



**New Jersey Department of Human Services (DHS)
Division on Aging Services (DoAS)**

**PO Box 807
Trenton, New Jersey 08625-0807**

MINIMUM STANDARDS:

**CARE MANAGERS, CARE MANAGEMENT SUPERVISORS,
AND CARE MANAGEMENT AGENCIES
FOR
APC AND JACC CARE MANAGEMENT**

Effective Date: December 2017

PURPOSE

The purpose of this policy is to provide the minimum standards that shall be met by care managers, care management supervisors, and care management agencies for Division-administered programs. The standards provided within this manual are to be applied consistently to all Division-administered care management programs unless otherwise specified.

Included are specific and detailed standards for operating Area Plan Contract (APC) and Jersey Assistance for Community Caregiving (JACC) care management programs.

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SECTION A – CARE MANAGER STANDARDS

SERVICE: CARE MANAGEMENT

CODE: 105

CATEGORY: Access

NAPIS: Cluster 1 Service – age, gender, lives alone, poverty, race, ethnicity, ADLs and IADLs required.

DEFINITION: Care Management is a collaborative process or activity including, but is not limited to, care planning, service coordination, Plan of Care (POC) monitoring, and advocacy provided by a qualified professional Care Manager. Care Management is intended to meet the care needs of vulnerable and/or functionally impaired participants, age 60 and over, who require the delivery of one or more services, cannot manage the coordination of these services on their own, and not currently receiving any other comprehensive care management services.

UNIT: 1/2 hour

STANDARDS: Care Management services shall meet or exceed the following standards:

1. Each program shall utilize staff that meet the following Care Manager Qualifications:
 - Care Managers shall be a:
 - Licensed or certified social worker in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G, OR
 - Registered nurse in accordance with N.J.S.A. 45:11-23 et seq. and N.J.A.C. 13:37, OR
 - Graduate of an accredited college or university with a bachelor’s degree, or higher, in a health-related field or behavioral science field, and one year equivalent of compensated work or internship experience with older adults or persons with disabilities in an institutional or community setting.

The license, certification and educational requirements for care manager supervisors and care managers may be waived for any care manager supervisor or care manager employed in such position prior to December 31, 2017.

- Within the first 30 days of employment as a Care Manager, shall complete an orientation provided by the Area Agency on Aging (AAA) regarding the Aging and Disability Resource Connection (ADRC) process.

- Care Managers shall attend annually a minimum of at least one continuing education training course or seminar related to older adults or persons with disabilities.
2. Each participant shall be assigned to a specific Care Manager.
 3. Under the direction of a Care Manager, paraprofessionals may be utilized for activities including but not limited to: making follow up calls (excluding monthly care management calls), gathering documents, copying, and other administrative program support.
 4. Each care plan shall be developed with the participant or the participant's guardian or designated representative, signed and dated by all parties. The Plan of Care (POC) document is the Division of Aging Services (DoAS) Form WPA-2 (attached with instructions).
 5. The POC shall be designated as open or closed. If closed, the POC shall have an end date.
 6. All case files, both paper and electronic shall be kept confidential in secured files.
 7. The Division's Health Information Portability and Accountability Act (HIPAA) data privacy policies shall be followed.
 8. In areas where a significant number of participants do not speak English as their principal language, Care Management services should be provided in the language spoken by those participants.
 9. As with all Older Americans Act (OAA) programs, participants of this service shall be informed that donations are accepted under this program and such donations will serve to expand the programs to others in need.

COMPONENTS: Service Activities shall include:

- **Assess Participant's Needs:**
Use the Screen for Community Services (SCS) to assess the needs of the participant, including the ability of the participant to obtain, arrange, and manage his or her own care. The Care Manager may utilize the SCS results from another staff person in the AAA, or by an agency which is contracted specifically for this purpose. Screeners shall obtain consent for release of information. The details of the verbal consent shall be documented in the participant's record located in the state designated database. The DoAS LTSS "Authorization for Release of Information" shall be mailed or given to the participant for their signature. Returned forms may be scanned and uploaded into the consumer record in the state database.

- **Develop a Care Plan:**

Develop an individualized plan of care (POC) based on assessment of the participant's needs and eligibility for services and in collaboration with the participant. The POC shall include goals, back up plans, and reassessment date. Starting with the date of referral (the date a consumer is formally assigned to a Care Manger), the Care Manager shall:

- Within three business days contact the participant.
- Within seven business days conduct an in-home visit with the participant.
- Within 30 calendar days sign and complete the participant's POC.

Based on the assessed needs, unmet needs, and unique requirements for the provision of the service, the POC shall identify and authorize the type, amount, frequency, duration and provider (including informal) of each service.

- **Implement Care Plan:**

Obtain formal and informal services according to an individualized care plan. This includes advocacy on behalf of the participant: to interpret, apply for, and secure benefits and services.

- **Monitor Care Plan Services:**

The Care Manager shall at a minimum:

- Oversee and monitor the participant, the provider, and the delivery of services to ensure quality, effectiveness, and compliance with the participant's POC and make revisions as necessary.
- Monthly, contact the participant.
- Every three months, visit the participant in any community setting.
- Every six months, one of those visits shall take place in the residence of the participant.
- Be responsible for monitoring and advising participants who are at risk of disenrollment from the programs or services.

- **Reassess Care Plan:**

- At a minimum, annually
- If there are any changes in the participant's condition(s), or service needs, a new SCS is required.
- Evaluate to determine if Care Management services are still appropriate to continue.
- If Care Management services are no longer needed, the case shall be reviewed with the Care Management Supervisor. Notice of case closure shall be provided in writing per program requirements to the individual or their designee and documented. Appropriate time shall be allowed for the individual to transition to another program, or independent service management, and assure continuity of care.
- Minimum requirements to be included in a Notice of Case Closure: Reason for case closure; appeal process; offer to assist in the future if needed; and other information appropriate to the county or consumer.

- The Care Management agency (if not the AAA) shall coordinate with the AAA to assure that duplication is not occurring with Medicaid Managed Long Term Services and Supports (MLTSS) by verification in Molina/NJMMIS.
- **Document Care Management Services:**
Maintaining records, preparing reports, and other efforts necessary to provide Care Management services. Case notes and POC may be scanned and uploaded as an attachment to the consumer record in the state designated database.

SECTION B – CARE MANAGEMENT SUPERVISOR STANDARDS

CARE MANAGEMENT SUPERVISOR QUALIFICATIONS

Care Management Supervisors shall have the following qualifications:

- Direct care management **or** supervisory experience in a social services setting for one year equivalent compensated work; **and** one (1) of the following:
 - Licensed or certified social worker in accordance with N.J.S.A. 45:15BB et seq. and N.J.A.C. 13:44G; **or**
 - Registered nurse in accordance with N.J.S.A. 45:11-23 et seq. and N.J.A.C. 13:37; **or**
 - Graduate of an accredited college or university with a bachelor's degree, or higher, in a health-related field **or** behavioral science field and one year equivalent compensated work or internship experience with the elderly or physically disabled in an institutional or community setting.

SCOPE OF CARE MANAGEMENT SUPERVISOR ACTIVITIES

Care Management Supervisors shall:

1. Implement federal, State and other program policies and procedures to ensure delivery of care management services in a manner that provides participants the opportunity to direct their care needs and choose their providers.
2. Provide orientation, training and professional development for Care Managers.
3. Assign each participant to a Care Manager within two business days of receiving a case referral.
4. Directly supervise the Care Managers assigned to participants, including case conferencing.
5. Oversee the implementation of individualized service plans (Plans of Care), quality assurance, program evaluation, and consumer advocacy.
6. Monitor all Care Management activities for compliance with federal, State, and other program policies and procedures.
7. Provide technical assistance to Care Managers.
8. Annually attend and require Care Management staff to attend a minimum of one continuing education training course or seminar on aging or disability related subjects and maintain documentation of participation.
9. Facilitate and coordinate quality assurance by completing a validated sampling of the Plans of Care to assure clinical needs are met, and other quality improvement activities for issues identified by self-monitoring and as requested by the Division.
10. Prepare reports and conduct audits as requested by the Division.

SECTION C – CARE MANAGEMENT AGENCY STANDARDS

A Care Management Agency is a qualified public or private organization or entity that holds a provider agreement or contract with the AAA as required by the Department of Human Services.

TYPES OF CARE MANAGEMENT AGENCIES:

Area Agency on Aging	Accredited Registered Homemaker Agency
County Welfare Agency	Proprietary or Not-for-Profit Care Management Entity
Licensed Certified Home Health Agency	Centers for Independent Living

CARE MANAGEMENT AGENCY STANDARDS

The Care Management Agency shall:

1. Employ at least one Care Management Supervisor who meets the criteria set forth in the Division’s Care Management Supervisor Qualifications.
2. Assure that all Care Management staff meets all Division Care Management standards.
3. Require all Care Managers to utilize the State designated client tracking database.
4. Train all Care Managers and Care Management Supervisors in the use of the State designated client tracking database.
5. Ensure that all Care Management staff shall attend annually a minimum of at least one continuing education training course or seminar related to aging or disability subjects.
6. Ensure the Care Manager completes the orientation with the AAA/ADRC within 30 days.
7. Ensure that appropriate agency staff attends required State meetings.

CARE MANAGEMENT AGENCY REQUIREMENTS

The Care Management Agency shall:

- Comply with all Division policies.
- Establish an internal Quality Management Strategy that includes Continuous Quality Improvement including an annual consumer satisfaction survey.
- Maintain an updated comprehensive Care Management policy/procedure manual, subject to DoAS review and approval upon request, which minimally includes:

Case assignment	Plan of Care (POC)
Case coverage for employee absence	Case Transfer: Agency to Agency
Case record documentation	Consumer Bill of Rights
Sexual harassment	Annual Employee Performance Evaluation (as applicable)
Conflict of interest	Emergency/Disaster Procedures
Confidentiality	Critical Incidents
Fiscal process	Job descriptions
Grievance procedures	Supervision
After Hour Policy	Employee Safety
Case Closure	Signed Business Associate Agreement

- Utilize a method for covering cases during Care Manager absence or other time when unavailable.
- Utilize a method for responding to cases after agency hours, where appropriate.
- Identify and manage critical incidents and emergencies appropriately.
- Follow an updated Continuity of Operations Plan (COOP) in case of emergencies and/or disasters.

SECTION D – JUSTIFICATIONS

Division Approved Providers

- Division Provider Contract
 - Par. 15.: The Contractor agrees to comply with all federal, state and municipal statutes, laws, rules, regulations and policies applicable to the provision of services hereunder, including but not limited to the following: Anti-discrimination – N.J.S.A. 10:5-1 et seq., Civil Rights Act of 1964, with amendments, 42 U.S.C.A. 2000a et seq., Americans with Disabilities Act – 42 U.S.C. 12101 et seq., Rehabilitation Act of 1973 with amendments – 29 U.S.C.A. 794(a), 42 U.S.C.A. 6101; New Jersey Conflicts of Interest Law – N.J.S.A. 52:13D-12-27; and Lobbying – 31 U.S.C. 1352. The list of laws cited herein is not intended to be an exhaustive list and is available for review at the State Library, 185 W. State Street, Trenton, New Jersey 08625.

SECTION E – CARE PLAN AND INSTRUCTIONS

New Jersey Department of Human Services Division of Aging Services

INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM

Plan of Care Document Instructions: Top of Page 1

1. **Participant Name** Print the participant's full (first and last) name.
2. **Plan of Care Date** Enter the full date (Month, Day, Year) the Plan of Care is developed. This is the first date the Plan contents are discussed with the participant. This is not necessarily the same date that the participant signs the Plan of Care once it is completed.
- 2A. **Closed Date** Enter date this Plan of Care was closed.
3. **Identification No.** Enter the participant's or JACC (SAMS or Other) identification number.
4. **Care Manager Name** Print the Care Manager's full (first and last) name.
5. **Plan of Care Renewal Due** Enter the estimated date (Month and Year) that the Plan of Care renewal is due for completion. Plans of Care are to be updated annually and revised as necessary when warranted by changes in the program participant's needs. For example, the annual Plan of Care is due one year (12 months) from the initial Plan of Care Date (indicated in #2).

JACC Only: The Long Term Care Re-Evaluation (level of care assessment) form (WPA-1), is to be completed prior to the annual Plan of Care renewal date. Separate instructions cover this document.
6. **Program** Indicate the Program in which the participant is currently enrolled.
7. **Residential Setting** Indicate the type of location where the participant is currently residing.
- 7 A. **Occupancy** Select if the participant resides alone or with others, i.e., family, friends, roommate.

Plan of Care Document Instructions: Body of Page 1

8. **Date** Enter the full date (Month, Day, Year) that each of the assessed needs (Problem Statements) is identified and written into the Plan of Care.
9. **Problem Statement** The Problem Statement is to illustrate the **reason(s)** for the assessed need. It should briefly describe the participant's health condition, personal goals, risk factors, and/or individual circumstances that serve as the basis for each assessed need and the way in which these impact the participant's functioning.

For example, a Column #9 entry should NOT state 'Locomotion' as the Problem Statement. Rather, it would describe the condition of the participant and his or her circumstances that have resulted in his or her limited mobility. Furthermore, the participant's diagnosis alone is not a sufficient summary of a Problem Statement justifying the assessed need. Rather, the impact of the diagnosis on the participant's day-to-day functioning should be indicated.
10. **Need Code(s)** Enter the Need Code(s) by which each assessed need is best categorized. For example, if the Problem Statement reads "Participant experienced a stroke and as a result has a poor hand grip, minimal use of her right arm, and is easily fatigued," the Need Code may be '2d' if the participant, as a result of this condition, needs assistance with '**Medication Management.**' When 'Option 8 – Other' is used, the assessor shall specify the Need in the blank provided.

INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM (Continued)

For all Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), use the **alphanumeric combination** indicated in the Code List. Also, it is possible for the assessor to enter more than one Need Code for each Problem Statement.

If the Problem Statement is best described as a Personal Goal of the participant (Option 3), please be sure that the participant's preference is clearly described and a Desired Outcome goal is also indicated in Column #12. Some examples of a participant's goal or preference are a) to be able to stay at home as long as possible rather than relocate to a nursing facility, b) to remain as independent as possible with the help of a home health aide, c) to obtain a personal computer to work out of his or her home, or d) to be able to go outside regularly or find transportation for preferred outings.

If the Problem Statement is best described as a Risk Factor (something that is likely to increase the chances that a particular event will occur), please describe these concerns on the last page of the Plan in Column #25. For example, a condition or behavior that increases the participant's chances for injury or the possibility of disease, such as the fact that smoking could lead to heart disease, lung cancer, eviction, or a serious fire hazard.

Assigned codes are used to identify the ADLs or IADLs with which the participant needs assistance or is unable to perform.

1. **ADLs** identify the specific Activity of Daily Living with which the participant needs assistance or is unable to perform.
 - a. **Bathing:** Bathing includes how the participant takes a full-body bath/shower or sponge bath. Includes how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, and perineal area.
 - b. **Dressing:** Upper Body Dressing includes how participant dresses / undresses (street clothes and underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc. Lower Body Dressing includes how the participant dresses/undresses (street clothes and underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, socks, and fasteners.
 - c. **Toilet Use:** Including using the toilet or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing special devices required (ostomy or catheter), and adjusting clothes.
 - d. **Transferring:** Including moving to and between surfaces – to/from bed, chair, wheelchair, standing position.
 - e. **Locomotion:** Including inside and outside of home. Note: If a wheelchair is used, regard self-sufficiency once in wheelchair.
 - f. **Bed Mobility:** Including moving to and from lying position, turning side-to-side, and positioning body while in bed.
 - g. **Eating:** Including taking in food by any method, including tube feedings.
2. **IADLs** identify the specific Instrumental Activity of Daily Living (IADL) with which the participant needs assistance or is unable to perform.
 - a. **Meal Preparation:** The ability to obtain and prepare routine meals. This includes the ability to open containers and use kitchen appliances, and how meals are prepared (e.g. planning meals, cooking, assembling ingredients, setting out food, utensils), with assistive devices, if used. If person is fed via tube feedings or intravenously, treat preparation for the tube feeding as meal preparation and indicate level of help needed.
 - b. **Housework:** The ability to maintain cleanliness of the living environment and how ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up).

INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM (Continued)

- c. **Managing Finances:** The ability to handle money, plan budget, write checks or money orders, exchange currency, handle coins and paper, do financial management for basic household necessities (food, clothing, shelter), pay bills and balance a checkbook.
- d. **Medication Management:** How medications are managed and ability to follow prescribed medication regime (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments).
- e. **Phone Use:** How telephone calls are made or received (with assistive devices such as large numbers or telephone amplification).
- f. **Shopping:** The ability to run errands and shop, physically acquire, transport and put away groceries. How shopping is performed for food and household items (e.g. selecting appropriate items, getting around in a store).
- g. **Transportation:** The ability to drive and/or access transportation services in the community. How participant travels by vehicle (e.g. gets to places beyond walking distance).
- h. **Accessing Resources:** The ability to identify needs and locate appropriate resources; the ability to complete phone calls, set up and follow through with appointments, and complete paperwork necessary to acquire services or participate in activities offered by the resources.
- i. **Laundry:** The ability to maintain cleanliness of personal clothing and linens.
- j. **Personal Hygiene:** Personal hygiene may include ability to perform grooming such as combing hair, brushing teeth, shaving, nail care, applying makeup, and washing/drying face and hands.

Assigned codes are used to identify other areas in which the participant requires assistance. The phrases in parentheses serve only as limited examples. Many more instances could be used to illustrate examples of each Need Code.

- 3. **Personal Goal:** Something that is a personal aspiration or objective stated by the participant (e.g. accessing transportation to attend social events, enrolling at a local community college, obtaining a personal computer, regularly attending religious services or functions, writing a book, or remaining in his or her own home for as long as possible rather than moving into a nursing facility).
- 4. **Communication Needs**
(e.g. communication disorders, hearing or speaking impairments)
- 5. **Social Isolation**
(e.g. lives alone, home in an area inaccessible to visitors)
- 6. **Caregiver Relief**
(e.g. at risk for reduction of informal supports, caregiver burnout)
- 7. **Mental Health**
(e.g. cognitive impairment, low self-esteem, depression, hopelessness, rage, emotional instability)
- 8. **Other (specify)**
- 9. **Risk Factors**
 - a. **Personal Safety Risk**
(e.g. supervision needed for personal safety; participant is self-neglecting, abusive of alcohol or other substance)
 - b. **Health Condition Risk**
(e.g. needs medical attention; visual impairments, obese, sedentary lifestyle, chronic illness, poor nutrition, sleep disturbance, poor health/hygiene, lack of oral/dental care, skin condition/bed sores, improper foot care, at risk of falls, at risk of long term institutional care in nursing facility)
 - c. **Behavioral Risk**
(e.g. risky or inappropriate behaviors or lifestyle habits)

**INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM
(Continued)**

- d. **Environmental Risk**
(e.g. home environment, living conditions are insecure or hazardous; neighborhood is unsafe)
- e. **Medication Risk**
(e.g. unable to appropriately manage medications; multiple medications and/or prescribing physicians)
- f. **Other Risk (specify)**

SERVICES

11. **Service(s) Needed** **Service(s) Needed** is used to identify distinct services. Enter the type of Service(s) that is required to address each of the assessed needs (e.g., Home Health, Transportation, Meals on Wheels).
12. **Desired Outcome Codes** **Desired Outcome Code** identifies the general objective of the service in terms of participant functioning in the need area.
- Enter the appropriate Desired Outcome from the Code List. Indicate the meaning of "Option 5 - Other" if used, in the space provided.
- The Code answers the following types of questions regarding the participant's functioning:
- 1. **Maintenance:** Does the participant want his current level of functioning maintained?
 - 2. **Independence:** Does the participant want to gain independent functioning in the area?
 - 3. **Rehabilitation:** Does the participant want to restore functional ability?
 - 4. **Prevention:** Does the participant want to prevent the problem from recurring?
 - 5. **Caregiver Relief:** Does the services provide respite to the caregivers?
 - 6. **Other (specify):** Does the participant want to resolve the issue, e.g. the installation of a ramp resolves the lack of access in and out of the home?
13. **Units Per Visit** **Units** refer to the number of units of service authorized/arranged for during an occurrence/visit.
- For APC:** Use current unit of service as specified in the taxonomy.
- For JACC Only:** Enter the units of service per visit/occurrence. (See JCN 407 form.)
14. **Frequency** **Frequency** codes are used to distinguish the number of times a service should occur. Indicate the frequency, from the list below, which best describes how often the support is provided/required.
- D– Daily, specifying the number of days per week** (e.g. 3x). If the participant wants services on the weekends or specific weekdays that preference can be indicated in the Problem Statement.
- W– Weekly:** Once every week
- B– Bi-Weekly:** Once every two weeks
- M– Monthly:** Every month (once within 30/31 days)
- Q– Quarterly:** Once every three months
- A– Annually:** Every year (once within 12 months)
- O– Other (specify)**

**INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM
(Continued)**

COSTS

15. Unit Cost Unit Cost

For JACC Only: Enter the **Rate per Unit** of service. (See JCN 407 form) Rates, where applicable, may not exceed those established. Specify the authorized cost for each service.

16. Payment Source

Payment source codes are used to identify the source of funding for a service. Enter code, from the list below, for service payment source.

1. Medicaid: Medicaid is medical assistance (health insurance) provided to certain persons with low incomes and limited resources as authorized under Title XIX (Medicaid) of the Social Security Act. Can include both traditional State Plan Medicaid services provided through a Managed Health Plan as well as non-medical services when provided under special Medicaid Waiver programs as authorized under section 1915(c) of the Social Security Act.

2. Medicare: Health Insurance generally for individuals over 65 and/or disabled.

Part A-Hospital Insurance: Helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care) and also helps cover hospice care and some home health care.

Part B-Medical Insurance: When medically necessary, helps cover doctors' services and outpatient care, often requiring a premium. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

Part D-Prescription Drug Coverage: Insurance which may help lower prescription drug costs. Private companies provide the coverage and beneficiaries choose the drug plan and may pay a monthly premium. NJ Medicaid Waiver participants do not have a premium.

3. Other Third-Party Liability (TPL): Private Health Insurance.

4. Local, Community-Based Organization: A church organization may be involved, or a local township or city community action program may be used.

5. County Funded Program: The county health department or a county human services office may use funds to maintain programs for seniors and persons with disabilities.

6. State Funded Program: Can include programs such as the Jersey Assistance for Community Caregiving (JACC) program, the Congregate Housing Services Program (CHSP), the Alzheimer's Adult Day Health Services Program (AADHS), or some other state-funded program.

7. Informal Support: Any free or uncompensated support given by a relative or immediate family member, friend, neighbor or other informal companion.

8. Private Pay: Any payment made directly by the participant out of his or her own income, resources or personal needs allowance.

9. APC Funded: Any service supported by funds from the County Office on Aging (AAA/ADRC) under the area plan contract.

10. Other (specify)

**INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM
(Continued)**

PROVIDERS

17. Provider Type

Provider Type codes are used to identify persons who assist a participant in the areas of need. Provider / Worker is defined as an individual or entity that demonstrates competence to qualify as a provider of services.

Enter code, from the list below, to describe each type of provider.

J – JACC Agency

A provider that has applied, been authorized and enrolled by the Division of Aging Services as a JACC provider agency and as such can submit claims for JACC covered services and supplies.

M – Medicare

A provider that has applied, been authorized and enrolled by the Centers for Medicare and Medicaid Services (CMS) as a Medicare provider and as such can submit claims for Medicare covered services and supplies.

PEP– Participant-Employed Provider (PEP)

A Participant-Employed Provider refers to an individual worker who has been approved to provide authorized services as a hired employee of the participant.

P – Private Provider

A provider that is rendering goods or services based on payment made directly by the participant out of his or her own income, resources or payment made on behalf of the participant by a relative or immediate family member, friend, neighbor or other informal companion.

F – Facility (JACC only)

A Hospital, Nursing Facility, or Assisted Living Facility that would typically be used for facility-based respite stays or for residents in an Assisted Living Facility.

I – Informal Support

A relative or immediate family member, caregiver, friend, neighbor or other informal companion who provides services to the participant.

18. Provider

Enter the specific name of the Provider Agency or the name of the Participant-Employed Provider responsible for rendering each service.

MONITORING

19. Monitoring Method

Monitoring Method codes are used to identify how service provision will be verified. Both State and Federal governments seek proof that services are delivered in accordance with the Plan of Care.

Enter the appropriate Code(s), from the following, to describe how service delivery will be confirmed: Select all that Apply

C– Participant Record/Chart: e.g., case file, facility chart.

T– Time Sheets:

S– On-site Review: e.g., face to face visit with participant while service occurring, observing participant and environment.

R– Receipts: e.g., review proof of payment, vouchers, or invoices of services delivered.

D– Documentation: e.g., review of assignment sheets, service delivery logs, medication or treatment administration records.

P– Phone Contact: e.g., telephone conversations with participant, caregiver, service provider, or billing agent.

O– Other (specify)

20. Monitoring Frequency

Monitoring frequency codes indicate how often service verification is to be performed.

Enter the minimum monitoring frequency, from the codes below, required for each service.

D– Daily

M– Monthly

R– Random

W– Weekly

Q– Quarterly

U– Upon reported completion

B– Bi-Weekly

A– Annually

O– Other (specify)

INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM (Continued)

21. **Unmet Need Code** **Unmet Need** codes convey those participant needs that have been identified but have no arranged services in place, as an obstacle/barrier limits the need from being met or resolved. Enter the code to indicate why this assessed need remains unmet.

In addition, in Column #25 on the last page of the Plan of Care, describe the impact the unmet need has on the individual's health, safety and well-being, which is likely to require the continued attention of the Care Manager.

Enter code, from the list below, for unmet need.

1. **Not available**
2. **Not affordable**
3. **Waiting list**
4. **Frequency not adequate**
5. **Refused** (service offered but participant declines)
6. **Other (specify) – expound on reason if necessary in Column #26**

JACC Only: Note: Any unmet needs described in this section must also be a component of the Long-Term Care Re-evaluation and must be acknowledged at the reassessment.

UPDATES

22. **Initials** **Plan of Care Updates or Changes:** Throughout the Plan of Care please indicate any changes that occur during the year, prior to the annual POC renewal date.

As per the Plan of Care Policy:

- Any change to a POC requires that the **Care Manager** (CM) make the change on the POC, initial and date it, and enter an explanation for the change in the Monitoring Record.
- Changes that reflect an increase, addition, decrease, or termination of an existing service must also be initialed and dated by the **Participant**, or his or her representative no later than the date of the next scheduled visit.

23. **Date** Enter the date(s), (mm/dd/yy), that the update or change to the Plan of Care was initialed by the Care Manager and by the participant if necessary.

24. **Special Instructions/Comments** If upon the initial completion of the POC, there are no comments to be added to this section, please check the **N/A** box.

Enter any additional comments including the date and initial each entry.

When utilized, this section should include but not be limited to:

Participant Preferences or Concerns: Please indicate any comments or preferences from the participant. (e.g., only services after 9 a.m.)

Unmet Needs: Expound on any needs that are identified as unmet in Column #22.

Back-up Plans: Please indicate assessed needs/behaviors/situations/conditions considered to be at-risk concern(s) for the safety and/or well-being of the participant. List the interventions that will be put into place to respond to these safety concerns if service delivery fails to occur as proposed (including description of the intervention, who is involved, emergency contact information, and responsibilities).

**INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM
(Continued)**

SIGNATURES

All Plans of Care (POC) are to include at least three signatures (Participant, Care Manager and Care Management Supervisor), and any others as applicable. All original signatures are to be secured within 30 days of receiving the case, upon completion of the POC. Copies are to be made available for all parties.

Participant's Signature: The participant's signature may be the mark of an **X** as performed by the participant. If the participant has a representative, that person may sign for the participant upon the participant's request.

Above the Participant's (or his or her Representative's) signature, the signer should attest to whether he or she Agrees (Yes) or Disagrees (No) with the following statements:

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | I agree with this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I had the freedom to choose the services in this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I had the freedom to choose the providers of my services based on available providers. |
| <input type="checkbox"/> | <input type="checkbox"/> | I helped develop this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am aware of my rights and responsibilities as a participant of this program (as contained in the Participant Agreement). |
| <input type="checkbox"/> | <input type="checkbox"/> | I am aware that the services outlined in this Plan of Care are not guaranteed. |
| <input type="checkbox"/> | <input type="checkbox"/> | I have been advised of the potential risk factors outlined in this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I understand and accept these potential risk factors. |

If the participant marks 'No' to any of the above-mentioned queries, an explanation of the participant's concerns is to be provided in Column #25 prior to acquiring his or her signature.

The Care Manager shall explain to the program participant the special note described below the participant's signature:

'All participants are evaluated at least annually to confirm that they continue to meet both the financial criteria and clinical eligibility requirements of this program.'

The Care Manager should explain, and periodically remind the participant, what specific clinical and financial criteria are required to participate in this program and who is responsible for re-determining his or her continued eligibility for both.

Care Manager (CM) Signature: The Care Manager shall sign the Plan of Care as indication that (1) the Plan of Care addresses all of the participant's assessed needs (including health and safety risk factors, and any unmet needs) and personal goals either by the provision of services or through other means; and (2) the Plan of Care has been developed in accordance with appropriate Plan of Care Policies and Procedures.

CM Supervisor Signature: The Care Management Supervisor shall sign the Plan of Care as indication that he or she has reviewed it in its entirety and agrees that the Plan of Care has been developed in accordance with appropriate Plan of Care Policies and Procedures. (If the Care Management Supervisor or Care Coordinator has a caseload and has prepared the Plan of Care, a designated qualified staff person may sign the Plan of Care as the reviewer.)

Other(s): Other involved parties, such as a family member, appointed guardian, legal representative, or other involved party, by the request of the participant, shall sign the Plan of Care as indication that he or she is aware of the assessed needs and authorized services that have been outlined in the Plan of Care.

PLAN OF CARE (Continued)

1. Participant Name <i>(print)</i>	2. Plan of Care Date <i>(mm/dd/yyyy)</i>	3. ID No. (JACC, SAMS, or Other)
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25. Special Instructions/Comments: [Include all of the following which apply – (1) Incorporate Client Preferences or Concerns; (2) Expound on Unmet Needs; and (3) Describe Back-up Plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns (including who is responsible with emergency contact information).] **N/A upon completion of initial POC**

Comment	Date	Comment	Date

Back-up Plan:

Safety / Emergency / Community-Wide Disaster:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I agree with this Plan of Care.
<input type="checkbox"/>	<input type="checkbox"/>	I had the freedom to choose the services in this Plan of Care.
<input type="checkbox"/>	<input type="checkbox"/>	I had the freedom to choose the providers of my services based on available providers.
<input type="checkbox"/>	<input type="checkbox"/>	I helped develop this Plan of Care.
<input type="checkbox"/>	<input type="checkbox"/>	I am aware of my rights and responsibilities as a participant of this program (as contained in the Participant Agreement).
<input type="checkbox"/>	<input type="checkbox"/>	I am aware that the services outlined in this Plan of Care are not guaranteed.
<input type="checkbox"/>	<input type="checkbox"/>	I have been advised of the potential risk factors outlined in this Plan of Care.
<input type="checkbox"/>	<input type="checkbox"/>	I understand and accept these potential risk factors.
Signature _____		Date _____
<input type="checkbox"/> Participant** / <input type="checkbox"/> Representative**		

Signatures:

Care Manager (CM): _____ Date: _____

CM Supervisor: _____ Date: _____

Other: _____ Date: _____

Other: _____ Date: _____

** Note: All participants are evaluated at least annually to confirm that they continue to meet both the financial criteria and clinical eligibility requirements of this program (as applicable).

* Code List						
Problem Statement: (Column #9) Briefly describe the client's individual circumstances which serve as the basis for each assessed need.	Need Codes, Continued 2. Perform IADL (specify letter) a. Meal Preparation b. Housework c. Managing Finances d. Medication Management e. Phone Use f. Shopping g. Transportation h. Accessing Resources i. Laundry j. Personal Hygiene	Need Codes, Continued 9. Risk Factors a. Personal Safety Risk b. Health Condition Risk c. Behavioral Risk d. Environmental Risk e. Medication Risk f. Other Risk (specify) _____	Frequency: (Column # 14) D- Daily (specify # of days per week) W- Weekly B- Bi-weekly M- Monthly Q- Quarterly A- Annually O- Other (specify) _____	Provider Type: (Column #17) J- JACC Agency M- Medicare PEP- Participant-Employed Provider P- Private Provider F- Facility I- Informal Support	Monitoring Frequency: (Column #20) D- Daily W- Weekly B- Bi-weekly M- Monthly Q- Quarterly A- Annually R- Random O- Other (specify) _____ U- Upon reported completion	Unmet Need Codes (Column # 21) 1. Not available 2. Not affordable 3. Waiting List 4. Frequency not adequate 5. Refused 6. Other (specify) - expound on reason if necessary in Column #26
Need Codes: (Column #10) Identify the Code by which each assessed need is best categorized. Client Unable to: 1. Perform ADL (specify letter) a. Bathing b. Dressing c. Toilet Use d. Transferring e. Locomotion f. Bed Mobility g. Eating	3. Personal Goal 4. Communication Needs 5. Social Isolation 6. Caregiver Relief 7. Mental Health 8. Other (specify) _____	Desired Outcome Code: (Column # 12) 1. Maintenance 2. Independence 3. Rehabilitation 4. Prevention 5. Caregiver Relief 6. Other (specify) _____	Payment Source: (Column #16) 1. Medicaid 2. Medicare 3. Other Third Party Liability (TPL) 4. Local Community-Based Organization 5. County Funded Program 6. State Funded Program 7. Informal Support 8. Private Pay 9. APC Funded 10. Other (specify) _____	Monitoring Method: (Column #19) C- Participant Record / Chart R- Receipts S- On-Site Review D- Documentation (specify) _____ T- Time Sheets P- Phone Contact With _____ O- Other (specify) _____		Updates (Columns # 22 and 23) Completed only as necessary if changes are made throughout the duration of the Plan of Care.