources that will be paid through another source (if any) or that there are no other resources available to meet the cost;
- e) Anticipated duration of request;
- f) Name of provider;
- g) Income amount and source;
- h) Amount of supplemental payment being made by the Department; and,
- i) Any other relevant information.

In addition to the above information, private pay clients must be paying the current state rate and must not have any resources to pay for the medical need (this must be explored thoroughly and documented). A policy exception must be requested and approved by the local supervisor, as well as the second tier approval before the Special Medical card can be issued. If a private pay client has any excess income after paying current state rate to the Adult Family Care Home, minus the personal needs allowance this amount must be applied towards the cost of the medical need before using the Special Medical card. The social worker must verify and document each month that all excess income has been applied towards the cost of the medical need and that the client is not using the excess income for unapproved items. A policy exception is required prior to the excess income being used for something other than medical needs.

Much of the required documentation should be recorded on various screens within FACTS (i.e., medications should be recorded on the Medical Screens,

income should be documented on the Income Screens, etc.). In addition, any other required and/or supporting information to justify the need for a Special Medical Authorization that is not recorded elsewhere, must be documented in the Contact Screen.

5.21.3 If Approved

The social worker must print the Special Medical Authorization and review the printed document to ensure that all information is complete and accurate. The social worker then must furnish the vendor who will be providing the service with this authorization. The information about this authorization will be forwarded electronically from FACTS to the Bureau for Medical Services (generally will occur within five (5) days following the approval, because of this delay, the vendor will not be able to immediately call to verify authorization with the Bureau for Medical Services, the written authorization printed by the social worker is to provide verification of the approval). If at any time during the approval period, the authorized services are no longer required, the social worker must send written notification to the vendor advising them to discontinue provision of the authorized services.

5.21.4 If denied

The social worker may provide additional information and re-submit the request if the denial was based on insufficient information, otherwise the social worker must seek alternate resources to cover the services requested.

Note: Clozaril or an equivalent is covered by Medicare Part D. If the client is not eligible for Medicare Part D, Medicaid covers this for recipients of Medicaid. If the client is not currently receiving Medicaid and is not eligible for Medicare Part D, an application for Medicaid must be made through Income Maintenance as a potential resource. There is a Special Pharmacy Program for individuals who cannot meet a Medicaid spend down and who meet certain other criteria.

5.22 Clothing Allowance

5.22.1 Purpose

The purpose of providing a clothing allowance is to insure that all clients placed by the Department of Health and Human Resources, and for whom the Department is making a supplemental vendor payment, have adequate clothing while in placement. Provision of a clothing allowance is not to be considered an automatic payment. Rather, it is to be based upon the individual client's need for clothing. There are two (2) types of clothing allowance available for eligible adults: an initial placement allowance, and a re-placement clothing allowance. An assessment of the need for clothing is to be done by the social worker at the time of placement and again every six (6) months, during the case review process to determine if a clothing allowance will be needed.

5.22.2 Determination of Eligibility

Certain adults in residential settings are eligible to receive a clothing allowance. In order to be eligible for this allowance, the client must meet two (2) criteria. These are: 1) they must reside in an Adult Family Care

Home and 2) the Department must be making a supplemental payment to the residential placement provider for the client's care. Private pay clients in the home **ARE NOT** eligible for a clothing allowance from the Department.

5.22.3 Initial Placement Allowance

In order to insure that the adult has sufficient and adequate clothing at the time of the original placement, an initial placement clothing allowance may be requested. Eligibility for the initial placement allowance begins on the date of placement and ends on the day prior to the date of the six (6) month review or the date of discharge, whichever occurs first. A lifetime maximum of \$100 is available for the initial placement clothing allowance. It is not necessary to use the entire amount permitted at one time, however, purchases do need to be completed prior to the six (6) month case review following placement. Any unspent portion of the client's initial clothing allowance will be forfeited and may not be carried over to the following six (6) month period.

The initial placement allowance is available at the first placement of the adult in an adult residential placement and is a one (1) time only allowance. In the event the adult would move from one residential placement setting to another, the adult is not again eligible for an initial placement allowance. The discharging provider is to send the adult's clothing with them at the time of removal from their home. The social worker is to insure that this occurs and that the adult has adequate clothing when placed with the new provider. If clothing is needed, any balance remaining in the client's replacement clothing allowance for the six (6) month period may be used to purchase needed clothing.

5.22.4 Replacement Allowance

In order to insure that the adult has sufficient and adequate clothing throughout their placement, a replacement clothing allowance may be requested every six (6) months. Eligibility for a replacement clothing allowance begins on the date of the six (6) month review and ends on the day preceding the date of the next six (6) month review or upon discharge, whichever occurs first. A maximum of \$75 is available for each six (6) month period. It is not necessary to use the entire amount allowed at one time, however, purchases must be completed prior to the six (6) month case review. Any unspent portion of the client's clothing allowance will be forfeited and may not be carried over to the following six (6) month period.

5.22.5 Required Procedures

To request an initial or replacement clothing allowance for an eligible client, the AFC provider may contact the social worker or, the AFC provider and social worker may jointly identify this as a need during the placement or review process.

Payment of clothing allowance shall be by a demand payment to either the Adult Family Care provider, or directly to the vendor. When a clothing allowance is needed, the following must occur:

5.22.6 Reimbursement to the Adult Family Care Provider

- a) The Adult Family Care provider must purchase clothing. The adult must be encouraged to assist with selection and purchase of their clothing whenever possible;
- b) If the adult is unable to assist, the provider is to purchase the needed clothing for the adult, taking into consideration the adults wishes and preferences; and,
- c) The AFC provider must submit the itemized receipts to the Department's District Office for approval and reimbursement.

5.22.7 Payment to the Vendor

- a) The social worker must issue a completed BA-67 to the vendor. (This form is available in the Reports Area of FACTS and must be used within thirty (30) days of issuance.); and,
- b) Upon completion by the vendor, the BA-67 is to be submitted to the Department's District Office for approval and payment through FACTS.

5.22.8 The social worker must do the following:

- a) Verify the accuracy and completeness of the invoice/documentation;
- b) Complete a demand payment request, selecting the "clothing allowance" payment type;
- c) Forward the request to the supervisor for approval (payment will be processed upon supervisory approval);
- d) Retain a copy of all receipts and/or BA-67's in the client's case record with documentation in FACTS as to the location of this documentation; and,
- e) If a BA-67 has been used, after information to generate the demand payment has been entered in FACTS, mark the BA-67 VOID or PAID to prevent duplicate payment.

5.23 Record Keeping by Provider

Upon placement of the client in the home or shortly thereafter, information about the client and his/her needs is to be given to the provider by the social worker. The provider is to establish a file for each individual placed in their home and maintain all information about the client for reference as needed. Information that must be given to the provider by the social worker and maintained in the client file by the provider includes the following.

5.23.1 Client Information

- a) Identifying information about the client;
- b) Information about significant others such as family members, friends, legal representatives, etc.;
- c) Information about the client's interests, hobbies and church affiliation;
- d) Medical status including current medications, precautions, limitations, attending physician, hospital preference, allergies, special diet, etc.;
- e) Advance directive(s) in force; and,
- f) Information about client's burial wishes, plans and resources.

Note: The Client Information and Client Medical and Psychological reports may be used for this purpose. These reports are available as DDE's in FACTS and may be accessed through the Reports area of FACTS.

5.23.2 Client Documents

- a) Copy of the signed Resident Agreement for Participation;
- b) Copy of the current and all previous Payment Agreements; and,
- c) Copy of the current Service Plan.

All other information received by the provider that is specifically related to the client is to be maintained in the provider's client file. This information must be maintained in a confidential manner. This applies to information provided by the social worker as well as information from other sources.

5.24 Exception to Policy

In certain circumstances, exceptions to AFC Policy may be requested. Exceptions will be granted on an individual basis and only in situations where client/provider circumstances are sufficiently unusual to justify the exception. However, such exceptions are expected to be requested **ONLY** after other methods and/or resources have been exhausted. In that event, requests may be submitted in accordance with the following procedure:

- a) The homefinder's request shall be submitted for approval through FACTS. (This requires a two tier approval-approval by both the supervisor and the appropriate second party);
- b) The request shall include reference to the policy in question, the information supporting the request and, if appropriate, the time period for which the exception is to apply; and,
- c) In an emergency situation the request may be made verbally without having first submitted the request through FACTS. The request may be verbally approved but the worker must still submit the request to the

supervisor through FACTS by the end of the next working day for approval. The supervisor must approve the request within five (5) working days following verbal approval.

Note: A policy exception will be required to continue approval of an Adult Family Care Home that is not in compliance with current AFC standards at the time of the annual review.

SECTION 6

CASE REVIEW

6.1 Reasons for Closure of Adult Family Care Provider

Adult Family Care homes may be closed for a variety of reasons including, but not limited to: 1) substantiated adult protective service/children's protective service allegations, 2) provider's request, 3) failure to comply with program standards, and etc. Prior to closure of an Adult Family Care Home the homefinder must complete an annual review, unless it is an emergency closure.

When there appears to be an imminent threat to the life, health or safety of a client, immediate closure of the home and/or removal of the clients may be necessary. Emergency closure is limited to those circumstances in which immediate action must occur to ensure client safety. Examples of situations when emergency closure of the home and/or removal of a client(s) may occur but not limited to are:

- a) Death or hospitalization of the provider;
- b) Abuse, neglect or exploitation of a client requiring removal of all clients in the home,
- c) Damage to the Adult Family Care home due to fire, flood, etc.;
- d) Non-compliance with standards that are deemed dangerous to the health, life, or safety of the clients;
- e) Presence of a serious physical or mental illness which may impair or preclude adequate care of the client by the provider;
- f) Failure of the provider to cooperate with the terms of the Correction Action Plan and/or to correct existing situations identified in the Corrective Action Plan;
- g) Presence of a non-compliance issue or multiple issues, which cannot be alleviated by a Corrective Action Plan. Or, a non-compliance issue or multiple issues which are serious enough to not warrant a Corrective Action Plan;
- h) Any other acts or situations that place the adult client at risk or acts seen as a detriment to the client's safety and wellbeing; and,
- i) Failure of the provider to meet the training requirements.

Note: FACTS ID numbers are provider specific. When a provider no longer is the primary caretaker for the client and a family member or other individual takes over the caretaking responsibilities of the client a new provider number must be entered into FACTS for the new caretaker. Also, the homefinder will document

the reasons for closure in FACTS.

6.2 Confidentiality

6.2.1 Confidential Nature of Adult Services Records

Legal provisions concerning confidentiality have been established on both the state and federal levels. In Federal Law, provisions are contained in the Social Security Act. On the state level, provisions related to confidentiality of provider information is contained in [§9-2-16](#) and [§9-2-17](#) of the Code of West Virginia. Additionally, requirements related to confidentiality specifically related to Adult Protective Services cases are contained in [§9-6-8](#). In addition, this provision requires DHHR to establish rules and regulations governing the custody, use, and preservation of the records, papers, files and communications concerning applicants and recipients of DHHR services. (For more detailed information refer to [Common Chapters](#)).

6.2.2 When Confidential Information May be Released

All records of the Bureau for Children and Families concerning an Adult Services client/provider shall be kept confidential and may not be released except as follows:

6.3 Records Maintained by the Department

Records shall be released to a court only upon receipt of a valid subpoena duces tecum or court order. Immediately upon receipt of a subpoena or subpoena duces tecum the social worker/homefinder must follow the protocol established to contact the Assistant Attorney General (regional attorney) in order to determine if further assistance or review is necessary.

For example, in some instances the request for document(s) in a subpoena duces tecum may not be relevant or their release may violate state or federal law. The attorney must make this determination and may file a motion to quash the subpoena duces tecum when this is appropriate.

If there is insufficient time to consult the Assistant Attorney General (regional attorney), seek the advice of the local prosecuting attorney. If there is insufficient time to obtain legal advice from either the Assistant Attorney General (regional attorney) or the local prosecutor prior to the hearing, the Department must comply with the subpoena or the subpoena duces tecum. Failure to do so may result in the social worker or the Department being held in contempt. Also, the Department must always comply with an order of the court unless that order is amended by the court or over-turned. Questions regarding the validity of a court order may be submitted to the state office of the Bureau for Children and Families for possible submission to the Assistant Attorney General for review.

- a) For reporting and statistical purposes, non-identifying information may be released for the preparation of non-client/provider specific reports; and,

- b) The provider may request to view his/her provider record and may be allowed to do so. Certain information contained in the record shall not be accessible such as: reference letters, APS information, and/or sensitive issues. Before any information is viewed or released, the social worker/homefinder must confer with his/her supervisor and Community Service Manager.

6.4 Records Maintained by the Provider

Records maintained by the provider are confidential and are to be maintained in a secure location. Information about the client shall only be released to other parties in order to provide needed services (i.e., medical information to medical providers, income information if eligibility is based on financial information, allergies/dietary needs to day treatment provider, etc.). If the client is discharged from the AFC Home, the client record is to be returned to the client's social worker. The social worker is to review the record to determine what information is to be passed on to the new provider, if applicable. If the client does not move to another adult residential placement, the client information is to be filed in the client's paper record maintained by the Department.

6.5 Subpoenas, Subpoena duces tecum & Court Orders

The department may be requested by the court or other parties to provide certain information regarding Adult Services cases with which we have/had involvement. The various mechanisms that may be used are: 1) subpoena 2) subpoena duces tecum or 3) court order.

Upon receipt of any of these, the Department MUST respond. Failure to comply is contempt of court and could result in penalties.

A subpoena commands a witness to appear to give testimony while a subpoena duces tecum commands a witness, who has in his/her possession document(s) that are relevant to a pending controversy, to produce the document(s) at trial. Subpoenas may be court ordered or administrative (ordered by a party other than the court). Though all subpoenas must be responded to, the manner in which this response occurs is somewhat different dependent on who issues the subpoena.

6.5.1 Court Ordered Subpoenas

These include subpoenas issued by the circuit court, the magistrate court or the mental hygiene commissioner. There may be times when a questionable court order or a subpoena requesting that confidential information be provided is received. In this event, the social worker must advise his/her supervisor immediately and promptly refer the matter to the appropriate Assistant Attorney General (regional attorney) for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the Assistant Attorney General (regional attorney). In the event there is not sufficient time for the Assistant Attorney General (regional

attorney) to become involved in the situation, prior to the scheduled hearing, the Department must request a continuance until such time as legal representation can be arranged. If a continuance is not granted, the Department must comply with the subpoena or court order.

6.5.2 Administrative Subpoenas

These include subpoenas issued by an attorney or administrative law judge. These subpoenas generally request that the social worker appear to provide testimony and/or produce the case record. Workers are to advise their supervisor immediately and promptly refer the matter to the appropriate Assistant Attorney General (regional attorney) for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the Assistant Attorney General (regional attorney). In the event there is not sufficient time for the Assistant Attorney General (regional attorney) to become involved in the situation, prior to the scheduled hearing, the Department must request a continuance until such time as legal representation can be arranged. If a continuance is not granted, the Department must comply with the subpoena or court order.

6.6 Relocation of AFC Provider

There may be times when an Adult Family Care Home provider moves from one county to another or relocates to a new residence within the same county. The provider is to notify the homefinder of their intention to relocate prior to the move taking place so that a home study of the new residence may be planned. A new home safety check needs to be done within thirty (30) days at the new residence. If the new place of residence does not meet the requirements as outlined in this policy, the provider must be closed. When relocation is from one county to another, the provider, and applicable client records, must be transferred from one county to another. When a case must be transferred, this is must be a planned effort with close coordination, between the sending worker/county/homefinder and the receiving worker/county/homefinder. The homefinder must notify the social worker when it is learned that the provider plans to move so appropriate action can be taken on the client's case.

6.6.1 Sending Worker/County/Homefinder Responsibilities

When it is necessary to transfer an Adult Family Care Home (AFC) provider and any associated client case(s) from one worker/county/homefinder to another, the sending county is responsible for completing the following tasks (**Note:** The following instructions are written specific for a county to county transfer, however, the same steps are applicable for transfers between workers within the same county):

- a) Prior to completing a transfer to another county, the supervisor in the sending county must call the supervisor in the receiving county to notify

them that the provider/client(s) is being transferred to their county, request assistance and/or provide pertinent information;

- b) Complete all applicable case documentation prior to case transfer (i.e., no overdue reviews);
- c) Immediately upon transfer of the provider(s) to the receiving county, send the updated provider(s) and the client's) record (if applicable) to the receiving county;
- d) Notify the DHHR Family Support staff, the Social Security Administration office, and all other appropriate agencies of the provider's change of address;
- e) Make arrangements for transfer of all medications, personal belongings, clothing, etc. are moved with the client; and,
- f) Insure that the client will continue to receive medical care either through the physician in the sending county or by a physician in the receiving county.

6.6.2 Receiving Worker/County/Homefinder Responsibilities

The receiving county is responsible for completing the following tasks in preparation for the transfer:

- a) Be involved in preparing for the transfer;
- b) Notify the DHHR Family Support staff of the provider's arrival when the transfer is complete;
- c) Do home visit and complete all applicable documentation (Fire Safety Checklist, Sanitation Report, Fire Safety and other applicable sections of the Home Study);
- d) Assist the provider with adjustment to the new community;
- e) Assist with arranging or initiating any needed community resources; and,
- f) This process is used only to evaluate and approve the new home (physical structure and environment), since the provider has already been approved in the former county of residence.

SECTION 7

CASE CLOSURE

7.1 General Information

A final evaluation must be completed as part of the review process prior to closure of the provider home. Upon completion, the homefinder must document the results of this assessment in FACTS, including the reason(s) closure is being recommended. The completed review is then submitted to the supervisor for approval of recommendation for closure. Upon supervisory approval, the provider is to be closed for Adult Family Care services.

7.2 Notification of Closure

If the provider case is closed for Adult Family Care services for any reason other than provider death, written notification to the provider is required. A form letter titled "Negative Action Letter" is to be used for this purpose. This form is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by using the "Save to FACTS" functionality. This functionality may be found in Microsoft Word under the "Add – Ins" menu and then selecting "Save to FACTS"; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality. Upon completion, this report must be saved to the file cabinet in the provider's record.

7.3 Provider's Right to Appeal

A provider has the right to appeal a decision by the Department at any time for any reason. To request an appeal, the provider must complete the bottom portion of the "Negative Action Letter" (SS-13) and submit this to the supervisor within thirty (30) days following the date the action was taken by the Department.

The supervisor is to schedule a pre-hearing conference to consider the issues. If the provider is dissatisfied with the decision rendered by the supervisor, the appeal and all related information is to be forwarded by the supervisor to the hearings officer for further review and consideration.

7.4 Grievances

Dissatisfaction with and objections to the way the homefinder supervises the Adult Family Care Home can usually be worked out between the provider and the homefinder. However, when this is not possible, it is important that the provider be aware of the grievance procedure for social services that is found in Chapter

700 of the [Common Chapters Manual](#). The homefinder must be familiar with the grievance procedure and be prepared to advise providers about how to file a grievance.

SECTION 8

OTHER

8.1 Application to Provide AFC/ESC

The AFC/ESC Application is part of the Application Packet and is to be furnished to potential providers upon request. It is to be completed by the applicant and returned within thirty (30) days. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file the original document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.2 Fire Safety Checklist

The Fire Safety Checklist is part of the Application Packet and is to be furnished to potential providers upon request. It is to be completed by the applicant and returned within thirty (30) days. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file the original document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.3 Physician's Letter (Provider)

Providers who furnish Adult Family Care and all members of the household are required to have a Physician's Letter completed as part of the application process. A new Physician's Letter must be completed thereafter at a minimum of every three (3) years, unless the homefinder questions the provider's ability to care for clients. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file the original document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.4 Personal Reference Letter

The Personal Reference Letter/Questionnaire is part of the Application Packet. The applicant is to make arrangements for these letters to be completed and returned to the local office within thirty (30) days. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file the original document in the client case record (paper record), and record in Document Tracking where the original signed document is located.

8.5 Credit Reference Letter

The Credit Reference Letter/Questionnaire is part of the Application Packet. The applicant is to make arrangements for this letter to be completed and returned to the local office within thirty (30) days. It must be completed by a current utility

provider or bank/lending institution. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file the original document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.6 W-9

The W - 9 is part of the Application Packet. The applicant is to complete the form and return it to the local office within thirty (30) days. This form is available as a DDE and may be accessed through the Reports area of FACTS. The provider's name, address and tax number (social security or federal identification) must be exactly as shown on income tax forms filed with the IRS by the provider. The original W-9 must be sent to the Bureau for Children and Families (state office) for final approval and a copy is to be filed in the provider record. The location of the copy of the signed document is to be recorded in Document Tracking.

8.7 Annual Fire and Safety Review

This form is to be completed by the homefinder in the initial interview and annually during the review process thereafter. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder may request the Fire Department to provide additional follow-up in those situations where he/she feels unable to make this determination. The homefinder must file the original document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.8 Annual Sanitation Review

This form is to be completed by the homefinder in the initial interview and annually during the review process thereafter. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder may request the County Health Department to provide additional follow-up in those situations where he feels unable to make this determination. This form may be completed by either the homefinder or the County Health Department. The homefinder must file the original document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.9 Home Study Summary

This form is to be used to document the results of the entire Home Study Process. Included are areas such as: all interviews, information about the home and neighborhood, characteristics of the provider and household members, results of references, homefinder's evaluation and recommendations, etc. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file the original document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.10 Provider Agreement for Participation

The Provider Agreement for Participation, which is completed during the Case Assessment phase of the case work process, and is to be completed annually. This is an agreement that the homefinder completes with the provider that specifies certain requirements that the provider agrees to abide by. This form is available as a DDE and may be accessed through the Reports area of FACTS. Finally, after printing the Provider Agreement for Participation, the homefinder must secure the required signatures, furnish the provider with a copy, file the original signed document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.11 Respite Provider Agreement for Participation

The Respite Provider Agreement for Participation, which is completed during the Case Assessment phase of the case work process, is an agreement that the homefinder completes with the respite provider that specifies certain requirements that the respite provider agrees to abide by. This form is available as a DDE and may be accessed through the Reports area of FACTS. Finally, after printing the Respite Provider Agreement for Participation, the homefinder must secure the required signatures, furnish the provider with a copy, file the original signed document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.12 Insurance Loss Notice

When the client does property damage to the provider's home and/or other negligent acts, the Insurance Loss Notice is to be completed by the provider and/or homefinder. The local office will then mail the original form to the Division of Assets and Project Management (Capitol Complex) and a copy to the Commissioner of the Bureau for Children and Families (See section titled [Liability Insurance](#) for detailed information). This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file a copy of the original document in both the provider record and the client record (paper record), and record in Document Tracking where the copies of the document are located.

8.13 Approval Letter

The Approval Letter is used to inform the applicant that his/her home has been approved to provide Adult Family Care Home services to a specific number of individuals. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file a copy of the document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.14 Certificate of Approval

Once the home is approved a Certificate of Approval is presented to the provider indicating the number of adults the provider is approved to care for and the period of certification. This Certificate of Approval is also issued when the home is re-certified. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file a copy of the document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.15 Re-certification Letter

This letter is used to inform the Adult Family Care provider that they have been re-certified to continue providing Adult Family Care Home services for another year. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file a copy of the document in the provider record (paper record), and record in Document Tracking where the original signed document is located.

8.16 Notification of Application for Social Services

Any time a negative action is taken in an Adult Family Care case, such as case closure or a reduction in services, the provider must be provided with written notification of the action being taken. This notification must be clearly and specifically stated, advising the provider of the action being taken and the reason(s) for the action. In addition to notification of the negative action, the provider must be made aware of their right to file a grievance on the decision and advised of what they must do to request a grievance hearing. The Notification of Application for Social Services is to be used for this purpose. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file a copy of the document in the provider record (paper record), and record in Document Tracking where the original signed document is located. This letter is also to be used to notify the respite provider when their application to become a respite provider has been approved and/or denied. (See [Common Chapters](#) (Chapter 700 Appendix C) for detailed information about the grievance procedure).

8.17 Payment Agreement

The Payment Agreement, which is completed during the Case Management phase of the case work process, is the document which sets forth the terms of payment for placement in the Adult Family Care Home. Within this document, the following are specified: 1) the payment amount due to the provider, 2) the portion of payment to be paid by the client, and 3) the portion of the payment to be paid by the Department. The agreement further identifies the monthly rate (for full month of placement) and the daily rate (for a partial month of placement). Finally, the agreement identifies the amount that is to be available to the client as

Personal expense allowance and whether the client is to retain this amount from their funds or if the provider is to furnish this amount from their reimbursement by the Department. The Payment Agreement is created by FACTS based on information entered by the social worker. After all required documentation has been completed, the Payment Agreement may be printed and all required signatures obtained.

This form is available as a DDE in FACTS and may be accessed through the Reports area. It may be opened as a WordPerfect document, populated with information that has been entered in FACTS. The social worker then has the ability to make modifications, as appropriate, before printing the document. The completed document must then be saved to the FACTS file cabinet for the case. Creation of this form must be documented in the Document Tracking area of FACTS. Finally, after printing the Payment Agreement, the worker must secure all required signatures, provide the client and all signatories with a copy, file the original signed document in the client case record (paper record), retain a copy in the provider record, and record in Document Tracking where the original signed document is located.

8.18 Annual Review Summary

The case review process is to occur during the Case Management phase. A formal review of the provider must be completed every twelve (12) months. In addition, a formal case review must be completed at any time there is a significant change in the provider's circumstances. When completing a case review the AFC/ESC Annual Review Summary must be followed to document the results of the review. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file a copy of the document in the provider record (paper record), and record in Document Tracking where the original document is located. In addition to the annual review, the provider must complete a face to face contact with the provider in their home, at a minimum, at least every six (6) months.

8.19 Adult Residential Services Corrective Action Letter

The Corrective Action Letter is to be issued after the provider has been verbally notified of deficiencies. Deficiencies may be identified either: (1) during the regularly scheduled review or 2) at any other time deficiencies are observed. This letter is to be sent to the provider within seven (7) calendar days of the verbal notification. The deficiencies to be corrected are to be listed and a time frame for the completion of the corrections specified. This form is available as a DDE and may be accessed through the Reports area of FACTS. The homefinder must file the electronic copy of the letter in the provider record in FACTS in the file cabinet and record in Document Tracking where the copy of the original signed document is located. Corrective Action Plans are to be done within thirty

(30) Days. Anything beyond this thirty (30) day time frame a policy exception needs to be requested.