HOME CARE INDEPENDENCE

AN OPERATIONS MANUAL FOR CONSUMER DIRECTED SERVICE PROGRAMS

NC DIVISION OF AGING AND ADULT SERVICES

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HOME CARE INDEPENDENCE OPERATIONS MANUAL
NC Division of Aging and Adult Services

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INTRODUCTION

Persons who are disabled by virtue of advanced age, illness, injuries, or congenital birth defects have a basic and strong desire to manage their lives and needs with as minimal assistance from others as possible. Where feasible and practical, based upon a number of factors, individuals who do need assistance from others should have the right to direct as much of their activities of daily living as their condition and family circumstances will allow. Public funds for the support of needed services to help with such activities should be flexible, allowing individuals or their responsible family members who want and are able to do so to determine what services they need, when they need them, and who will provide them. Services should be provided in such a manner that individuals derive physical and mental benefits that are personally satisfying and consoling to them during periods of both vulnerability as well as normalcy.

The commitment of the Division of Aging and Adult Services (DAAS) to the concept of Consumer Directed Service (CDS) grew out of participation in work groups relative to the Real Choice Grant that was awarded to the Department of Health and Human Services (DHHS) in 2001. A major emphasis of this grant was to create a system of home and community based care that emphasizes, encourages, and enables consumers to have more direct control and influence over needed services and how these services will be provided. This is a very different system of service from the traditional home and community care service system that is largely controlled by professionals and rules and regulations regarding how services are attained and provided. Home Care Independence is the name adopted for the DAAS CDS program supported with Home and Community Care Block Grant funds. (*As the program matures, additional sources of support will be identified)*

The following principles should guide the creation of DAAS funded Consumer Directed programs:

- Older adults have the right to choice and self-determination
- Person-centered service plans should reflect the views of older adults regarding their wants and needs

- The strengths of the person from a holistic standpoint are critical when considering consumer direction as the way of enabling independence in the home setting
- Consumer direction of services should be put together in such a manner that older and disabled adults opting for this approach to service are protected from physical or mental harm from others.

DESCRIPTION OF CONSUMER DIRECTED SERVICE

Consumer Directed Service available through local community agencies that receive DAAS funding for support of services to the aging is a method of service delivery that promotes and enables the consumer (called a Participant) to recruit, hire, train, supervise, and, when necessary, terminate the employment of chosen Personal Assistants who provide them personal and home management services in their home settings. Participants in CDS programs may also select vendors of other goods, equipment, and services that may be needed for their care and well-being. They are not required to select vendors who have been pre-approved by the state or local governmental units. The one exception to this will be the statewide Fiscal Management Service (FMS) selected by DHHS to provide payroll services in behalf of Participants for their Personal Assistants.

In North Carolina, CDS, under the auspices of DAAS, enables Participants to take on all management activities with paid caregivers called Personal Assistants, with the exception of paying their salaries and other payroll related tasks. This aspect of worker employment is handled by the FMS that has been selected by DHHS for this purpose. Participants are required to use the payroll services of the FMS if they choose to participate in Consumer Directed Service funded with Home and Community Care Block Grant (HCCBG) or other DAAS funds that may be made available for the creation of CDS programs. Overall responsibility for the FMS contract with DHHS has been delegated to the Division of Medical Assistance (DMA). Each participating division will have a designated staff person to oversee the CDS program set up by that division. This person will work with the person designated in DMA for overall management of the FMS contract to resolve issues that may arise and have some relevance to all divisions. DAAS designates the monitoring of local programs supported with HCCBG funds to the relevant Area Agency on Aging (AAA) that will also provide technical assistance to local CDS program in cooperation with the designated DAAS staff person.

Goal of HOME CARE INDEPENDENCE

The goal of Home Care Independence, which is the name given to the program for consumer directed services offered by DAAS, is the establishment of home and community based consumer directed programs of service within communities that want to offer consumers more control over how, when, and by whom their care needs are met in their home settings. DAAS will provide overall direction for the program as it develops in communities all across the state. This will include the initial and

subsequent training for the staffs AAAs and for local agencies in counties where there is interest in establishing CDS programs. DAAS and the AAAs will provide technical assistance and monitor the activities of agencies to help assure the integrity of the CDS programs as they begin to develop and operate within counties. Funding for Home Care Independence will come primarily from HCCBG allocations to counties. As is true for all services funded with HCCBG, the decision to provide CDS in a county is determined in the annual county planning process through the work of county planning committees and with final approval by the Board of County Commissioners.

ENROLLMENT PROCESS FOR CDS

To be an eligible participant for Home Care Independence, a consumer must be:

- 60 years of age or older
- Unable to carry out at least two tasks essential to the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) that do not indicate the need for nursing home or other facility care, thus enabling them to remain in the home setting
- Willing to participate in Home Care Independence and understands the rights, risks, and responsibilities of managing their own care with a budget of public funds
- Able to make decisions regarding:
  - employment and the direct activities of caregivers with no or limited input from others or
  - the choice of someone to act as their Representative in securing and directing caregiver activities and
- Willing to assure that employees are paid in a timely manner and to work cooperatively with the FMS appointed to provide this service for local Home Care Independence programs

The agency making Home Care Independence available must screen for HCCBG eligibility using DAAS Form 101. Once this screening has determined the person is eligible for HCCBG service assistance, the specific needs must be assessed using the forms listed in the Appendix to this Manual. The assessment process must address the following:

- The person is not a current consumer of other more appropriate CDS programs such as CAP Choice, the CDS program of Mental Health, or the Independent Living Program of Vocational Rehabilitation
- The individual's health concerns
- The housing and living arrangements and income of the individual
- The individual's cognitive functioning and perception of his/her well-being
- Availability of caregiver support (paid or unpaid)
- How daily functioning needs (ADLs and IADLs) currently are being met

- How the person perceives his need for assistance, what he wants, and how he wants it delivered
- What, if any, services currently are being received by the individual
- The person appears to have the ability either to self-direct care, has someone who can act in this capacity for him/her, or needs to identify someone who can perform this function

Activities of eligibility determination should include information to assure that all potential Participants interested in home care assistance will have the option of considering CDS as the program to meet their home care needs. Eligibility screening begins the process of determining whether or not they have a good understanding of the rights, risks, and responsibilities of self-management. The person interested in CDS may designate a Representative to handle the responsibilities of managing their care. The probability of enrolling appropriate and successful individuals is greatly enhanced in situations where the potential Participant needs assistance and is willing for a trusted friend or relative to make decisions in his/her behalf; ***however, not all prospective CDS Participants will need or require a Representative to act in their behalf.*** This is not a position that requires the person to be legally appointed, although someone who has Power of Attorney or is a legal guardian may act in this capacity.

Enrollees in Home Care Independence become “Participants.” Home Care Independence is not intended to be an alternative program to nursing home placement. HCCBG funds are not to be used to pay for goods and other non-Personal Assistant services that the individual is eligible for in some other program (i.e., durable medical equipment available through Medicaid or Medicare or through a private or work-related health care plan). North Carolina assures all Participants and their paid caregivers, called Personal Assistants, of non-discrimination and equal opportunity in compliance with all applicable Federal laws, regulations, Executive Orders and Civil Rights rules or regulations and laws of Equal Opportunity and Affirmative Action. Both will be provided Bill of Rights documents that address aspects of their relationships with one another. These are in included in the Appendix to this manual.

When it is determined that the potential Participant needs specific service assistance and is interested in the Home Care Independence program, the following should be explained or provided to them:

- A discussion with the person about CDS to facilitate the participant using this service approach appropriately
- A discussion with the person who may need assistance in using the service that he/she may appoint someone to serve as their Representative in making care need decisions and in managing employees who will provide direct services
- Information that the state has secured payroll and related services from an FMS that will provide this assistance to all Participants who enroll in the CDS program
- Information by the provider agency about other services available in the community and provided assistance, if needed, in seeking out other sources of help for those who do not proceed with CDS

The Home Care Independence Agency will maintain records and document the requests for service. The following documents must be included in the file on each Participant:

1. The DAAS 101
2. The Self-Assessment Form completed by the potential Participant
3. The agency Service Assessment/Reassessment Form* for identification of need completed by the Care Advisor
4. Forms related to appointment of Representative* when applicable
5. The Participant Enrollment Form
6. The Care Plan and Budget for assistance completed together by Participant and Care Advisor
7. The Back Up Plan for assistance
8. Dated notes of contacts with Participants
9. All forms related to referral and future updates submitted to the FMS by Care Advisor
10. Participant Bill of Rights form signed by all who are required
11. A copy of the Criminal Background Report from the FMS
12. Annual forms completed during reassessment of continuing eligibility and need for CDS

NOTE: .If an agency has a Service Assessment Form that collects the same information as the DAAS CDS/ Assessment/Reassessment Form; they may use the local form.

The following are the steps for enrolling and maintaining an individual in the CDS program.

The Care Advisor of the CDS provider agency will perform the following, using documents contained in the Appendix to this manual:

- ✓ Determine eligibility for HCCBG using DAAS Form 101.
- ✓ Determine potential of individual to self direct care using DAAS Form 101, comments by the Participant recorded on the Participant Self-assessment Form and the Care Advisor's observations of the person when discussing CDS with them.
- ✓ Assess individual's need for personal care and home management assistance using the Participant Self-Assessment Form and the Service Assessment Form.
- ✓ If needed, engage with the Participant in Choosing a Representative using the Appointment of Representative Form.
- ✓ Enroll Participant for CDS using Participant Enrollment Form.
- ✓ Engage with the Participant in completing Consumer Directed Services Plan of Care/Budget Form and the Back Up Plan for Consumer Directed Services Form.
- ✓ Notify FMS of new CDS Participant and hours of weekly service authorized in addition to any vendor services for which the FMS is authorized to make payment using the FMS Authorization Form.

- ✓ Provide the Participant an Employment Application and Criminal Record Consent Form for Participants to use in selecting employees.
- ✓ Offer guidance to the Participant in choosing Personal Assistants if this is requested.
- ✓ Provide the individual the Participant Employer Bill of Rights document.
- ✓ Review records of Criminal Background checks, conducted by the FMS, with the Participant. Those whose background records reflect the convictions specified in the Criminal Background Check Policy included in the Appendix to this manual may not be hired. Participant makes the ultimate hiring decision regarding applicants who are eligible for hire.
- ✓ Notify the FMS if changes in service hours, vendor services, or any other changes are needed for a Participant, using the FMS Change Order Form.
- ✓ Be available to assist the Participant and FMS if payroll issues arise to assure that Personal Assistants are paid properly.
- ✓ Contact Participant per time frames and as specified in the manual
- ✓ Maintain forms and dictation in individual Participant files
- ✓ Be involved with the Participant as an advisor rather than as a manager of care

The FMS will perform the following tasks relative to the DAAS CDS program:

- ✓ Contact a new Participant upon notification from the Care Advisor to begin the enrollment process for payroll service
- ✓ Complete all necessary federal and state tax paperwork and other documents required for provision of payroll assistance
- ✓ Discuss the role of the Participant as the “Employer of Record”
- ✓ Perform Criminal Background checks for the Participant for potential Personal Assistant applicants but will not make a recommendation regarding the findings.
- ✓ Send Criminal Background reports to both the Participant and the Care Advisor for their review and decision to hire
- ✓ Enroll Personal Assistants for payroll services when the Participant selects a worker….the initial Personal Assistant unit rate for start up programs is $10.87
- ✓ Review time sheets submitted by Personal Assistants per the authorization of hours submitted by the Care Advisor
- ✓ Resolve issues of recorded hours worked by Personal Assistants if there are two consecutive payroll periods when hours worked are 10% or more than the hours authorized
- ✓ Pay Personal Assistants twice per month per the FMS payroll schedule
- ✓ Submit payroll hours and FMS initial and monthly administration fees directly to ARMS
- ✓ May also submit other goods and services to ARMS (Aging Resources Management System) if authorized by the Care Advisor to do so. Participant would pay for the goods and then submit receipts of payments made to vendors to the FMS for submission to ARMS for reimbursement. The AAA would enable the FMS to enter reimbursement requests to ARMS for other services provided to Participants

- ✓ Stress to Participants and to Personal Assistants that consistently late or incorrect Time Sheets submitted will result in salary checks not being issued until the next pay period.
- ✓ Reconcile on a quarterly basis, at the end of the third month of a calendar quarter (September, December, March, June) all reimbursement payments received per routine HCCBG procedures for hours of payroll service provided for Participants of each local provider agency to determine the average current Personal Assistant unit rate for the period for that agency….every reconciliation covers
- ✓ all units retroactive the beginning of the fiscal year.
- ✓ Pay all taxes and other payroll related expenses required by law per the timetable of respective governmental entities for both the Participants and Personal Assistants
- ✓ Provide payroll reports to the Participant and the local provider agency
- ✓ Provide a secure web site where payroll reports and other reports will be available for review by the provider agency, the AAA, and the state DAAS using password protected IDs

NOTE: ***When a local provider begins to provide CDS, the FMS and the local provider agency will complete a Memorandum of Agreement that specifies the responsibilities of each in the service and payroll process for individuals enrolled as Participants in the consumer directed program.***

HOME CARE INDEPENDENCE TEAM

PARTICIPANT

A Participant is:

- A consumer who needs assistance in performing routine and incidental activities of daily living
- 60 years of age or older and needs the direct assistance of another person
- Someone who expresses an interest in CDS and is assessed as having the capability to employ and manage the work of providers and self-direct the care received or has someone who is willing to do this in their behalf
- The “Employer of Record” of all workers hired as their Personal Assistants.
- Someone who does not have nursing home care needs and for whom the cost of meeting their needs does not exceed the maximum monthly allowable by the local provider agency for participation in Home Care Independence.

NOTE: An agency providing Home Care Independence should not automatically budget the maximum allowable by the agency for each Participant unless the assessment indicates that the maximum is needed. Ultimate decision regarding the maximum allowable monthly budget is at the discretion of the local provider agency based upon the total HCCBG and local funds allocated to the CDS program.

REPRESENTATIVE

A Representative is someone who makes decisions for a Participant when the person is unable due to mental or physical impairments to fulfill the tasks of an employer of someone providing direct care assistance. A Representative will be required for any Participant who is determined during the assessment for service process as unable:

- to understand his/her own personal care needs
- to make decisions about his/her own care
- to recruit, hire, train, direct, and supervise Personal Assistants
  or
- has a court appointed legal guardian who may act in this capacity

A Representative may need to be identified at any time it is noted by professionals working with the family or by other family members that the Participant is less and less mentally or physically able to handle all that is involved in CDS. The voluntary appointment of a Representative by the individual is far preferable than taking legal action at a time when mental faculties have deteriorated and the person is declared incompetent. Family members as well as friends may serve as Representatives. Selection of a non-legal Representative is not intended to be a laborious process but one that an informal negotiation involving the Participant and someone they may want to serve them in this capacity. The Home Care Independence staff person should participate in the discussion as deemed appropriate, particularly in situation where the Participant has mental disabilities or a history of being unable to mange personal finances. Selection of a Representative by the Participant in concert with other family members will help to assure that Home Care Independence is an experience that enables the Participant to have continued involvement in determining personal wants and needs to the fullest extent possible.

Traits of a good Representative would be reflected in:

- Behaviors that indicate a personal commitment to the Participant’s well-being
- Good rapport with the Participant when interacting and communicating with him or her
- Expressed knowledge about the Participant's preferences
- Regular and frequent contact with the Participant
- Expressed willingness of complying with the responsibilities of the Participant as the Employer of Record
- General, non-confrontational, consensus from other family members that the person would fulfill the role adequately
- May have been an unpaid caregiver and now requires respite from this role
- Behaviors that do not reflect discernable abuse of alcohol or drugs
- A reputation for not having a history of physical, mental or financial abuse

Anyone who serves as a Representative must be no younger than 18 years of age and cannot also serve as the paid caregiver of the Participant.

NOTE: If someone serves as a Representative for a Participant, this person may not also be employed as a paid caregiver for the Participant.

CARE ADVISOR

Care Advisors are representatives of Home Care Independence programs and assess with CDS applicants their potential for participation in the self-directed care program. They work with them to explain the program and all that is involved with consumer direction of care. They provide information that will help individuals to determine if they want to engage in the employment of their direct care workers. They also engage with individuals to identify specific care needs and how these needs may be addressed.

The initial and on-going contacts between the Care Advisor and a consumer/Participant and/or Representative will enable:

- Attention to be focused on assessment of need for service and how best to meet these needs
- Determination that the person has the aptitude for self-directing his/her own care and for dealing with issues that arise in this process
- Understanding of Home Care Independence and what is involved in the employment of direct care workers
- Helping Participant to determine plans of care that specifies services to address the needs
- Helping Participant to develop budgets and any modifications that are warranted for the cost of services, within limitations of the local maximum allowed budgets, for Home Care Independence
- Assistance in securing a Representative for the Participant should the need for one be determined at any point
- Help or advice to be provided, if needed, when the process of locating and employing Personal Assistants begins
- Help to be provided the Participant ,if needed, in accessing other community services

The State Department of Health and Human Services (DHHS) has established a contractual agreement with a statewide FMS for payroll services for Participants in CDS programs in all local agencies operating under the auspices of one of the Divisions of DHHS. When a Participant hires a Personal Assistant, the Care Advisor will refer the Participant to the FMS for payroll services. Payroll service for Participants in CDS programs cannot begin until the Participant is enrolled with the FMS. The form for authorizing the FMS to enroll a Participant for assistance is included in the Appendix.

After the Participant is approved for CDS in the Home Care Independence program and the payroll process is functioning, Care Advisors will establish periods of contact with the Participant to monitor the quality of self-directed care, to provide support and

assistance as indicated and to assure that essential needs of Participants are being met. *These contacts at a minimum are as follows*:

- **At least one telephone call and one in home visit within the first month that the Participant is accepted into the program and receives assistance from their Personal Assistance.**
- **Two additional home visits during the first year of service**
- **A quarterly telephone call for the purpose of monitoring the provision of assistance by the Personal Assistant**
- **Other contacts as needed or requested by the Participant or deemed necessary by the Care Advisor**
- **A complete annual reassessment for service on or before the one year anniversary date of enrollment to CDS and every year thereafter**
- **After year one of service, quarterly telephone calls and at least two home visits during the twelve month period.**

Participants should be advised that calls to the Care Advisors for help and advice can be made at any time that the Participant feels the need for assistance or has concerns relative to consumer directed services. Care Advisors will not function in the take-charge approach attributable to care managers in the traditional agency-provider care program. They will allow the Participant to make decisions regarding when and how they want service to be provided by their Personal Assistant. When the Participant seeks guidance, the Care Advisor should be available to offer advice and information. They should function as advisors to Participants and should engage in problem-solving activities if requested by the Participant. If it seems that the Participant is experiencing stress and concerns in the process of being served by a Personal Assistant or in working with the FMS, the Care Advisor should acknowledge this with the Participant and offer to be of assistance. All contacts made with Participants, Personal Assistants, and the FMS will be documented and dated in a case file maintained on each Participant by the Care Advisor.

Specific Care Advisor duties in Home Care Independence include:

- **Service Marketing and Orientation**
    - **Marketing**: Care Advisors can help market Home Care Independence in communities to the public at large and to potential consumers in particular. Examples of marketing activities might include: distribution of information brochures, presentations to groups, public service announcements, newsletter articles, one-on-one contacts, etc.
    - **Orientation:** Care Advisors should provide information to individuals who inquire about the Home Care Independence program. This would be provided prior to screening for eligibility and assessment of the need for assistance. The process should include at a minimum: an overview of the concept of CDS; and of the FMS component; ways of recruiting, interviewing, hiring, supervising, and even terminating Personal Assistants. The person needs to

understand that they become the employer of workers that will provide them the services that they need in their homes.

- **Specific Needs Screening and Assessment**

Each consumer must be initially screened for eligibility for service per HCCBG requirements using the DAAS Form 101. This initial screening also will give some indication of the person's care needs, the desire to self direct care, and the ability to direct the activities of a Personal Assistant. It will identify whether or not the person is already a consumer of another CDS program such CAP Choice, Independent Living, or consumer directed respite programs for family caregivers. It will reveal how needs are currently being met and what help the person perceives he/she needs.

The screening activities and the assessment for specific service needs may be thought of as one flowing process to determine whether or not the person meets the criteria for the funding source and has needs that can be met in the home setting. For Home Care Independence, the process determines that the person has abilities to self-direct care, has someone who can do this in their behalf, or needs assistance to find someone to act in this capacity. This process involves the self-assessment by individuals and the assessment completed by the Care advisor. Once the person is determined eligible for program participation and is enrolled as a Participant, the on-going assessment of the continuing need for service and the continuing ability to self-direct service must be fully reassessed no less than annually thereafter. The initial assessment and subsequent reassessments are joint processes involving both the Participant and the Care Advisor. The process of assessment is critical to the determination of specific needs and how best to meet the needs. ***The Participant and/or their Representative take the lead in the needs assessment.*** The full reassessment for continuing in CDS must be completed on or before the end of the twelve month period from the date of the original assessment and subsequent reassessments.

NOTE: ***The DAAS Form 101 for eligibility screening will be used in concert with the Participant Self-Assessment and the Assessment/Reassessment forms included in the Appendix to this Operations Manual*** **for the purpose of initial and on-going assessment of need for service**

- **Plan of Care and Service Budget**

Each participant in the CDS program must have a written Plan of Care (POC) and a monthly Service Budget for carrying out the plan. The Plan of Care indicates all of the services that will be needed by the Participant including the services of a Personal Assistant during a seven day period, Sunday-Saturday. The POC will specify **what** tasks the Personal Assistant will perform but not **when** the tasks are to be performed. It will also specify the other goods and services needed, if applicable, to maintain the individual in the home setting.

Development of a Plan of Care is part of the assessment process which ***must* be conducted at least every twelve months,** but ***must be updated whenever any significant change in the consumer's physical, environmental, or family situation occurs.*** Both the Participant and Care Advisor will have copies of the Service Plan when completed initially and at times of reassessments. ***The Participant takes the lead in the care planning process*.** The Care Advisor should engage in the person-centered approach to service determination. Care Advisors co-sign service plans and budgets and works with the Participant in an advisory capacity to assure that budget items are related to the assessment of need and that the monthly budget does not exceed the maximum allowable monthly amount determined by the local provider agency.

The Personal Assistant will carry out tasks specified on an Employment Agreement form that will be provided Personal Assistants by the FMS when they are hired by the Participant. The sheet will list the services needed and the number of hours of service deemed necessary for the provision of services over the course of seven days from Sunday-Saturday. It is not critical to designate the specific hours, length of time, or days when service is to be provided. The Participant will specify with the Personal Assistant when they want service assistance and this could vary from day to day. The tasks in the Employment Agreement will only need to specify the services needed with a total of service hours available during the seven day period.

The Care Plan/Service Budget Form maintained by the Care Advisor for assessed services for a Participant must not exceed the monthly maximum amount determined by the provider agency as allowable for participants in this program. To exceed the agency determined maximum, the file maintained on a Participant should reflect approval by the agency administrator responsible for CDS for the higher amount.

The following services are those allowable in a program of CDS and, when included on the Care Plan/Service Budget Form, must be related to the care needs identified in the assessment process:

- A unit rate for the Personal Assistant …..**Code 501**.... that includes salary and taxes for the Personal Assistant. **The initial figure is a DAAS determined rate (currently at $10.87), with a unit rate adjustment for each CDS participating agency made at the end of the third month of a calendar quarter (September, December, March, and June) by the FMS based upon the average of actual Personal Assistant salary rates and taxes and applied to the entire previous periods beginning July 1.** The local agency must recompute Participant budgets to assure that funds are adequate to support the individual Participants within the total agency amount budgeted for CDS. This will enable the agency to determine if additional Participants can be accepted into the program or make other financial adjustments to keep the program viable.

- FMS start up and monthly fee ….**Code 503**….(currently a prorated $75 initial start up fee at $6.25 for twelve months and $75 monthly)....after year one, the cost is monthly fee only
- Adult Day Services **Code 502**….must not be provided at a higher rate than the established state rates for Adult Day Care.
- Home Delivered Meals **Code** 505….at the going rate for this service in the county
- Emergency Response Systems **Code 506**….(ERS) not to exceed a monthly maximum of $50 unless the provider agency documents approval in writing for a larger amount…or Participant pays the difference
- Personal goods, incidental environmental services, and nutritional supplements **Code 504**….to improve health and safety of client per monthly amount budgeted for Participant.
- Medical/Adaptive Equipment*….**Code 507**…. not to exceed $300 annually and allowable only if the consumer is not eligible for Medicaid or another funding source that would cover the items
- Care Advisor….**Code 500**….*This position is not included in the Participant budget for CDS* but is a cost that should be included in the overall budget for a local program of CDS and when entered to ARMS under Code 500 by the local agency will be reimbursed to the agency from the HCCBG budget for the CDS program.

NOTE**: **If the Participant is Medicaid and/or Medicare eligible and has the need for durable medical adaptive equipment or other covered medical goods, HCCBG funds may not be used for this purpose. Funds set aside for CDS should not be used for services that the person is eligible for under other funding sources. CDS under DAAS is not intended to serve clients who have needs that are those determined to be at a nursing home level of care. Care Advisors should work with Participants to locate and utilize other community resources. Documentation that other resources for equipment have been explored must be maintained by the Care Advisor.

Total allowable annual expenditures for the assessed needs of each Participant are capped at a maximum of twelve times the monthly allowable as determined by the provider agency**. The local agencies set the monthly cap at an amount that their HCCBG budget will accommodate.** Services assessed as needed should not to exceed the locally determined amount unless the agency administrator approves an increase in the monthly amount per individual situations. To allow for the cost of medical equipment not covered by Medicaid or other funding sources, personal goods and service, and home improvements, the items should be planned for and the totals prorated over a 12 month period or prorated over the months remaining in the fiscal year. The items that fluctuate during the year should be monitored by the Participant and the Care Advisor to assure that total annual expenditures do not exceed the maximum allowable. Since expenditures for goods and services will fluctuate, Care Advisors should monitor monthly expenditures at least quarterly for the purpose of adjusting budgets to keep within the maximum annual spending limits. All incidental goods

and services that are budgeted should be directly related to the on-going assessment of need.

As changes are made in service plans and budgets, if this changes the hours authorized for Personal Assistants, this must be shared with the FMS, using the Change Order Notice to FMS. Any change made in services that affect the tasks of the FMS must be conveyed to the FMS using the FMS Change Order Form

The agency that operates the CDS program in a county will use the DAAS 101, the Participant Self-assessment Form, the Provider Agency Assessment Form, the Plan of Care/ Budget form, and forms authorizing FMS that are found in the Appendix to this operations manual.

The FMS will enroll the Participant for the purpose of payroll, using forms developed by the FMS or official tax forms required by the state or federal tax divisions. These will be completed with the Participant at the time of enrollment with the FMS. The FMS will prepare a separate FMS budget for each Participant referred for payroll and for vendor services for which the FMS is requested to make payment and is based upon the information on the referral form for FMS services prepared by the Care Advisor. <u>The FMS budget is not the same as the total Service Budget maintained by the Care Advisor.</u> The FMS budget is one that is based upon the services authorized to be provided by the FMS, whereas the local agency budget reflects all services budgeted for the Participant. Changes that occur in the Care Plan/Budget only need to be communicated to the FMS if the amount of Personal Assistant hours increase or decrease or if other services must be authorized or changes made to previously authorized services to be performed by the FMS.

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- **Back-up Plans**

The Care Advisor will assist the Participant/Representative in developing a Back-up-Plan to outline how the participant's needs will be met should the Personal Assistant be absent from the home for any reason. The Back-up-Plan may identify informal caregivers or identify an agency from which hours may be purchased. If a Back-up-Plan should be utilized, the overall budget for services may need to be amended by the Care Advisor and this information conveyed to the FMS if there are any budget changes affecting the provision of FMS. If care requirements indicate that more than the maximum monthly budget allowable by the local agency is needed because of the back up plan being used, the local provider agency administrator would need to review the factors to determine if an exception to the maximum allowed can be approved. Back-up-Plans should be amended as necessary when circumstances change. As periodic contacts and annual reassessments with the Participant are made to determine the continuing need for service, the Care Advisor should confirm plans of care/service budgets and review back-up-plans with the Participant.

- **Supportive Counseling and Service Monitoring**

It is the responsibility of the Care Advisor to monitor the plan of care and service budget to the degree necessary to ensure that participation in Home Care Independence does not compromise the health, safety, and well being of the participating individual. At a minimum, one home visit and two telephone contacts during the month is required during the first month of service; thereafter, at least two home visits is required during remaining months of the twelve month period, with telephone calls on a quarterly basis. Other contacts would be made as needed or as requested by the Participant. All contacts with the Participant must be documented and dated by the Care Advisor in the case file of the Participant maintained by the Home Care Independence program. The Care Advisor should be available to the Participant for help as needed by telephone or in person as requested by the Participant. This may include discussions on personality issues, handling conflict, or doing what is required to assure that the Personal Assistant is paid in a timely manner by proper handling of time sheets, or by discussing payroll concerns with the FMS provider. It may involve the use of educational videos on the consumer-directed approach to service or through written newsletters or informational materials regarding this approach. Care Advisors are encouraged to be creative in assuring that supportive counseling and advisement are provided in ways that do not relieve the Participant of personal decision making so critical to the consumer directed process. The Care Advisor should exert caution not to take over the decision making process when interacting with the Participant. Principles of person-centered planning and client interaction are a guiding principle of CDS.

- **Documentation**

  A case file on each Participant assigned to the Care Advisor must be created and maintained by the agency operating the Home Care Independence program. Each contact with the Participant and/or the Representative, Personal Assistant, FMS, or others related to the care of the Participant should be documented and dated in a summary note to be maintained in the case file. These files will also maintain copies of all screening forms, assessments/reassessments, care plans, service budgets, and payroll reports from the FMS.

PERSONAL ASSISTANT

Personal Assistants will be recruited, interviewed, hired, and managed by the Participant/Representative. Family members, other than those with legal responsibility to the participant, i.e., court appointed legal guardian or designated as the Representative, and friends may serve as a Personal Assistant. The FMS will work closely with the Participant to perform criminal background checks on prospective Personal Assistants and after they are selected for hire, the FMS will enroll them for payroll services, make established payrolls, and pay payroll taxes to the state and federal governments as required by law.

The criteria for this position include:

- Being a US citizen or legal alien with approval to work in the US
- Having a valid Social Security Number
- Being 18 years of age or older
- Being able to communicate successfully with the Participant and/or Representative
- Being willing to provide two or three personal references if the prospective Personal Assistant is someone other than a family member
- Submitting to a criminal background check (**See the Criminal Background Policy included in the Appendix to this manual**.)
- Being willing to sign an Employment Agreement with the Participant and/or Representative
- Obtaining any health related tests that the Participant may require….at the Participant's personal expense
- Agreeing to work cooperatively with the FMS for purposes of payroll

After a Personal Assistant is selected, the Participant and/or Representative will complete an Employment Agreement to be jointly signed with the Personal Assistant. This agreement is one that will be provided by the FMS. The agreement will identify the type of tasks needed, the number of weekly work hours and rate of pay, the starting date of employment, and any other information that the Participant wants to convey. The specific work tasks and number of hours available during the period from Sunday-Saturday will be specified on the Task sheet. When the work is to be performed is at the discretion of the Participant. The work actually performed by the Personal Assistant and the amount of time worked daily will be documented on a Time Sheet, provided by the FMS, that is to be signed by both the Personal Assistant and the Participant. Salary payments will be calculated by the FMS from these time sheets. Information about formal training opportunities that might be beneficial to the performance of care giving tasks can be maintained by the Care Advisor and made available to the Participant as information about such opportunities becomes available. Attendance of Personal Assistants in training possibilities is an issue between the employer and employee. The maximum hourly salary recommended to offer a prospective Personal Assistant is recommended to be no more than $10 an hour. Care Advisors are cautioned to advise Participants that initial salaries should be at a lower rate than the maximum to allow for salary increases to reward good work or for modest salary increases to meet rising inflationary costs. Larger salary rates will increase the total unit rate for the Personal Assistant due to the employer portion of taxes that must also be paid. It is critical that Care Advisors work closely with Participants as they consider salary offers for prospective employees, not to determine the salary but to over advice and guidance.

PROVIDER OF FISCAL MANAGEMENT SERVICES

The state Department of Health and Human Services (DHHS) has in place a contract with a Fiscal Management Service (FMS) organization for statewide assistance to Participants in CDS programs to provide payroll and payroll related support services for Participants in CDS programs. Overall management of the contract has been delegated to the Division of Medical Assistance (DMA), with staff at various levels in other divisions of DHHS supervising, monitoring, and providing technical assistance to local CDS programs operated by local entities of the various divisions. Within DAAS, direct monitoring of local programs of CDS is delegated to AAAs. Overall monitoring of the CDS programs supported with DAAS funding will be conducted per usual procedures by state DAAS staff.

Upon receiving the Participant Referral Form for FMS by a Care Advisor that a new Participant in a DAAS local program of CDS has been selected, the FMS will contact the Participant to explain the process of payroll, to complete necessary paperwork to enroll the Participant, and to explain the Criminal Background Check they will provide for each Personal Assistant the person may consider as a potential employee. When a Personal Assistant has been selected, the FMS will initiate the legal paperwork necessary to perform the payroll service for the Personal Assistant. The FMS will enter units directly to ARMS for payroll services provided and their FMS administration fee as well as other services for which they may be granted authorization.

The FMS is paid a fee of $75 monthly for payroll and other services provided per Participant each month. In addition, when a new Participant is enrolled in CDS, the FMS charges a one-time administrative start up fee of $75. Payroll is not a function of the local provider agency. **Personal Assistants are** not employees of the local agency but are **employees of the Participants in the CDS program.** The results of criminal background checks will be shared with the Participant and the Care Advisor for consideration of candidates eligible for hire. **No person may be hired if the results of the background check indicated they have offenses that are described in the Criminal Background Check Policy described in the policy included in the Appendix to this manual.** The FMS will make no recommendation regarding the employment of a person based upon the results of the Criminal Background Check. Employment decisions are the responsibility of the Participant or their Representative

The Fiscal Management Service will perform the following tasks:

- **Payroll Functions**

  The FMS enrolls Participants for payroll services for their respective Personal Assistants. This also entails enrolling the employees for provision of payrolls that are issued twice a month. All work with both the state and federal internal revenue programs regarding payroll and taxes for Personal Assistants is a function of the FMS. Payroll hours must not exceed those that are indicated on Authorization forms issued to the FMS by the Care Advisor. When the hours

recorded on Time Sheets and signed by both the Participant and the Personal Assistant exceed more than 10% of those authorized for the two pay periods in a month, the Participant and the Personal Assistant will be contacted by Customer Service of the FMS. If there is no resolution of the problem, the Customer Service representative will contact the Care Advisor to request help to resolve the issue. The Program Director at DAAS or the AAA Director may also be contacted by the FMS for help with resolving payroll related issues. When problems arise, all relevant parties involved in the process must be involved in the resolution. Payroll checks or Direct Deposits will be issued by the FMS. Required filings to state and federal tax divisions will be made by the FMS per the schedules required by law. Payroll and related report will be available for review in a secure website of the FMS with passwords to access the site provided each entity that will need access for purposes of monitoring the FMS service. These include the local provider agency, the AAA, and the state DAAS.

- **Entering Payroll Hours and Vendor Services to ARMS**

Monthly, the FMS will enter units of payroll hours for Personal Assistants and other authorized services into the DAAS Aging Resources Management System (ARMS). The process for entering payroll hours (units of service) is a three part process which is described below:

1. Timesheets

    - Timesheets are received by the FMS for review to determine accuracy including appropriate signatures and budgeted hours. Questions or issues with timesheets are communicated with the Personal Assistant to determine necessary corrections.
    - The FMS processes payroll data and issues payment of Personal Assistants according to the agreed upon schedule.

2. Payroll
    - All hours, taxes and costs are calculated to determine the unit hourly cost per Personal Assistant and a summary of cost per client is generated.
    - $75 per client per month payroll processing fee is charged and entered into ARMS for reimbursement. (Note a one time setup fee of $75 is also charged)
    - Invoices are created and sent to each Care Advisor (local agency provider) for the total payroll per program and for the total FMS fee for processing of payroll (either electronic or hardcopy).

3. Reconciliation and Billing

- Since there can only be one unit rate in ARMS for each Home Care Independence Program per county, an 'average rate' must be established.
- **Initially, the average unit rate for all new programs is $10.87 in ARMS**. A new average unit rate, based upon salary rate, taxes, etc is calculated quarterly thereafter.
- The average rate is done by taking the actual cost of each Personal Assistant per county and dividing it by the number of Personal Assistants. For example: If there are 5 Personal Assistants working in one county, their costs are broken down as follows:

  Personal Assistant 1: $10.05
  Personal Assistant 2: $ 9.23
  Personal Assistant 3: $ 8.62
  Personal Assistant 4: $11.01
  Personal Assistant 5: $ 9.85
  Total $48.76

  Divided by 5 workers equals $9.75 average hourly/unit cost and is entered as the unit rate in ARMS.

- The FMS performs this reconciliation and communicates the new unit rate to the Care Advisor on a quarterly basis at the end of **September, December, March** and **June.** Care Advisors must communicate adjusted unit rates to their Area Agency on Aging as a budget revision to ARMS and should also revised Participant budgets to reflect the new unit rate.
- Invoices are adjusted monthly by the FMS to match unit rates and amounts reimbursed through ARMS. The FMS will reconcile ARMS and actual costs monthly to ensure accountability.

The FMS will notify the provider agency of the actual payroll amount, inclusive of hourly salary and all related employer taxes at the end of two payroll periods for all new employees. This will enable the provider agency to have better control over the funds that are supporting a Participant in the CDS program such that decisions can be made regarding additional hours of service that might be authorized or to enable provider agency budgets for Participants to be adjusted up or down as indicated. Six months from the date that CDS was established by a local provider, the agency will be advised by the FMS that the average salary and taxes for the agency's program has changed or that it remains the same. It is this average figure that the FMS will enter to ARMS until it is evaluated at the end of the state fiscal year, at which time the figure is adjusted once again. The adjustment may or may not result in a payment adjust of funds between the FMS and local agency.

NOTE*: Adjusted unit rates in ARMS are retroactive for all units reported from July 1 of the fiscal year. Therefore, each reconciliation must encompass all Personal*

Assistants who have worked in the program from July 1 to the present (including those still active and those who have dropped out).

- **Reporting**

  The FMS will comply with all established terms of the State contract for reports. Problems such as failure of the Personal Assistant to submit time sheets as required, or problems with the preparation and distribution of payrolls per deadlines, among other many possible situations affecting payrolls must be reported to the Care Advisor when efforts to resolve a problem are futile. Payroll reports will be submitted to the CDS provider agency and to the Participants in the CDS program on a monthly basis. Payments to the State and Federal governments of payroll taxes will be made as required by law and reports of this activity provided to the Participant and the provider agency. Payroll and other reports will be available on a secure website of the FMS for review by the local provider agency, the relevant AAA, and by DAAS. HIPAA protected passwords will be issued by the FMS for viewings the reports.

- **FMS Online CDS Documents**

  The following items would be available to view online (this is not an all-inclusive list and could be modified as necessary):
  Timesheets
  Payroll Journals
  Budget Reports
  QuickBooks Invoices
  Vouchers
  Cost Reconciliations
  EZClaim Claim Lists
  Text/Excel Files with claim info
  ARMS rate adjustments/reconciliations

  A generic user account is available to see how the SecureDrawer system functions.

  Upon request; each individual user is created; utilizing the user's email and a unique password for login credentials.
  With regard to the folders created; if it is a recurring item; once the latest version (i.e. timesheets) is available it will be moved onto the SecureDrawer site and the end user will receive an email notification that there are new documents to be viewed.

  The end user does have the option of deleting the document once they have retrieved it; it does not delete it from the internal repository of the FMS.

- **Employment Related Tasks**

  The State DHHS contract with the FMS specifies tasks that the FMS will perform to help the Participant become a good employer of Personal Assistants. This will include providing criminal background checks on prospective employees of Participants, and counseling them on how to handle time sheets in a manner that best accomplishes accurate payrolls and salary payments. The FMS will provide all the forms that are required to provide payroll services, provide payrolls twice a month, make the payments for taxes related to payroll services, and generate payroll reports. They will also offer advice to Participants on ways they can be good employers of Personal Assistants.

- **Vendor Payments for Community Goods and Services**

  The local agency may be request the FMS to make payments to community vendors of goods and services for items included the Plan of Care for CDS maintained by the Care Advisor. This may include payments for across- the-counter medications from drug stores or for home items such as micro waves or lift chairs not covered by other funding sources and yet are related to the care needs of the individual in the home setting. Other allowable services could include incidental yard work and minor home repairs that are necessary for the health and safety of the Participant. These items will be specified to the FMS during the enrollment process of a Participant for this service and at other times when the care needs of the Participant indicate the need for such assistance. The Care Advisor would authorize the FMS to work with the Participant to obtain the needed services or items. The AAA would make this possible through the ARMS. Reimbursement requests for these purchases would then be entered to ARMS by the FMS. The FMS should maintain documentation of the reimbursement payment process for the authorized goods and services. Participants would pay for the items, submit a paid receipt to the FMS who, in turn, would enter the cost to ARMS and reimburse the Participant upon receipt of funds for the payments made to vendors.

AREA AGENCIES ON AGING

AAAs will have primary responsibility for providing technical assistance and monitoring to ensure that the quality of the Home Care Independence Program is developed according to the procedures of the Home Care Independence Manual. The AAA will set up the FMS in ARMS for entering all allowable unit costs for which the local agency gives approval. AAAs will monitor the Participant records maintained by the CDS agency, including the required contacts with Participants, all Participant forms for

service, and review of FMS reports maintained on a secure website, using a protected password, of the FMS for payroll and related taxes and payments of goods and services made by the FMS. AAA Directors will work with local agencies and county planning groups for aging services to obtain and sustain funding for the CDS programs and to promote by all means available this new approach to service delivery.

DIVISION OF AGING AND ADULT SERVICES

The Program Director for the Home Care Independence Program with DAAS will provide overall guidance to AAAs, working cooperatively with them and with local entities that elect to develop programs of CDS, to provide technical assistance, training, and other enabling assistance as AAAs and local providers strive to put Home Care Independence programs in place at the local level. The Program Director will also work closely with the Division of Medical Assistance which serves, at the appointment of the Department of Health and Human Services, as the state management entity for the overall contract with the FMS to assure that the requirements for payroll services are fulfilled with regard to Participants in the Home Care Independence program. In addition, the Program Director will review the AAA overall monitoring of the program, , reports submitted by the FMS to the local entity and the AAA, and all relevant reports maintained on the secure website of the FMS. This review will include AAA notations of corrective measures that were taken by the FMS to resolve issue relative to payroll, taxes, or payments for goods and services. Oversight monitoring of AAA monitoring of CDS programs will be carried out by state DAAS staff per the usual monitoring procedures of DAAS.

CHANGES IN STATUS OF PARTICIPANTS

HOSPITALIZATION OR REHABILITATION SERVICES

When a Home Care Independence Participant is hospitalized, the service will be suspended until the person returns to the home setting.

If at any time a participant requires placement in a hospital or rehabilitation facility, the Care Advisor for Home Care Independence will suspend CDS. The Personal Assistant may assist with the transition to facility but ***may not provide assistance while the participant is in the facility.*** The FMS must be notified, using the FMS Change Order Form, that the participant is temporarily suspended from service. The Personal Assistant may also help to transition the person back to the home setting. The FMS should also be notified when the participant is returning to the home setting.

The Participant will be suspended for service for no more than one month following the

date of entry to the hospital or rehab facility. At the end of thirty days of placement in a facility, if the person is not discharged, participation in Home Care Independence is terminated Should it be determined that the person will be discharged within seven days following the thirty days in the facility, the local provider agency administrator must approve the extension of time in order to prevent termination of Home Care Independence participation. No monthly expenditures for Home Care Independence service is allowed during a period of institutionalization for hospital or rehabilitation services. When a person is discharged to home from the facility, the Care Advisor should meet with the family to determine if care needs have changed and adjustments needs to be in the plan of care. Those Participants who enter a rehabilitation facility following hospitalization are to be re-evaluated for service needs upon their discharge as well. The reason the person was hospitalized and entered rehab should be considered when the person returns home and requires continuation of services. Care plans should be revised as appropriate and the FMS should be notified to resume service as well as other information necessary for appropriate services to be provided. Those former CDS Participants who are in facilities for more than one month and one week will be completely re-assessed for Home Care Independence, if they make the request for CDS upon discharge from the facility. The reason they were in a rehab facility should be taken into consideration when making this assessment. The person may need to go on a waiting list for service if the availability of funding is limited when the person requests service.

PERMANENT ADDRESS CHANGES

Should the Home Care Independence Participant move out of the state of North Carolina or to any county in the state where Home Care Independence is not an option, the local agency that had been providing service will terminate the person's program participation in that county. If the Participant moves into another county operating a Home Care Independence program under DAAS funding, the Care Advisor will contact the agency in the new county to find out if service can be initiated. If Home Care Independence is not feasible for whatever reason, the second county should provide information to help the consumer locate other sources of help. The second county may also choose to place the person on a waiting list for Home Care Independence if the county has this service but does not have immediate funding to initiate service.

VOLUNTARY DISENROLLMENT

The Participant may elect to discontinue participation in Home Care Independence at any time. When a Participant expresses an interest to withdraw from the program, the Care Advisor first will make every effort to determine if there is dissatisfaction with the service. If the effort does not result in continued participation in the program, the Care Advisor will document and date when participation in Home Care Independence was closed. The Participant should notify the FMS and arrange for payroll service to terminate. The Care Advisor will confirm that this has been done. At any point in

working with a Care Advisor, a Participant may decide not to proceed with Home Care Independence. The Care Advisor will document and date when the person elected to discontinue participation in the program and will work with the individual, if requested by the person to do so, to help them obtain other services that may be available in the community to meet their needs.

INVOLUNTARY DISENROLLMENT

Participants may be disenrolled from Home Care Independence for the following reasons:

- **Health, Safety and Well-being**
  At any time that the Care Advisor and others involved with the Participant determine that the health, safety and well-being of the Participant is compromised by continued participation in Home Care Independence, the Participant may be terminated from the program and efforts made to obtain more traditional services. The person's needs may have changed to the point that nursing home placement or CAP/DA or CAP Choice is more appropriate. The Care Advisor should work with the local CAP agency to discuss the Participant's need for CAP service. At least two weeks notice must be provided the Participant or the Representative before the Participant's service is terminated.

- **Change in Condition**
  Should the Participant's ability to direct his/her own care diminish to a point where they can no longer do so and there is no responsible Representative available to direct the care, participation in Home Care Independence will be terminated and efforts made to obtain services through more traditional service programs. At least two weeks notice must be provided the Participant before service is terminated. The Care Advisor should maintain vigilance during the period in monitoring the well-being of the Participant.

- **Misuse of Funds Budgeted for Plan of Care**
  If it is determined that budgeted funds are not being used for the intended purpose specified in the Plan of Care and ***efforts to improve the situation do not result in funds being used as intended***, the Care Advisor will give a week's notice to terminate Home Care Independence. If serious and fraudulent use of funds has been determined, the local agency will terminate service immediately and initiate legal action per local agency procedures to retrieve the funds. If the family is determined to be unable to mange self-direction of service, the Care Advisor should assist the Participant to obtain needed services through more traditional service programs or other available sources of help.

- **Death of Participant**
  Should a Participant die, the Care Advisor will maintain the Service Budget until all costs of care incurred during the period before the consumer's death are

paid. The Home Care Independence agency will close out the Participant's record and work with the FMS to assure that all appropriate taxes have been paid and all remaining payroll activities have been finalized. Part of this assurance will be to verify that all payroll and related taxes for the Personal Assistant(s) of the deceased Participant have been paid when due and all appropriate and required reports are submitted in a timely fashion. Reports prepared by the FMS will not be available to the local agency, the AAA, or DAAS until that time of the year when such reports are submitted to the appropriate federal and state agencies.

FAMILY VACATION

Although Home Care Independence services are designed to be provided in the home of the Participants, the services of a paid caregiver may be provided outside the participant's home when the Participant is vacationing with family. This must be approved by the Care Advisor and the Participant advised that care received must not exceed the budgeted amount; however, family members may choose to provide the needed care at no cost to the budget during the vacation period.

STANDARD PROGRAM REQUIREMENTS

CRIMINAL BACKGROUND CHECKS

The FMS will provide this service in behalf of program Participants when they are in the process of screening applicants for Personal Assistant positions. The decision to hire someone after the review of Criminal Background Checks will be the decision of the Participant after consultation with the Care Advisor. The FMS will not make any recommendation for hiring Personal Assistants. ***See the Criminal Background Check Policy included in the appendix to this manual.***

APPEALS

The current local appeals process already in place in a local provider agency will be followed whenever this process is needed. If the local provider agency does not have an appeals process, one must be adopted by the agency within three months following the start up of the Home Care Independence program.

REPORTING OF ABUSE

Anyone can make a report of abuse and neglect to the county department of social

services if the person has reasonable cause to suspect that an adult has been abused or neglected. Home Care Independence staff in local agencies, AAAs, the FMS, and others involved with CDS program must report suspected abuse of older adults participating in the program to the department of social services in the county where the alleged abuse or neglect occurred.

RETENTION OF RECORDS

Unless stated otherwise, all Home Care Independence participant files must be maintained for a period of five (5) years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever is longer. The records must be made available to authorized representatives of DAAS or at the request of the Department of Health and Human Services (DHHS) for any state or federal entity representing the Department for purposes of audit or legal issues.

CONSUMER CONTRIBUTIONS

Programs of CDS are expected to observe the HCCBG policy of Consumer Contributions.

QUALITY MANAGEMENT

The local provider agency responsible for the Home Care Independence program must follow the procedures outlined in this state manual for the operation of the program and will determine written local procedures that describe how to locally structure and operate the program. This would include but not be limited to;

- Where in the organizational structure of the agency the program is placed.
- Who in the agency has a role in the CDS program.
- Will the Care Advisor be a staff person or a contract worker.
- How marketing the program will be carried-out or how potential clients for the program advised of its existence.
- The process of determining eligibility for HCCBG, assessing the specific needs of individuals for service, and screening appropriate applicants for CDS participation.
- The process for assuring that Personal Assistants hired by the Participant meet the allowable criteria, including the results of Criminal Background Checks, outlined in the DAAS Home Care Independence Manual.
- Identifying how paperwork relative to CDS will be maintained by the agency.
- Identifying the internal procedures for responding to Participants when issues of service are identified.
- Identifying the internal procedures for responding to issues related to the FMS when they are identified.

- Procedures for assisting a Participant to locate services if there is termination from CDS for reasons other than death, a move to facility care, or a move from a county.
- How the local agency will review the procedures of the FMS for the purpose of determining that payrolls are made within budget guidelines, that payroll taxes are being paid when due, that payroll related reports are submitted to the local agency when due, and that other services of the FMS are being provided according to specified procedures of the FMS.

REMINDER: ***The FMS will file monthly reports on payroll and other financial activities on a secure website.***

The DAAS Program Director and designated AAA staff will offer technical assistance if needed in the preparation of the required local procedures that will describe the operation of the local agency's CDS program. These procedures should be adopted by the local agency's governing body by the end of the second quarter following the start up of a program of CDS. The AAA and DAAS will be provided a copy of the approved procedures manual. Until the local manual is approved, the local entity should work closely with the AAA, with input from DAAS as needed in setting up a program that meets the guidelines set forth in the state operations manual. It is understood that the process will be a fluid one until such time as the process of identifying Participants, assessing needs, working with the FMS, and working within guidelines of ARMS become standardized.

A Memorandum of Agreement, included in the Appendix to this manual, must be signed between the local provider agency and the FMS when a CDS program is created. The

Memorandum specifies the tasks and responsibilities of both the local agency and the FMS in working with Participants and their Personal Assistants in the provision of payroll services.

Local staff should review reports from the FMS and should maintain open communication with both the Participant and the FMS. The FMS procedures outlined in the DAAS Home Care Independence Operations Manual will be reviewed by the local Home Care Independence agency and applied to their review of payroll and other reports prepared by the FMS to determine if the contractual terms for providing payroll, related tax functions, and other contractual services are being fulfilled. The local agency operating a Home Care Independence program should determine that goods and services included in a Participant's budget have been purchased. Reports submitted to the local agency by the FMS relative to payroll payments and goods and services would be reviewed to determine if payroll related costs and vendor services have been made in accordance with authorized hours of service recorded on time sheets and payments for goods and services have been properly invoiced. When the Home Care Independence agency is monitored, the AAA staff would look for evidence that the local agency has worked closely with the FMS to assure that payrolls have been issued in a timely and correct manner and that other specified payments

authorized to be made by the FMS have been issued correctly.

Throughout the process of consumer direction, Participants, Care Advisors, FMS personnel, AAA staff, DAAS staff, and Representatives for Participants, when applicable, are all involved in a team approach to the provision of service. This team approach serves to protect the Participant from harm and abuse in an approach to service delivery that enables the person to have more direct and daily control over how, when, and by whom personal care and/or home management needs will be met in his/her home setting.

AGING RESOURCES MANAGEMENT SYSTEM (ARMS)

The Aging Resource Management System (ARMS) is a client tracking system for demographic data and a reimbursement system that ties reimbursement to performance for HCCBG defined services. The following chart indicates the unit based codes and unit definitions and the non-unit based codes and definitions that have been defined for services reimbursable under the DAAS Consumer Directed Services program. For detailed ARMS instructions go to http://www.ncdhhs.gov/aging/arms/manual/CDS-ARMS.pdf

CHART OF CONSUMER DIRECTED SERVICE CODES AND RATES

UNIT-BASED ARMS SERVICES			
SERVICE	**ARMS CODE**	**RATE**	**OTHER**
PERSONAL ASSISTANT (100 HOURS MAXIMUM/MONTH)	**501**	**$10.87**	**Initial entry for new agencies, with adjustments third month of calendar quarters**
ADULT DAY SERVICES (26 UNITS MAXIMUM/MONTH)	**502**	**The State daily rate for Adult Day Care****	**The rate for Adult Day Services is adjusted as the state rate for Adult Day Care is adjusted…effe.2/1/13, rate is $33.07**
Financial Management Services Fees (FMS)	**503**	**$75.00**	**Initial entry fee of $75.00 and monthly fee of $75.00 per Participant.**
Home Delivered Meals (99 maximum/month)	**505**	**At established rate in county**	**NA**
NON-UNIT BASED ARMS SERVICES			
Care Advisor	500	The provider agency's salary rate plus all	Typically entered as 1/12 of annual amount into ARMS

		payroll related taxes and benefits	
Medical Adaptive Personal Care, Nutritional Supplements, and Incidental Yard and Minor Home Repair Services	504	Actual cost per terms of Participant's budget	NA
Emergency Response Equipment	506	Monthly cost of service not to exceed $50	If monthly amount more than $50, Participant would pay the difference
Medical Adaptive Equipment	507	Actual cost per Participant budget terms	**Up to a maximum of $300 annually….Actual amount may be prorated over 12 month period**

SECTION II: APPENDIX……**SEE FORMS THAT FOLLOW**

PROVIDER AGENCY FORMS AND DOCUMENTS:

MEMORANDUM OF AGREEMENT
DAAS CLIENT REGISTRATION FORM
PARTICIPANT SELF-ASSESSMENT FORM
SERVICE ASSESSMENT/REASSESSMENT FORM
APPOINTMENT OF REPRESENTATIVE FOR PARTICIPANT
PARTICIPANT ENROLLMENT FORM
CDS PLAN OF CARE/BUDGET
BACK UP PLAN FOR CDS
PARTICIPANT BILL OF RIGHTS
EMPLOYMENT APPLICATION AND CRIMINAL RECORD CHECK CONSENT FORM
PARTICIPANT REFERRAL FORM FOR FMS
CHANGE ORDER FORM FOR FMS
CDS CRIMINAL BACKGROUND CHECK POLICY

FMS FORMS AND DOCUMENTS*:**

FMS AGREEMENT
EMPLOYMENT AGREEMENT
PERSONAL ASSISTANT BILL OF RIGHTS
SELF DETERMINATION EMPLOYEE TIME CARD
SELF DETERMINATION TIMESHEET INSTRUCTIONS
PAYROLL SCHEDULE E
FAX COVERSHEET FOR SELF-DETERMINATION CLIENTS
LETTER OF INQUIRY TO PERSONAL ASSISTANTS WHO MAY WANT EXTRA WORK WITH OTHER RECIPIENTS
CAREGIVER LINK TO CAREGIVER DIRECTORY FOR THOSE PERSONAL ASSISTANTS SEEKING ADDITIONAL EMPLOYMENT

***THERE ARE OTHER FMS RELATED FORMS REQUIRED BY LAW FOR PROVISION OF PAYROLL SERVICES OR ARE FORMS THAT THE FMS NEEDS FOR INTERNAL PURPOSES….THESE HAVE NOT BEEN INCLUDED

Local Provider Agency Forms

MEMORANDUM OF AGREEMENT (MOA)
Between
GT Financial Services
And

This Memorandum of Agreement (MOA) is entered by and between GT Financial Services (hereinafter referred to as the "FMS"), and the _____ (hereinafter referred to as the "local provider"), for the purpose of providing payrolls for Participants in the Consumer Directed Services (hereinafter referred to as "CDS") program and their employees called Personal Assistants, in addition to making payments to community vendors for other identified services provided the Participants in the program. For purposes of this MOA, Consumer Directed Service program means a program that enables Participants to hire their caregivers directly and provide for their training, supervision, and payments of salary. Local providers of CDS are required by the State Department of Health and Human Services (hereinafter referred to as "DHHS") to use the payroll services of the FMS per terms of a three year contract signed with GT Financial Services for this purpose in CDS programs operated locally by any division of DHHS.

GT Financial Services agrees to:

1. Provide payroll services for Participants in the CDS program.
2. Enroll Participants for the payroll service and to obtain all needed signed forms and permissions to perform in this capacity. The primary method by which GT will enroll participants will be through home visits unless the home situation makes it inconvenient for the Participant to do so, making occasional enrollments through the mail a necessity. This process includes enrollment of Personal Assistants for payments of payroll services by obtaining signed legal forms and other data from them that are critical to this procedure.
3. Conduct Criminal Background Checks on every employee and transmit the results to the Participant and the local provider agency. (Whether or not the prospective employee will be hired by the Participant is based upon the criteria specified in Criminal Background Check policy of the state and the decision of the Participant so long as the person does not have criminal offenses that are Lifetime Bans for employment in the Home Care Independence program.)
4. Provide the Personal Assistant with a copy of the Personal Assistant Bill of Rights, signed by both the Personal Assistant and the Participant, with a copy provided the Participant and the original provided the Personal Assistant.
5. Train Participants and Personal Assistants how correctly to use Time Sheets that are provided by the FMS.
6. Review Time Sheets submitted per the published payroll schedule by Personal Assistants to assure that hours submitted are reflective of the hours authorized per the Participant Referral Form for Financial Management Services.
7. Clarify any discrepancies on Time Sheets with regard to hours of service with the Participant/Personal Assistant and/or Care Advisor.
8. Enter Personal Assistant units of service and, if authorized to do so, enter reimbursements for other goods and services directly to ARMS.
9. Issue payrolls within current payroll time periods unless discrepancies cannot be resolved before the beginning of another payroll period, at which time payrolls are included in the next payroll period.
10. Provide payments to local vendors for specific services if authorized to do so on the Participant Referral Form for Financial Management Services.
11. Maintain open communication with all parties to the provision of CDS…Participants (and Representatives, if applicable), Personal Assistants, Care Advisors, AAA staff, and the program manager of the DAAS Home Care independence program….by having a Customer Service Representative of the FMS assigned to each local provider agency of CDS.

12. Make all payments per required periods to appropriate government entities of all taxes due in behalf of Participants and Personal Assistants in the local CDS program.
13. Issue payroll reports to the local provider agency and Participants per month.
14. Make certain forms available for access by local agency staff via a secure web-based connection including individual monthly reports, billing reports and claims information. Make any information related to provision of services available via mail or fax when appropriate or needed for purposes of contract monitoring by representatives of the state.
15. Work cooperatively and collaboratively with the Participants, Personal Assistants, Care Advisors, the relevant AAA, and the state DAAS to provide a CDS program recognized by all involved to be one of outstanding quality.
16. Be attentive and responsive to issues that may arise during periods of program monitoring by the relevant AAA and the state DAAS.
17. Work with the local provider agency and others to resolve any issues that are presented during monitoring.
18. Provide the local CDS a description of all services and procedures to be carried out by GT Financial Services with respect to Home Care Independence.

The local provider agency, _____, agrees to:

1. Screen individuals for HCCBG eligibility and potential participation in the local CDS program
2. Provide a Participant Self-Assessment Form for CDS to prospective CDS participants for their determination of what services they want and need.
3. Complete a professional Assessment/Reassessment form. This assessment is completed by a Care Advisor.
4. Review the two assessment forms with the individual and complete a Participant enrollment Form if the person appears to be a good candidate for CDS.
5. Complete the Appointment of Representative form if the person wants or needs someone who can help make decisions regarding services and other aspects of participation in the CDS program.
6. Complete a Consumer Directed Services Plan of Care/Budget form with the Participant. The plan encompasses input from both the self-assessment and agency assessment of need. Both the Care Advisor and Participant sign the document.
7. Provide the Participant two copies of the Participant Bill of Rights, to be signed by both the Participant and the Personal Assistant upon hire. A copy will given to the Personal Assistant. When additional or replacement Personal Assistants are hired, this process will be repeated.
8. Provide the Participant an Employment Application/Criminal Record Check Consent Form for their use in securing an employee.
9. Complete a Participant Referral form for Financial Management Services and transmit by Fax to the Enrollment Specialist of the FMS authorizing services to be provided by the FMS.
10. Review Criminal Background Check reports received from the FMS to determine that the prospective employee of a Participant meets the acceptable criteria for consideration of hire by the Participant. It is the Participant or their Representative who make the hiring decision. If the person has offenses that warrant a Lifetime Ban from employment in the Home Care Independence program, this must be communicated to the Participant and documented in the Participant's file.
11. Complete a Change Order Form for Financial Management Services when changes occur that will affect the services provided by the FMS and transmit by Fax to Customer Services of the FMS.
12. Prepare a local procedures manual that specifies how the local provider agency will carry out CDS at the local level, designating staff positions involved in the process, how the program will be marketed, and the attention to details of the maintenance of case files and contacts with the Participants, their Personal Assistants, the FMS staff, and with the relevant AAA, and the state DAAS.

13. Maintain individual Participant files with copies of forms, monthly payroll reports, dictation of contacts with Participants and others involved in the provision of service or monitoring of the CDS program
14. Provide advice and guidance to Participants in the CDS program, applying principles of person-centered service. The Participant makes the decisions regarding wants and needs expected from the program.
15. Access the website of the FMS to review payroll reports, tax payment reports, and other reports to monitor the payroll service to individual Participants.
16. Work cooperatively and collaboratively with the Participants, Personal Assistants, the FMS, the relevant AAA, and the state DAAS to provide a CDS program recognized by all involved to be one of outstanding quality.
19. Be attentive and responsive to issues that may arise during periods of program monitoring by the relevant AAA and the state DAAS.
20. Work with the FMS, the relevant AAA, the state DAAS and others representing the state to resolve any issues that are determined during routine contacts with the Participants and others to resolve routine issues presented or that are presented during times of official program monitoring.
21. Assure that the FMS is paid on a monthly basis for Personal Assistant units and other expenditures entered to Arms by the FMS per the established procedures for HCCBG reimbursement in the AAA region.

This MOA shall begin on _____ and does not need to be renegotiated each year unless the state of North Carolina through the Department of Health and Human Services should terminate the contract with GT Financial Services or there are deletions or additions to the payroll and vendor services to be provided by the FMS. In addition, the MOA may be amended if there are special additions to the local services requested by the local provider agency and agreed to by the FMS. If the local provider that has signed the agreement changes names or is moved to another administrative auspice, the MOA must be renegotiated and signed by the new local provider and the FMS. The MOA does not need to be renegotiated each year. This MOA is agreed to by the following individuals representing the local provider agency for CDS and GT Financial Services,

Financial Management Service: GT Financial Services	Local Provider Agency for CDS: _____
By; _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

Eff. 7/1/11
Revised 2/1/13

CLIENT REGISTRATION FORM • DAAS 101 (Long Form)

NC Department of Health and Human Services, Division of Aging and Adult Services

Section I: Required for all clients

Service Code(s):

Region Code:

Provider Code:

Complete all sections of this form identified for the applicable service codes.

- HCCBG congregate nutrition **(180)**, NSIP-only congregate meals **(181)**, congregate liquid nutritional supplement **(182)** – complete Sections I, II, and VII only.
- HCCBG general **(250)** or medical **(033)** transportation – complete Sections I and VII only.
- Family Caregiver Support Program (all codes in **820, 830, 840, 850 except 821, 822, 831, 841, 851, 861**) and Project C.A.R.E. – enter information for caregiver in Sections I, VI, and VII and for care recipient in Sections III, IV, and V.
- HCCBG In-home Aide Respite **(235, 236, 237, 238)**, Group Respite **(309)**, and Institutional Respite **(210)** – enter information for the hands-on recipient of services (not the caregiver) in Section I, IV, V (if appropriate), VI (if appropriate), and VII.
- HCCBG care management **(610)**, home-delivered meals **(020)**, NSIP-only home-delivered meals **(021)**, home-delivered liquid nutritional supplement **(022)** – complete Sections I, II, IV, V (if appropriate), VI (if appropriate), and VII.
- For **all other** HCCBG services, complete Sections I, IV, V (if appropriate), VI (if appropriate), and VII.

1. **Client Status**: *Check the appropriate box(es). Enter the date of client status change.*

☐ New Registration/Activate (Date: _____)

☐ Waiting for Service (complete Section I only): (Date: _____)

☐ Enter waiting for service codes: _____ _____ _____

☐ Change of information (Date: _____) (Complete Section 1 – Items 2, 4, 5, plus information that needs to be changed)

☐ Inactive (Date that provider believes client became inactive for the reason stated below: _____)

Enter reason for making client inactive below. Make a client inactive only if the person is thought to be permanently leaving the service system.

If the client is a caregiver receiving FCSP or Project C.A.R.E. services and the reason for making the client inactive relates more to the care recipient's status, check the box for "Care Recipient."

Reason for making client inactive applies to: *Client/Caregiver* ☐ OR *Care Recipient* ☐

☐ Moved to adult care home/assisted living
☐ Alternative living arrangement
☐ Death
☐ Hospitalization (not expected to return)
☐ Nursing home placement
☐ Moved out of service area
☐ Improved function/Need eliminated
☐ Service not needed/wanted
☐ Illness (not expected to return)
☐ Other (Specify): _____

2. Legal Name, Last First MI Suffix

4. Last 4 digits SSN

Not for data entry -- name person likes to be called, if different from legal name on SS card:

5. Date of Birth

☐ *Check if special eligibility*

3. Street Address

Mailing Address ☐ Same as street address

6. Phone #

City State Zip County

☐ No phone

7. Sex *(check one)*

☐ Female
☐ Male

8. At or Below Poverty Level? *(check one)*

☐ Yes
☐ No

9. Marital Status *(check one)*

☐ Single (never married)
☐ Married
☐ Single (divorced/widowed)
☐ Refused to answer

10. Household Size *(check one)*

☐ Lives alone
☐ 2 in home
☐ 3 or more in home
☐ Group/shared home
☐ Refused to answer

11. Race

	Check the one race with which client most identifies:	*Check all that apply:*
Black or African-American	☐	☐
Asian	☐	☐
American Indian or Alaska Native	☐	☐
White	☐	☐
Native Hawaiian or other Pacific Islander	☐	☐
Unknown/refused	☐	

12. Ethnicity *(Are you of Hispanic or Latino origin?)*

☐ Not Hispanic or Latino
☐ Hispanic Puerto Rican
☐ Hispanic Mexican American
☐ Unreported
☐ Hispanic Cuban
☐ Hispanic Other

13. Primary language spoken in the home:
(see 30 language options in CRF instructions manual)

Name of Emergency Contact: _____ ☐ *Refused to provide emergency contact information*

Day phone no.: _____ Evening phone no.: _____

14. Caregiver's Overall Functional Status: ☐ Well ☐ At risk ☐ High risk

(When the caregiver is registered as the client, use this field for the caregiver's self-reported functional status and then complete Section IV for care recipient.

Section II: Required only for clients of HCCBG congregate meals, home-deliverd meals, liquid nutritional supplement meals, NSIP-only meals, or care management services.		
15. Nutrition Health Score		Refused to Answer
a. Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐ Yes ☐ No	☐
b. How many meals do you eat per day?	#	☐
c. How many servings of fruit per day?	#	☐
d. How many servings of vegetables per day?	#	☐
e. How many servings of milk/dairy products per day?	#	☐
f. How many drinks of beer, liquor, or wine do you have every day or almost every day?	#	☐
g. Do you have tooth/mouth problems that make it hard for you to eat?	☐ Yes ☐ No	☐
h. Do you always have enough money or food stamps to buy the food you need?	☐ Yes ☐ No	☐
i. How many meals do you eat alone daily?	#	☐
j. How many prescribed drugs do you take per day?	#	☐
k. How many over-the-counter drugs do you take per day?	#	☐
l. Have you lost 10 or more pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
m. Have you gained 10 or pounds in the past 6 months without trying?	☐ Yes ☐ No	☐
n. Are you physically able to shop for yourself?	☐ Yes ☐ No	☐
o. Are you physically able to cook for yourself?	☐ Yes ☐ No	☐
p. Are you physically able to feed yourself?	☐ Yes ☐ No	☐

Section III: Complete for the care recipient (not caregiver) if services are funded by Family Caregiver Support Program and/or Project C.A.R.E.

CARE RECIPIENT #1 ***(For additional service recipients, attach an additional DAAS-101, Section III, IV, and V.)***

16. Name, Last	First	M.I.	SUFFIX	**Last 4 Digits SSN (or zeros)** ____ ____ ____ ____
Street Address		**Phone #** ☐ No phone		**Date of Birth** ____ ____ _____ MM DD YYYY
Mailing Address		☐ Same as street address		
City	State	Zip		**Sex** ☐ Female ☐ Male

17. Is care recipient a person with severe disabilities? ☐ **Yes** ☐ **No**

18. Does care recipient live in same household as caregiver? ☐ **Yes** ☐ **No**

19. Care recipient marital status: ☐ **single (never married)** ☐ **single (divorced/widowed)**
(check one) ☐ **married** ☐ **refused to answer**

Section IV: Complete for all clients unless the client is the caregiver, in which case complete Section IV for the care recipient. The only exception is that Section IV is not required for FCSP services involving minor relative children.

20. Does client (care recipient) have significant memory loss or confusion? ☐ Yes ☐ No

21. Number of IADL (Instrumental Activities of Daily Living)	Client (or care recipient) can carry out the following tasks without help.		*If the answer to items a –h in question #21 or items a-f #22 is "no," then select one of the following:*			
	YES	**NO**	Client (or care recipient) cannot do and has <u>someone unpaid</u> who assists.	Client (or care recipient) cannot do and has <u>someone paid</u> who assists.	Client (or care recipient) cannot do and has <u>both unpaid & paid</u> assistance.	Client (or care recipient) has <u>no one</u> who assists.
a. Prepare meals	☐	☐	☐	☐	☐	☐
b. Shop for personal items	☐	☐	☐	☐	☐	☐
c. Manage own medications	☐	☐	☐	☐	☐	☐
d. Manage own money (pay bills)	☐	☐	☐	☐	☐	☐
e. Use telephone	☐	☐	☐	☐	☐	☐
f. Do heavy housework	☐	☐	☐	☐	☐	☐
g. Do light cleaning	☐	☐	☐	☐	☐	☐
h. Transportation ability	☐	☐	☐	☐	☐	☐
Total "no" column = IADL impairments						

22. Number of ADL (Activities of Daily Living)						
a. Eat	☐	☐	☐	☐	☐	☐
b. Get dressed	☐	☐	☐	☐	☐	☐
c. Bathe self	☐	☐	☐	☐	☐	☐
d. Use the toilet	☐	☐	☐	☐	☐	☐
e. Transfer into/out of bed/chair	☐	☐	☐	☐	☐	☐
f. Ambulate (walk or move about the house without anyone's help)	☐	☐	☐	☐	☐	☐
Total "no" column = ADL impairments						

23. How many unpaid caregivers involved in care including primary caregiver? Enter # _____
(If answer to this question is "0," skip to Section VII.)

Section V: Complete for HCCBG respite, FCSP, and others responding with "1" or more in Q23.

24. How many hours per day of help, care, or supervision does care recipient need?

a. # of daily hours needed _____ b. If not daily, # of hours per week needed _____

25. How many hours per day of help, care, or supervision does primary caregiver provide?

a. # of daily hours provided _____ b. If not daily, #of hours per week provided _____

26. Primary caregiver's relationship to care recipient: *(check one)*

☐ wife	☐ sister	☐ mother	☐ aunt	☐ other relative
☐ husband	☐ brother	☐ father	☐ uncle	☐ non-relative
☐ daughter/daughter-in-law	☐ neice	☐ grandmother	☐ granddaughter/granddaughter-in-law	
☐ son/son-in-law	☐ nephew	☐ grandfather	☐ grandson/grandson-in-law	

Section VI: Complete for all caregivers. Questions 27-30 should be answered only by caregiver.

	1	2	3	4	5
27. Primary caregiver's self-reported health on scale of 1 (poor) to 5 (excellent) *(choose one)*	☐	☐	☐	☐	☐
28. Primary caregiver: How stressful for you is caregiving on a scale from 1 (not at all/very low) to 5 (very high) *(choose one.)*	☐	☐	☐	☐	☐

29. Primary caregiver's paid employment status:

☐ Full-time ☐ Part-time ☐ Quit due to caregiving ☐ Is not/was not working
☐ Retired early due to caregiving ☐ Retired/full benefits ☐ Lost job/dismissed due to caregiving

30. Is the primary caregiver a long distance caregiver? ☐ Yes ☐ No

Section VII: REQUIRED FOR ALL CLIENTS.

I, the client, understand the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. I understand that any entitlement I may have to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information. My signature authorizes the providing agency to begin the service(s) requested.

DATE:_____ CLIENT (Caregiver) SIGNATURE: _____

DATE:_____ AGENCY EMPLOYEE SIGNATURE: _____

Provider Use Only – inital below if no changes:

Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____

Provider Use Only – inital below if no changes:

Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____
Registration Update ____/____/____ Staff Initials _____

NC DAAS CONSUMER DIRECTED SERVICES
PARTICIPANT SELF-ASSESSMENT FORM

The Purpose of Self-Assessment is to help the Care Advisor in the local provider agency to determine the capacity of the consumer to be a Participant in the Consumer Directed Service program.

Based in part on the need assessment provided by the Participant and the consideration of factors by the Care Advisor, the combined observations will help to determine:

- ✓ **What help in the home is needed by the potential Participant in Consumer Directed Services**
- ✓ **The ability of the potential Participant to self-direct the care needed**
- ✓ **If there is a need for and someone available who can help the potential Participant function as the director of services and the employer of Personal Assistant(s)**

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Consumer Directed Services is a program that allows an individual to decide how their personal care and home management needs will be met by allowing them to choose who will assist them, how they want to be assisted, and when this assistance is wanted.

Please respond to the following statements/questions and sign and date the form when you have completed your responses.

Statement of why I need assistance in my home:

Services…… Respond as fully as possible. *This is the beginning of your opportunity to have direct input to the services you may receive*.

1. What services in your home do you want and need (bathing, dressing, ambulation, meals, shopping, laundry, etc)?

2. What other services (equipment, personal care items purchased, other community services) would help you maintain your independence in your home setting?

Caregivers…. Consider how you will deal with the following tasks as a Participant in the program of Consumer Directed Services:

1. How will you find and select people to help you in your home?

2. How will you determine what you may need to pay someone to assist you in your home?

3. How would you go about showing someone what you want them to do for you?

4. If you are not happy with the way your caregiver is assisting you, how would handle the situation?

Working with a Care Advisor from the local provider agency and the Financial Management Service that will do payroll services for you in behalf of your paid caregiver:

1. How would you work with someone who stands ready to help you make the best of the opportunity to self-direct your care by offering advice and guidance but does not tell you that things MUST be done a certain way? How do you feel about this approach to service?

2. The Consumer Directed Services program that you are interested in has only one MUST requirement and that is for you to use the Financial Management Servicet chosen by the state for payroll services for caregivers of Participants in consumer directed programs. Describe what this means to you and whether you like this one requirement for you to participate in the consumer directed program.

Representative…..this is someone you may appoint to help you make decisions and also manage the caregiver that you will hire. This person may be a family member or a friend. They could meet with the Care Advisor or representative from the Financial Management Service when they make contact with you for home visits.

1. Do you want to appoint someone to be your Representative?

   Yes ☐

   No ☐

2. **If** you answered **Yes**, who do you want to be your Representative?
   _____ Telephone # _____
   Address_____
   This person is my relative☐ or friend☐

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I would like to participate in the Consumer Directed Service program of _____.
(Name of Provider Agency)

_____ _____
(My Signature) (Date)

NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

SERVICE ASSESSMENT/REASSESSMENT FORM

Initial☐ or Annual☐ or Other☐

DATE_____

Participant_____
Address_____
_____ Tele:_____
Date of Birth_____
Marital Status: M☐S☐D☐W☐ If married, name of spouse_____

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I. <u>Health Status</u> …..Ask the following of the Participant and note any observations relative to mental agility:

	Yes	No	Comments
✓ **High blood pressure**	☐	☐	_____
✓ **Any heart related concerns**	☐	☐	_____
✓ **Ever had a stroke**	☐	☐	_____
✓ **Diabetes**	☐	☐	_____
✓ **Bone/Joint problems**	☐	☐	_____
✓ **Cancer**	☐	☐	_____
✓ **Respiratory problems**	☐	☐	_____
✓ **Allergies**	☐	☐	_____
✓ **Short term memory issues**	☐	☐	_____
✓ **Long term memory issues**	☐	☐	_____
✓ **Ever had mental disorder**	☐	☐	_____
✓ **Vision problems**	☐	☐	_____
✓ **Hearing problems**	☐	☐	_____
✓ **Speech problems**	☐	☐	_____
✓ **Dental problems**	☐	☐	_____
✓ **Incontinent**	☐	☐	_____

Are you currently receiving treatment for any of the above or for any other condition? Yes☐ No☐
If Yes, for what? _____

What medications do you take on daily basis? Please specify……

Participant does not take daily medications_☐_

Primary Physician: Name_____
Address_____ Telephone_____

II. Activities and Instrumental Activities of Daily Living…..

ADLs	Independent	Needs Some Help	Needs Total Help
Eating	☐	☐	☐
Dressing	☐	☐	☐
Bathing	☐	☐	☐
Toileting	☐	☐	☐
Ambulation	☐	☐	☐
Transfers	☐	☐	☐

Comments regarding ADLS:

_____

_____

_____

IADLs	Independent	Needs Some Help	Needs Total Help
Meals	☐	☐	☐
Cleaning	☐	☐	☐
Money Mngmt.	☐	☐	☐
Tele. Usage	☐	☐	☐
Laundry	☐	☐	☐
Reading	☐	☐	☐
Writing	☐	☐	☐
Shopping	☐	☐	☐
Transportation	☐	☐	☐

Comments regarding IADLs:

_____

_____

_____

III. Environmental

Home Type: House☐ Apt.☐ Mobile☐
Home Ownership: Owns☐ Rents☐
Condition of Home: Clean☐ Cluttered☐ Needs repairs☐
Adequate cooking and/or plumbing facilities: Yes☐ No☐
Any comments about the condition of the home:

_____

IV. Social

Who has been involved in the care of this Participant?
Agency caregiver☐
Family member☐ Specify_____
Friend☐ Specify_____
Privately hired person☐

Does the Participant have family members who attend to needs of this person as they arise? Yes☐ No☐

Does the person seem to have a good support system of both friends and relatives? Yes☐ No☐

Does the Participant engage in social activities in the community?
Yes☐ No☐

What community agencies provide assistance to this person?
None☐
Specify those they do assist, if any_____

V. Economic

Total monthly income of Participant and Spouse, if married_____
Sources of income: Soc.Sec.☐ SSI☐ VA pension☐ other☐

Financial Affairs managed by:
Participant☐ Relative☐ Guardian☐ Trust☐
Power of Attorney☐ Other☐ (specify)_____

If person manages his/her own finances, does it appear that there are problems? Yes☐ No☐

VI. Summary Comments by Assessor:

_____
_____
_____
_____
_____
_____
_____

Signature of Assessor_____ Title_____
Date_____

NORTH CAROLINA
HOME CARE INDEPENDENCE PROGRAM

APPOINTMENT OF REPRESENTATIVE FOR PARTICIPANT

Participant Name: _____

Participant Address: _____
_____

The above named person (Participant) is interested in receiving Consumer Directed Services (CDS) and wants to appoint another person, called a Representative, to act in his/her behalf for selecting, training, and directing Personal Assistants that they will hire for direct provision of care to them in their home setting, in addition to working cooperatively with the Care Advisor and Financial Management Service involved in the person's care.

Questions for the individual being considered for the volunteer position of Representative:

1. *What is your relationship to the Participant?*
   Family Member ☐ Friend ☐ Legal Guardian __ Other ☐
2. *Do you receive money from the client or anyone else to care for the person? Yes ☐ No ☐*
   ***If Yes**, you will be unable to act in the capacity of Representative in the CDS program of the NC Division of Aging and Adult services unless you are wiling to give up the paid care giving responsibilities.*
   Are you willing to give up the paid position? Yes ☐ No ☐
   ***If Yes**, please proceed to the following questions.*
3. *After reading the following duties and responsibilities, please indicate your understanding and acceptance by initialing each statement:*
   a. ___*Accept responsibility to monitor the health care needs of this person and to seek help with issues from an appropriate health care person whenever this becomes necessary*
   b. ___*Work cooperatively with the Financial Management Service (FMS)that will provide payroll and other financial services for the person by verifying the provision of service by Personal Assistants who work with the person*

c. ___*Supervise the work of Personal Assistants*
d. ___*Show a strong personal commitment to the person*
e. ___*Show knowledge about the person and their personal preferences*
f. ___*Show sound judgment to act on the person's behalf*
g. ___*Be at least 18 years of age*
h. ___*Have known the person for at least two years*
i. ___*Do not have a convicted felony record of abuse, neglect, assault, criminal sexual conduct, fraud, or theft against a minor or adult*
j. ___*Understand that I may not receive money to be the Representative of the person*
k. ___ *Cannot serve as the Personal Assistant of the person*
l. ___ *Do not have a mental ,emotional, or physical condition that could result in harm to the person*

4. *Do you understand that as this person's Representative you cannot be both a paid Personal Assistant and the Representative? Yes ___ No ___*

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I wish to appoint this person to serve as my Representative while I am a Participant in the Consumer Directed Services program.

Signature _____ Date _____
(Participant)

I accept the volunteer position of Representative for the above person.

Signature _____ Date _____
(Representative)
Address_____
Telephone _____

I have witnessed the signatures of the Participant and Representative.

Signature _____ Date _____
(Care Advisor)

Eff.7/1/11……a copy goes to each person who has signed this form and to the FMS

NORTH CAROLINA
HOME CARE INDEPENDENCE PROGRAM

PARTICIPANT ENROLLMENT FORM

I, _____, choose to participate in the Home Care Independence program. I understand my participation in Home Care Independence is voluntary and comes with certain responsibilities.

As a Participant in the Home Care Independence Program:

1. I will develop a Plan of Care and a Home Care Independence budget with the support of my Care Advisor and others, if needed
2. I understand that the fiscal agent, GT Financial Services, will assist me by paying the workers I hire and by deducting taxes from my employees' paychecks as well as filing these taxes with the appropriate authorities when due.
3. I understand administrative and payroll costs for the fiscal agent are built into my Home Care Independence budget.
4. I understand I may get assistance from my Care Advisor at any time in making sure the budget follows my Plan of Service if for any reason my needs change.
5. The budget that is developed will be used to meet my monthly needs to purchase services and supports related to my current Plan of Care and to any revisions in the Plan of Care that may be necessary.
6. I am responsible for monitoring my expenses to remain within the budget. I will request training as needed for managing my budget.
7. I will choose services and supports that will meet my Plan of Care needs in a cost-effective manner. I will utilize natural supports whenever possible. I will not use Home Care Independence funds to purchase services and supports that I may be eligible for under other existing programs such as Medicare or Medicaid.
8. I will choose who provides my services and supports. I understand that individuals I may want to employ as Home Care Independence providers are required to meet certain employment criteria. They must be:
    - 18 years of age or older
    - U.S. citizen or legal alien authorized to work in the U.S.
    - Have a picture I.D. and a copy of his/her Social Security Card.
    - Ability to communicate successfully with me, the Participant, or my Representative, if applicable
    - Submit an employment application.
    - Submit to a criminal background check.
    - Submit to drug testing or health testing
9. I understand I will be the employer of record for the workers that I may employ.
10. I understand I am responsible to verify that self directed services are accurately delivered as planned or scheduled. I am responsible for notifying my Care Advisor

11. I understand that Home Care Independence options may be limited or discontinued if I and/or my Care Advisor find the following:
    - My health and safety or that of another person becomes threatened and I am in harm's way
    - My expenditures become inconsistent with the established plan and budget and cannot be resolved
    - The conflicting interests of another person are taking precedence over my desires, best interests, and/or ability to make decisions regarding the care that I need and I have no one to act as my Representative.
    - Funds allocated for my care have been used for illegal or non-intended purposes.
    - My needs have reached the level of institutional requirements.
12. I understand that my Care Advisor is available during normal business hours of provider agency to answer questions about my rights and responsibilities as a participant in the Home Care Independence program.
13. I understand that if I am not satisfied with how I am treated while participating in the Home Care Independence program, I have the right to participate in the grievance process established by the local agency operating the Home Care Independence program.

I have read this document and understand my responsibilities as an enrollee in the Home Care Independence program. I will be provided a copy of the document for my records.

Participant (Enrollee) **Signature**/Date	If Applicable **- Representative or Guardian Signature**/Date
Printed Name of Participant (Enrollee)	If applicable - Representative or Guardian Name **(Print)**

I have received a copy of this document: Initial_____ and Date _____

Eff. 7/1/11

NORTH CAROLINA
HOME CARE INDEPENDENCE

CONSUMER DIRECTED SERVICES PLAN OF CARE/BUDGET
Initial Date_____ or Revised Date_____

Participant_____
Address _____
_____ Tele:_____

++

I. Plan of Care

Tasks of Personal Care and Home Management that are needed:

ADLs;

- **Bathing☐**
- **Toileting☐**
- **Assistance with Eating☐**
- **Dressing☐**
- **Ambulation☐**
- **Other(specify)_____**

IADLs:

- **Shopping☐**
- **Meal Preparation☐**
- **Laundry☐**
- **Housekeeping☐**
- **Other(specify)_____**

TOTAL WEEKLY HOURS FOR PROVISION OF ADLs AND IADLs=_____

****Client decides when and how services are to be provided**

++

Other Community Services/Equipment/Goods:

Adult Day Care☐ How often(specify)_____

Home Delivered Meals☐ How often(specify)_____

Emergency Response Equipment (Monthly Rental, $50 max)_____

Medical Adaptive Equipment (not covered by other funding and maximum of $300/annually)☐ What needed_____

Personal Care and Nutritional Supplements (within limits of budget) What needed_____

II. Budget

SERVICES NEEDED	QUANTITY	COST
Personal Assistant	**Total hrs. Sunday-Saturday**	**Rate_____ X # of hours____ x 4.333 weeks=**
Other Community Services/Equipment/Goods	**One time purchases or estimated number of services/items**	**Estimated quantity x estimated cost(See * and ** info below)**
Adult Day Care		
Home Delivered Meals		
Emergency Response Equipment (rounded to nearest dollar… rental not to exceed $50/mo)		
Medical Adaptive Equipment*		
Personal Care and Nutritional Supplements		
FMS Fee **		
		Total Participant Budget=

I approve this POC and Budget for my service as a CDS Participant:
SIGNATURE OF PARTICIPANT/REPRESENTATIVE_____
Date_____

SIGNATURE OF CARE ADVISOR _____ **Date**_____

***Med. Adaptive Equipment**, Prorated and not to exceed $300. ENTIRE COST ENTERED TO ARMS AT TIME OF PURCHASE. When prorated period ends, remove cost and revise budget.

****FMS Fee** includes Start Up fee prorated at $6.25/mo. TWO UNITS OF SERVICE (2X$75) WOULD BE ENTERED TO ARMS FOR MONTH ONE OF SERVICE. At the end of the twelve month period, $6.25 would be removed and $75 becomes the monthly FMS fee for service. Budget would be revised to reflect the change.

Original to Participant **Cc: Provider Agency File**
Eff. 2/1/13

NORTH CAROLINA
HOME CARE INDEPENDENCE

BACK UP PLAN FOR CONSUMER DIRECTED SERVICES
Initial_☐_ or Revised_☐_

Participant_____
Address_____
_____ Tele:_____

++

In the event that care giving as determined on the Plan of Care for on-going service is not able to be fulfilled on any given day, the following is my plan for obtaining service:

I have a relative_☐_ (specify)_____whom I can call upon.
Address and Telephone number of relative:
_____
_____ Tele:_____

I have neighbor/friend____ (specify)_____whom I can call upon.
Address and Telephone number of neighbor/friend:
_____
_____ Tele:_____

As a last resort, I will contact a licensed Home Care Agency_☐_.

I know that if I use an agency that my budget for service will need to be adjusted_☐_

I will contact my Care Advisor if I need to use an agency for service so that my service budget can be adjusted as needed_☐_

I will also let the FMS know that service on a given day was based upon my backup plan_☐_

Signature of Participant_____ Date_____

Signature of Care Advisor_____ Date_____

Eff.7/1/11

NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

PARTICIPANT BILL OF RIGHTS AND RESPONSIBILITIES

As a Participant of the Home Care Independence program I have the RIGHT:

- To be safe.
- To be treated with courtesy, consideration and respect.
- To trust my instincts.
- To take and negotiate risks.
- To agree or disagree with others.
- To be informed of choices and consequences.
- To be free from mental, physical, financial and sexual abuse.
- To have communication appropriate to my communication needs.
- To be accepted for Home Care Independence services only if services can be provided in a safe and professional manner.
- To direct my own care or select a Representative who is willing and capable of assuming this responsibility.
- To be aware that I may request changes in services within the Home Care Independence Plan of Care from my Care Advisor.
- To know about all fees for the services I may receive and how my budgeted money may be spent.
- To tell my Care Advisor about any problems or concerns I may have without fear of being terminated from participating in the program or expressing those concerns. I may voice complaints verbally and/or in writing.
- To expect that all service providers that come into my home will respect my personal privacy and property.
- To expect that information I provide to Home Care Independence staff will be respected and held in confidence and that this information will be not be shared without my written consent.
- To request assistance from my Care Advisor and Fiscal Agent as needed.
- To be referred to other community agencies as appropriate.
- To be notified of any appeal rights I may have upon termination for cause from the Home Care Independence program.

As a Participant of the Home Care Independence program, I have the RESPONSIBILITY:

- To treat the people providing services to me with respect and courtesy.
- To notify the Fiscal Agent and my Care Advisor as soon as possible if there is:
    - Any change in my address

  - Any change in my phone service
  - Any change in my support system
  - Any change in my physician
  - Any admission to the hospital, nursing or rehabilitation facility or visit to the emergency room resulting in my not receiving service per normal
  - A change in the Personal Assistant who is providing my service
  - A need for changes in my Plan of Care determined with my Care Advisor or in the care plan followed by the Fiscal Agent
- To keep track of the balance of my monthly budget based upon the Plan of Care so that I do not overspend.
- To submit all required paperwork to the Fiscal Agent on time.
- To observe all tax and labor laws as explained to my by the Fiscal Agent.
- To have someone available to provide care for me in the absence of my Personal Assistant who may be out due to illness, emergency and/or holidays, in accordance with my back-up Plan of Care and to notify the Fiscal Agent when this occurs.
- To have a 24-hour a day supervision schedule in place, if it is required on my Home Care Independence Plan of Care, in order to maintain my health, safety, and well-being.
- To provide a safe working environment for those who will provide my care.
- To engage in a cooperative working relationship with my Personal Assistant, Care Advisor and Fiscal Agent.

The Consumer Bill of Rights and Responsibilities has been explained to me by my Care Advisor. I will be provided two copies of this document after I sign it. I will obtain the signature of the person I hire as my Personal Assistant and one copy will be provided this person.

(*Participant's Signature*) _____ (*Date*) _____

(*Care Advisor's Signature*) _____ (*Date*) _____

(Personal Assistant's Signature) _____ (Date) _____

++

This form has been reviewed with my Personal Assistant and a copy has been provided this person. _____ (Participant's Initial) _____(Date)

Eff. 11/01/10

North Carolina
Home Care Independence Program

Employment Application and Criminal Record Check Consent Form

Application Date _____

Person you applying to work for: _____ **and this person's mailing address** _____ **and Telephone Number** _____

How did you learn about this employment opportunity?_____
_____ _____

Last Name	**First Name**	**Middle Initial**
Street Address/City	**State/Zip**	**Tele Numbers:** **Home** _____ **Cell** _____
Gender: **Male** _____ **Female** _____	**Ethnic Group:** **White** ☐ **Black** ☐ **Hispanic** ___ **Asian** ___ **American Indian** ☐ **Other** ☐	**Maiden Name, if applicable** _____ **or any previous names** _____ _____
Date of Birth _____	**Social Security Number** _____	**Driver's License Number** _____ **State** _____
How long have you resided in NC **Less than 5 years** ☐ **More than 5 years** ☐	***If less than 5 years*, list previous addresses:** **City**_____**State** _____ **Dates** _____ **City** _____ **State** _____ **Dates** _____	
Education: Circle highest grade completed……. **Elementary or Middle School: 1 2 3 4 5 6 7 8** **High School: 9 10 11 12** **College, Trade, Business: 1 2 3 4** **Graduate School: 1 2 3 4**		

Describe any experiences you have had as a caregiver:
_____
_____
_____

Employment History (Begin with the most recent position)

Employer:	**Employer Address:**	**Supervisor:**
Supervisor's Phone #:	**Job Title:**	**Duties and Responsibilities:**
Starting Salary:	**Ending Salary:**	**Reason for Leaving:**
Employer:	**Employer Address:**	**Supervisor:**
Supervisor's Phone #:	**Job Title:**	**Duties and Responsibilities:**
Starting Salary:	**Ending Salary:**	**Reason for Leaving:**
Employer:	**Employer Address:**	**Supervisor:**
Supervisor's Phone #:	**Job Title:**	**Duties and Responsibilities:**
Starting Salary:	**Ending Salary:**	**Reason for Leaving:**

Certification and Authorization

The above information is true and correct. I understand that, in the event of my employment, I shall be subject to dismissal if any information that I have given in this application is false and misleading or if I have failed to give any information herein requested, regardless of the time elapsed after discovery. I authorize the Potential Employer to inquire into my educational, professional, and past employment history references as *needed to* research my qualifications for this *position. I hereby give my consent to any former employer to provide employment-related information about me to the Potential Employer. I will hold the Potential Employer, and my former employer, harmless from any claim made on the basis that such information about me was provided or that any employment decision was made on the basis of such information. I further authorizer the Potential Employer to obtain any credit and consumer checks. I understand that nothing in this employment application, the granting of an interview or my sub sequent employment with the Potential Employer is intended to create an employment contract between myself:" and the potential employer, and that my employment could be terminated only for cause. On the contrary, I understand and agree that, if hired, my employment will be terminable at will, and may be terminated by me or the Potential Employer at any time, and for any reason. I understand that no person has any authority to enter into any agreement contrary to the foregoing. If employed, I will be required to provide original documents which verify my identity and right to work in the United States under the immigration Reform Control Act (IRCA) of 1986. The documents provided will be used for completion of Form I-9.*

I give permission to GT Financial Services, on behalf of my Potential Employer, to conduct criminal background, driving, and employment reference checks. I understand that the results of the background checks will be provided to my Potential Employer. The information gained from the background checks will remain confidential and will be used by the Potential Employer for deciding whether or not to enter into an employer-employee relationship with me. **I understand that falsification o*r willful omission of information provided by me may be sufficient grounds for rejection of my application for employment.***

Applicant Signature: _____ Date: _____

Return form to potential Employer

Eff.2/1/13

North Carolina
Home Care Independence Program

Participant Referral Form for Financial Management Services

PARTICIPANT'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: (___)_____ **E-MAIL:** _____

REPRESENTATIVE or GUARDIAN NAME (IF APPLICABLE): _____

RELATIONSHIP TO PARTICIPANT: _____

ADDRESS: _____

CITY/STATE/ZIP_____

PHONE: (___)_____ **E-MAIL:** _____

CARE ADVISOR: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

CITY/STATE/ZIP: _____

AGENCY PHONE: (___)_____ **E-MAIL:** _____
AGENCY FAX: (___)_____

FISCAL MANAGEMENT SERVICE ASSISTANCE REQUESTED FOR PARTICIPANT:

a. *PAYROLL SERVICES (CODE 501/Personal Assistant)* **Eff. Date** _____

TOTAL HOURS AUTHORIZED: _____ **PER WEEK**

MONTHLY BUDGET FOR PAYROLL(unit rate) _____ **X hours** _____ **X 4.333) = $**_____

b. *VENDOR PAYMENTS FOR COMMUNITY GOODS/SERVICES, IF APPLICABLE*:* **Eff. Date**_____
PERSONAL CARE/ENVIRONMENTAL/NUTRITIONAL SERVICES (CODE 504): $_____

EMERGENCY RESPONSE EQUIPMENT(CODE 506): $ _____

MEDICAL ADAPTIVE EQUIPMENT (CODE 507) $ _____

*List monthly cost of Pers. Care items, monthly rental of Emer. Response. Equipment, and full purchase price of Med. Adapt. Equipment

SIGNATURE OF CARE ADVISOR _____**DATE**_____

Eff.2/1/13

North Carolina
Home Care Independence Program

Change Order Notice for
Financial Management Services

Date: _____

Participant's Name; _____
Date of Birth: _____
Address: _____
City/State/Zip: _____
Phone: (____)_____

Change Order Information: *mark all that apply*

a. The following Personal Assistant has been terminated from employment effective_____
Name of Personal Assistant _____

b. The Participant is temporarily suspended from Consumer Directed Services (CDS) effective _____

c. Resume FMS for Participant effective _____

d. The Participant has been terminated from CDS effective _____

e. There is a change in the Care Advisor: Name _____
Tele#_____ E-mail_____

f. There is a change in the following:

a. *PAYROLL SERVICES (CODE 501/Personal Assistant)*:

TOTAL HOURS AUTHORIZED: _____ PER WEEK

MONTHLY BUDGET FOR PAYROLL (unit rate) _____ X hours _____ X 4.333) = $_____

b. *VENDOR PAYMENTS FOR COMMUNITY GOODS/SERVICES*:

PERSONAL CARE/ENVIRONMENTAL/NUTRITIONAL SERVICES (CODE 504): $ _____

EMERGENCY RESPONSE EQUIPMENT(CODE 506): $ _____

MEDICAL ADAPTIVE EQUIPMENT (CODE 507): $_____

c. Effective date of change for hours: _____ and Effective date of change for vendor payments; _____

e. Other (specify) _____

Submitted by: _____, Care Advisor
Phone: (_____)_____ Agency _____

CONSUMER DIRECTED SERVICES
HOME CARE INDEPENDENCE
CRIMINAL BACKGROUND CHECK POLICY

Results of recorded Criminal Background checks and NC Healthcare Registry checks conducted by GT Financial Services for Home Care Independence applicants for positions as Personal Assistants will be reviewed by the Home Care Independence Participant, Care Advisor, and the person who is the director of the agency providing the Home Care Independence program. One of the services provided by GT Financial Services is to assist and educate the Home Care Independence Participant with the hiring process. GT Financial will educate the Participant to the definitions of all specific charges that appear on the Criminal Background check and the NC Healthcare Registry check so that the Participant can make an informed decision regarding hiring of the prospective Personal Assistant. ***If any of the convictions or substantiations listed in the chart below appear on either of the background checks, the prospective Personal Assistant cannot be hired by the Participant to work for them in the Home Care Independence program.*** **Hiring decisions regarding criminal activities, other than those listed below, of potential Personal Assistants revealed in the check of records by GT Financial will be at the discretion of the Participant after input/advice from the Care Advisor and director of the provider agency.**

Length of Time Barred from Working	Types of Convictions or Substantiated Allegations
Lifetime Ban	• Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance • Felony health care fraud • More than one felony conviction • Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd, or 3rd degree), fraud or theft against a minor or vulnerable adult • Felony or misdemeanor patient abuse • Felony involving cruelty or torture • Misdemeanor Healthcare Fraud • Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult • Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry • Any substantiated allegations listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC

Financial Management Service Forms

NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

FISCAL MANAGEMENT SERVICE AGREEMENT

This agreement is between _____, a Participant in the Home Care Independence program and _____the Fiscal Management Service (FMS).

Responsibilities of Participant:

1. Determines the personal and/or home management tasks that the Personal Assistant will provide.
2. Establishes an hourly salary rate for the Personal Assistant(s).
3. Acts as the Employer of Record for the Personal Assistant(s).
4. Provides the FMS with the records/forms/information required for payment of salary to the Personal Assistant(s).
5. Provides _____, the local provider agency, with the information they require in order to be a Participant in the program of consumer directed care.
6. Trains the Personal Assistant(s) to do the personal and/or home management tasks identified and supervises them in the carrying out of these tasks.

Responsibilities of Fiscal Management Service:

1. Utilizes aging funds for payrolls for Personal Assistants and for vendor services or goods specified in the care plan for services rendered by the FMS.
2. Educates Participants regarding the FMS process for paying Personal Assistants and for payments to community vendors of other goods and services specified in the FMS care plan for services.
3. Assures that all the financial and personal information required by the FMS from the Participant is accurate, updated when necessary, retained as appropriate and available for monitoring purposes by the local agency, the AAA, and the Division of Aging and Adult Services.
4. Works cooperatively with the Participant, the local consumer directed services agency, the AAA, and the Division of Aging and Adult Services in behalf of Participant to assure that Personal Assistants are paid appropriately and that payments to other specified services specified in the care plan of the FMS are made.
5. Be available by telephone or in person to the Participant, the Personal Assistant(s), and/or the Care Advisor in the local community directed service agency to help resolve payroll and vendor services issues.
6. Distribution of state/federal taxes deducted from paychecks and those paid

This agreement will terminate when the Participant no longer is a client of the Home Care Independence program.

_____ _____
Participant or Representative Signature Date

_____
Printed Name of Participant or Representative

_____ _____
Fiscal Management Service Representative Signature Date

_____
Printed Name of Fiscal Management Service Representative

Cc: Participant's Care Advisor
Rev.2/1/13

NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

EMPLOYMENT AGREEMENT

This document is an Employment Agreement of the Home Care Independence program between _____, the Employer (Participant) and _____, the Employee (Personal Assistant).

Both the Employer and the Employee agree to the following:

1. The offer and acceptance of the rate of pay as $_____ per hour for _____ hours of work per week. Both the Employer (Participant) and Employee (Personal Assistant) agree to the number of hours. Additional hours worked must be approved by the Care Advisor in advance. Both the Employer and the Employee must keep track of the hours worked each week.
2. Completed time reports will be correct and signed by the Employee, reviewed for accuracy and signed by the Employer, and submitted to the Financial Management Service (FMS) by the Employer or Employee, as agreed upon, according to the schedule published by the FMS.
3. The Employer will approve, with his/her signature only those hours of service provided by the Employee that have been prior approved by the Care Advisor in the care plan or modified as extenuating circumstances arise. The FMS will make salary and related payments as authorized by the Care Advisor in the care plan or by verbal, followed by written, authorization of changes on an as-needed basis.
4. The Employer and Employee understand their rights as indicated in the Consumer Bill of Rights and the Personal Assistant Bill of Rights. These documents have been read by the Employer and the Employee and each will receive copies of both documents.
5. The Employee may request and receive planned time off from regular work schedule with adequate/reasonable advance notice to the Employer. Number of vacation days will be set by agreement between the Employer and the Employee.
6. The Employee will notify the Employer when illness prevents service provision.
7. The Employer and Employee will advise one another of any changes in personal status such as name, address, telephone number, as soon as they occur.
8. They will discuss job related concerns when they occur.
9. Both should give at least two weeks notice regarding termination or resignation of employment unless the reason for ending the relationship is for extenuating circumstances that necessitate immediate termination/ closure
10. The Employee is not an employee of the agency operating the consumer directed services program nor of the FMS. The Employee is employed by the Participant in the consumer directed program.
11. The Employee meets the minimum qualifications to be employed:
    a. 18 years or older
    b. U.S. citizen or legal alien authorized to work in the U.S
    c. A picture I.D. and a copy of his/her Social Security Card
    d. The ability to communicate successfully with the Employer
    e. Passes a criminal background check to the satisfaction of the Employer and the local agency funding the program
    f. Prospective Employer wants to employ the individual
11. This is an at-will employment agreement. The Employer or the Employee may cancel this agreement at any time, for any reason.
12. If the Employers' participation in this program ends, the Employee's employment also ends.

Job Duties of Employee:

1. Provide services relating to activities of daily living by assisting, the Employer with (mark those needed):
    a. Meal preparation _☐_
    b. Laundry _☐_
    c. Activities of daily living:
        Bathing _☐_
        Toileting _☐_
        Eating, _☐_
        Dressing _☐_
        Ambulation _☐_
        Other (specify) _____☐_
    d. Routine household care and maintenance _☐_
    e. Shopping for food and other daily necessities _☐_
2. Other duties as assigned (specify):
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____

WORK SCHEDULE (Hours to be worked)

Day	Start Time*	Finish Time*	**Total Hours**
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
			Weekly Total =

** These hours may vary as to when worked. However, it is critical that the total hours worked per week do not exceed the sum of the projected daily hours.*

We have reviewed and agreed to the above responsibilities and schedule.

_____ _____ _____ _____

Employer Signature Date _ Employee Signature Date

CC: FMS

Eff.7/1/11

NORTH CAROLINA

HOME CARE INDEPENDENCE PROGRAM

PERSONAL ASSISTANT
BILL OF RIGHTS AND RESPONSIBILITIES

As a Personal Assistant in the Home Care Independence program I have the RIGHT:

- To be safe in the provision of my work duties
- To be treated with courtesy, consideration, and respect by my Employer.
- To trust my instincts.
- To be informed of choices in my work arrangement and the consequences of negligent behavior as I work in my Employer's home.
- To be free from mental, physical, financial, and sexual abuse.
- To be shown or directed as to how my Employer wants services to be provided him/her.
- To be informed when changes in services are appropriate and desired by my Employer and to expect that I will be shown how the new services are to be provided.
- To expect that I will not be asked to provide any assistance that is fraudulent, illegal, or immoral.
- To be paid appropriately, in a timely manner, and at the agreed upon rate of pay if I have followed payroll instructions.
- To tell my Employer about any problems or concerns I have without fear of job loss or other negative treatment for expressing those concerns. I may voice complaints verbally and/or in writing.
- To expect that visitors to my Employer's home will respect my personal privacy and property.
- To expect that Personal information I provide to my Employer or the Fiscal Management Service will be respected and held in confidence and that this information will be shared only with my written consent.

As a Personal Assistant in the Home Care Independence program, I have the RESPONSIBILITY:

- To treat my Employer with respect and courtesy.
- To notify my Employer and the Fiscal Management Service as soon as possible if there is:
    - Any change in my address
    - Any change in my phone service
    - Any change in my name
    - Any change in my banking procedures or banking provider
    - Any change in my ability to work the agreed upon schedule
    - Any change in my legal status (citizenship, incarceration, etc)

- To keep track of the hours I am authorized to work so that I do not work for more hours in the Home Care Independence program than my Employer has been approved.
- To submit all required paperwork to my employer and/or the Fiscal Management Service on time.
- To maintain a clean and safe environment for my employer.
- To engage in a cooperative working relationship with my employer, the Fiscal Management Service, and my Employer's Care Advisor in the Home Care Independence program.

The Personal Assistant Bill of Rights and Responsibilities has been discussed with me by my Employer and/or the FMS. I will be provided a copy of this document after my employer (the Participant) and I have signed it.

(*Participant's Signature*) (*Date*)

(*Personal Assistant's Signature*) (*Date*)

Eff. 7/1/11

Self Determination Employee Time Card

GT Financial Services

7720339168

AGENCY

PERSON RECEIVING SERVICE

PERIOD BEGIN __ / __ / __ (MM DD YY)

PERIOD END __ / __ / __ (MM DD YY)

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

Employee Last 4 Digits of your SSN

Month / Day	Service Code	Time In hh:mm	AM(A) PM(P)	Time Out hh:mm	AM(A) PM(P)	Hours Worked	Tasks
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	
/		:		:		.	

Total Hours .

I certify that I worked the hours shown on this card on the days indicated and that this card has been certified by a person that I believe is an authorized representative of/or the person receiving service.

Employee Signature: ____________ Date __ / __ / __

As the person receiving service or authorized representative, I certify that this employee's hours shown on this time sheet are correct and that the work was performed satisfactorily.

Supervisor Signature: ____________ Date __ / __ / __

Self Determination Timesheet Instructions

1. Time worked should be recorded according to GT Financials payroll schedule
2. Enter employee's First Name
3. Enter employee's Last Name
4. Enter the last four digits of employee's social security number
5. Enter the Month and Day of each time the employee worked
6. A Service Type is required for each day worked
7. Enter the time in and time out for each day worked. This must equal the total hours for that day. If this is incorrect, GT Financial will adjust the total hours according to the hours worked. Hours must be recorded in 15 minute increments. (ex: 1:00, 1:15, 1:30, 1:45)
8. Indicate ***A*** for am or ***P*** for pm
9. List the general job duties performed
10. Total all of your hours worked. If this is incorrect, GT Financial will adjust the hours to add up correctly.
11. Employee must sign and date the timesheet after the last day has been worked
12. Person Receiving Services or authorized Representative sign and date after the last day worked

Other important information

- Please write clearly with black ink in each box to help avoid problems.
- Timesheets can not be submitted *before* all of the hours have been worked.
- Employees may not turn in hours for the same time period. These are considered 'overlapping hours' and the person receiving services will be contacted to correct the timesheets.
- Employees may not turn in time while the person receiving services is hospitalized or in a nursing facility.
- You do not have to wait until the due date to fax in your timesheets. Our fax machines are capable of accepting faxes 24 hours a day, 7 days a week.
- Timesheets are accepted until 5 pm (Eastern Standard Time) on the due date indicated on the payroll schedule. Late timesheets will be held until the next pay period. CLS Oakland timesheets due by 3pm
- We encourage employees to call the office to verify that their fax was received regardless of a fax machine confirmation

2010 Service Provider Payroll Information

Payroll Schedule E

Payroll Period :	If received by FAX 5pm by this date:	We will prepare direct deposits & mail checks by:	If received by MAIL by this date:	We will prepare direct deposits & mail checks by:
Jan. 1st - 15th	Monday, Jan. 18	Monday, Jan. 25	Friday, Jan. 22	Friday, Jan. 29
Jan. 16th - 31st	Wed., Feb 3	Wed., Feb. 10	Monday, Feb. 8	**Tuesday, Feb. 16
Feb. 1st - 15th	Thurs. Feb. 18	Thurs. Feb. 25	Monday, Feb 22	Monday, Mar. 1
Feb. 16th - 28th	Wed., March 3	Wed., March 10	Monday, March 8	Monday, March 15
Mar. 1st - 15th	Thursday, March 18	Thursday, March 25	Monday, March 22	Monday, March 29
Mar. 16th - 31st	Friday, April 2	Friday, April 9	Wed., April 7	Wed., April 14
April 1st - 15th	Monday, April 19	Monday, April 26	Thursday, April 22	Thursday, April 29
April 16th - 30th	Monday, May 3	Monday, May 10	Friday, May 7	Friday. May 14
May 1st - 15th	Tuesday, May 18	Tuesday, May 25	Friday, May 21	Friday, May 28
May 16th - 31st	Thursday, June 3	Thursday, June 10	Monday, June 7	Monday, June 14
June 1st - 15th	Friday, June 18	Friday, June 25	Tuesday, June 22	Tuesday, June 29
June 16th - 30th	Friday, July 2	**Monday, July 12	Wed., July 7	Wed., July 14
July 1st - 15th	Monday, July 19	Monday, July 26	Thursday, July 22	Thursday, July 29
July 16th - 31st	Tuesday, Aug. 3	Tuesday, Aug. 10	Friday, Aug. 6	Friday, Aug. 13
Aug. 1st - 15th	Wed., Aug. 18	Wed., Aug. 25	Monday, Aug. 23	Monday, Aug. 30
Aug. 16th - 31st	Friday, Sept. 3	**Monday, Sept. 13	Tuesday, Sept. 7	Tuesday, Sept. 14
Sept. 1st - 15th	Friday, Sept. 17	Friday, Sept. 24	Wed., Sept. 22	Wed., Sept. 29
Sept. 16th - 30th	Monday, Oct. 4	**Tuesday, Oct. 12	Thursday, Oct. 7	**Friday, Oct. 15
Oct. 1st - 15th	Monday, Oct. 18	Monday, Oct. 25	Friday, Oct. 22	Friday, Oct. 29
Oct. 16th - 31st	Wed., Nov. 3	Wed., Nov. 10	Monday, Nov. 8	**Tuesday, Nov. 16
Nov. 1st - 15th	Wed., Nov. 17	Wed., Nov. 24	Monday, Nov. 22	**Tuesday, Nov. 30
Nov. 16th - 30th	Friday, Dec. 3	Friday, Dec. 10	Tuesday, Dec. 7	Tuesday, Dec. 14
Dec. 1st - 15th	Friday, Dec. 17	**Monday, Dec. 27	Wed., Dec. 22	**Thurs, Dec. 30
Dec. 15th - 31st	Mon, Jan. 3, 2011	Mon, Jan. 10, 2011	Fri, Jan. 7, 2011	Fri, Jan.14, 2011

**** Indicates a variance in dates due to Federal Holidays**

The GT Financial Services office will be closed on the following days:

Friday, Jan. 1st
Monday, May 31st
Monday, July 5th
Monday, Sept. 6th
Thursday, Nov. 25th
Friday, Nov. 26th
Friday, Dec. 24th
Friday, Dec. 31st

Please remember the following about your time sheets:

They are to be signed by you AND your employer
Must be completed with employer & employee name as well as dates, times and service type
If time sheets are not completed properly, you may be asked to re-submit them
Incomplete data could delay payment to you
If you work for multiple employers, please turn in a timesheet for each employer

Fax Coversheet for Self-Determination Clients

To:	From:	Alternate Contact:
GT Financial Services Connie Outlaw Sturgis, MI 49091 Phone: (877) 659-4500 Fax: (877) 203-4139	Phone:	Phone:

Today's Date: _____ Employer's Name:_____

Number of Pages including cover sheet: _____ Total Hours reported: _____

Employers and Employees: Before you send this fax, please double check your time sheets. Make sure that you can check off each question below.

Checklist:

____ Have you filled in the period dates at the top?
____ Have you included all of the time you worked for this payroll period?
____ Does your time in and time out equal the hours reported for each day?
____ Did you include the Service Code for each day worked?
____ Did you total your hours at the bottom for the pay period?
____ Did your employer sign the time report?
____ Did you sign the time report?

Additional Information:

- Payroll is processed twice per month. Please refer to your Payroll Schedule for due dates.
- The pay periods are the 1st through the 15th and the 16th through the last day of the month.
- Paychecks will be released 5 business days after the due date. Please note changes on the payroll schedule due to federal holidays.
- Time sheets must be correctly labeled and signed by both the employee and employer.
- Time sheets that are filled out incorrectly will result in delayed payment of wages.
- Late timesheets will be paid on the following pay period.

GT Financial Services

Dear Caregiver,

Are you interested in expanding your work hours? Often times we are asked for referrals by individuals who are seeking care giving services. To help them connect with caregivers, we are starting a Caregivers Online Directory. Access to the Directory will be limited to Case Managers who work with the agencies that we work with. In other words, your information will not be shared with the general public. If you are interested in expanding your work hours *by working with one or more additional people*, please complete the enclosed application and return it to:

GT Financial Services
113 North Monroe St.
Sturgis, MI 49091

Or fax it to us at 877-203-4139.

Providing us with this information will not guarantee additional hours; however, it will give you the opportunity to connect with others who are looking for workers. This could result in you being contacted, interviewed and possibly hired to assist others who may not have enough workers to meet their care needs.

Regards,

GT Financial Services Customer Service Team