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02.10 INTRODUCTION

Assessment is a method of determining an applicant's current long term care needs through the use of a comprehensive standard instrument. Information obtained during the assessment process should be adequate for the CLTC **Nurse Consultant** to make a level of care decision and for the CLTC **Case Manager** to initiate service planning for discussion with the applicant and primary contact.

An assessment form must be completed for any person referred to CLTC who meets the intake criteria, unless the applicant is terminated prior to assessment completion.

02.20 ASSESSMENT POLICIES AND PROCEDURES

02.21 Consent Form

The Consent Form, DHHS Form 121, must be signed by the applicant at the time of the pre-admission screening and submitted, along with the S.C. Long Term Care Assessment, to the local CLTC Office. The purpose of this form is to ensure that the applicant, whenever possible, is involved in planning his/her long term care needs and to obtain consent from the applicant for CLTC to share information with involved service providers.

NOTE: For nursing facility cases, continue to accept the previous hard copy Consent Form until the presently used Phoenix form may be printed.

If a case, not an application, is closed for any reason and later reopened, a new Consent Form must be obtained. An exception to this policy is made for re-certifications. (See Chapter 8 Nursing Home.)

The Consent Form may be signed by the primary contact only when the applicant is not mentally or physically able to sign the form, or at the applicant's request. When this determination is made and there is no available responsible relative, another knowledgeable person may sign as the primary contact. It must be signed before the **Nurse Consultant** can take any action on the case.

If an applicant signs by making a mark, the form must be witnessed by two (2) people.

A person other than the assessor should witness the Consent Form. The person completing the assessment may witness the Consent Form only when there is not a third person present.

It is appropriate to accept telephone consent when all other options are exhausted. The telephone consent must be signed by the person receiving the consent and

one other witness.

The **CLTC representative/worker** updates the Consent section of the Participant Information in Phoenix each time Consent is obtained.

02.22 Choice of Locus of Care

A written locus of care must be secured from the applicant to ensure that the applicant is involved in planning his/her long term care. This locus will remain in effect until such time as the applicant changes his/her locus choice. If the applicant lacks the physical or mental ability required to make a written choice regarding his/her care or the applicant requests, the primary contact may sign the Service Choice, DHHS Form 164. In these cases, if the primary contact is not available, efforts should be made to make a phone contact with the primary contact to discuss locus and document the discussion in the Comment Section of the form. The absence of a signature from the applicant or primary contact must be documented in the Comment Section of the Service Choice, DHHS Form 164.

A nursing home certification should not be denied if a written choice cannot be obtained. If a **Nurse Consultant** is asked to complete a nursing home certification and the applicant refuses to sign a locus choice indicating nursing home, the **Nurse Consultant** should counsel with the applicant and family or interested agency and try to negotiate the disputed locus of care. When a capable applicant is presented with realistic options and ultimately chooses community placement, the **Nurse Consultant** should support that decision. However, when the applicant's choice is unrealistic and the choice puts the applicant in an unsafe situation, the **Nurse Consultant** should point out to the applicant that the choice is not in keeping with his/her service needs. All efforts made in this area should be carefully documented. The **Nurse Consultant** should also consider making a referral to DSS Adult Protective Services for further intervention. Once this is done, the locus choice is still the applicant's decision. Even though a CLTC certification may be issued, this does not constitute disregard for the applicant's choice nor should it be considered assistance with nursing home placement.

An individual has the right to assume risk, commensurate with that person’s ability and willingness to assume responsibility for the consequences of that risk. This, of course, does not abrogate a State’s statutory duty to ensure the health and welfare of individuals served under the Home and Community- based Services waivers. Staff should exercise good professional judgment in dealing with cases where the applicant’s health, safety, and welfare are questionable. Cases should be staffed with **designated Lead Team** and **Area Administrator**. Central Office should be consulted. Legal counsel may also be needed. Documentation is crucial in these cases. Referrals must be made to other agencies (DMH, DSS, etc.) as appropriate and/or as required by State law.

02.23 Financial Eligibility for Medicaid

Verifying an applicant's financial eligibility is an important function of the CLTC **Intake Nurse Consultant and Area Office Nurse Consultant**. This determination is made by the local Social Security Office or the County Medicaid Eligibility Office. This financial determination is not required before the referral is accepted; however, the applicant must intend to make an application for financial eligibility. Efforts should be made by the **Intake Nurse Consultant and Area Office Nurse Consultant** to arrange for assistance with the application process if there is not an identified primary contact. (If the applicant has not applied for Medicaid financial eligibility **within thirty (30) calendar days** of the level of care determination by the Nurse Consultant, a 10-day notice should be sent using the CLTC Notification Form 171. If no response is received, the case can be closed upon discretion of the **Intake Nurse Consultant** as **financial application not completed.**

Note: See Chapter 4 – Eligibility for interaction with Medicaid Managed Care.

02.24 Individuals Who May Complete Pre-Admission Screening Assessment

Individuals who may complete an assessment are as follows:

1. CLTC **Nurse Consultant**;

2. Any person who is professionally involved in the applicant's case and is a nurse, social worker, social services worker, and/or physician.

No portion of the assessment can be completed by any person who is related to the applicant.

02.24.10 How to Determine Who Will Complete the Assessment

The location of the applicant at the time of assessment may determine who will complete the assessment.

An applicant located in a Title XIX certified long term care facility will be assessed by the staff of that facility. When an applicant is located in a non-Title XIX certified facility, the assessor will be determined by an agreement between the CLTC **Area Administrator** and the nursing home administrator.

When an applicant is located in the community at the time of the assessment, the staff of the agency actively involved with the applicant may complete the assessment. If no agency is currently involved with the applicant or if that agency is unable to complete

the assessment, a CLTC **Nurse Consultant** will complete the assessment.

When an applicant is located in the hospital at the time of the initial assessment, the assessor will be determined by agreements between each CLTC **Area Administrator** and each hospital administrator.

02.25 Timeliness Standards for Completion of an Assessment

When a referral is received for a Nursing Home applicant from a hospital, the CLTC **Nurse Consultant** must visit and complete the assessment on the hospital applicant **within five (5) business days** of the case assignment date.

When a referral is received for a Nursing Home applicant from a nursing home, the CLTC **Nurse Consultant** must visit and complete the assessment **within ten (10) business days** of the case assignment date. A level of care decision is rendered **within three (3) business days**.

When a referral is received for a Community applicant from any referral source, the CLTC **Nurse Consultant** must visit and complete an assessment on a community applicant **within ten (10) business days** of the case assignment date. A level of care decision is rendered **within three (3) business days**.

Any exceptions to these time frames must be documented in the Narrative.

02.26 Application Withdrawal

After intake, an applicant who does not appear to exhibit functional deficits can withdraw his/her application prior to or during the assessment process. If the **Nurse Consultant** determines that application withdrawal is appropriate, the CLTC Application Withdrawal Form, DHHS Form 150, must be reviewed with the applicant and/or primary contact and the signature of the applicant and/or primary contact can be requested. The **Nurse Consultant** should not utilize the Application Withdrawal Form if there are any questions about the applicant's ADL/Medical condition, or if the applicant/primary contact does not agree with the withdrawal of the application. Once the applicant and/or primary contact signs the form, the program application and case where applicable will be terminated in the Status Changes section of Phoenix as "Declined participation." The **Nurse Consultant** will advise the applicant and/or primary contact that a new application can be made at any time. In the event the applicant/primary contact declines to sign the form after it has been explained to them, the assessment process must continue using established policy and procedures.

02.27 Accurate Assessment Completion

The **Nurse Consultant** will contact the applicant and/or family, hospital, or agency, as appropriate, to arrange for assessment completion on assigned cases. The **Nurse Consultant** may complete the assessment by conducting a face- to-face visit or by a telephone interview. If the assessment information is not clearly obtained or the information is questionable, a face-to face visit is required. If the Level of Care is not clearly Intermediate or Skilled or the accuracy of the information is questionable, a face-to-face visit and/or input from the Physician or knowledgeable other may be required.

The **Nurse Consultant** will have the Consent Form, DHHS Form 121 completed if a face-to-face assessment is completed. If a telephone interview is conducted, the **Nurse Consultant** will obtain verbal consent. The verbal consent will be indicated on the Consent Form, DHHS Form 121 and must be signed by the person receiving the consent and one other witness. (A Consent Form, DHHS Form 121 in Phoenix will be obtained at the Initial Visit by the on-going **Case Manager**.)

The **Nurse Consultant** will have the Service Choice Form, DHHS Form 164 completed if a face-to-face assessment is completed. If a telephone interview is conducted, the **Nurse Consultant** will obtain the verbal service choice. The verbal service choice will be indicated on the Service Choice Form, DHHS Form 164 and must be signed by the person receiving the service choice. (A Service Choice Form, DHHS form 164 in Phoenix will be obtained at the Initial Visit by the on-going **Case Manager**.)

The assessment form must be completed accurately, obtaining all available information. The assessor should read the South Carolina Assessment & Level of Care Manual for Medicaid-Sponsored Long Term Care Services before completing an assessment and reference help sections in Phoenix. Only assessment information obtained and verified by the **Nurse Consultant** should be entered into Phoenix. Required assessment sections are determined by the type of program application. Each program designated section must be completed. When the assessment is completed in a location other than the applicant's residence, such as a nursing home or a hospital, the Home Assessment information section must be obtained verbally from the applicant and /or primary contact. It is the **Nurse Consultant's** responsibility to ensure that the assessment is properly completed before a level of care decision is determined.

When the assessor has created a telephone interview assessment in Phoenix, and then it is determined that a face-to-face assessment is required, the assessor should continue documenting the information on the same assessment form in

Phoenix and document in the narrative.

Accurate observation can only be made when the assessor asks comprehensive and interview led questions. If accurate assessment information cannot be obtained during a telephone assessment, a face-to-face assessment is required. The assessor must attempt to involve the applicant as much as possible in the actual assessment process.

When an applicant is physically or mentally unable to participate in an interview, the primary contact, guardian, or primary caregiver can be interviewed for completion of the assessment. Assessors should complete the Mental Status Questionnaire (MSQ) to aid in the determination of the applicant's mental awareness. Every effort should be made to include the applicant in the interview and planning process.

The CLTC **Intake Nurse Consultant** informs applicant and/or family about the Medicaid Eligibility application process if applicant is not a current Medicaid recipient during the intake process. The **Assigned Nurse Consultant** informs the applicant and/or family of his/her options concerning nursing home care or CLTC waivered services and obtains a Service Choice, DHHS Form 164; Completes all appropriate areas of Phoenix; Annotates the Narrative; Completes correspondence as appropriate to referring agency, applicant, and other individuals involved with the applicant; and routes correspondence file to **designated Support Staff** if correspondence is to be mailed.

The **designated Support Staff** mails correspondence, if appropriate, and returns correspondence file to assigned **Nurse Consultant** or files as indicated.

02.28 Medical Information Completion

The Diagnoses/Conditions section of the Assessment is the medical summary. This section must be completed on all applicants reviewed by CLTC for a final level of care determination. The assigned **Nurse Consultant** completes all appropriate information in Phoenix.

When CLTC is completing the assessment, the **Nurse Consultant** should contact one or more informed sources to obtain medical information: physician, physician's staff, hospital staff, medical record, home health agency, primary contact/applicant, and/or involved agencies. The **Nurse Consultant** is responsible for obtaining the most reliable and accurate information available. The **Nurse Consultant** should not delay the level of care decision in an effort to

have Diagnoses/Conditions section verified by the medical source. (For medically ineligible cases, refer to Section 02.28.10.)

02.28.10 Obtaining Medical Information for Medically Ineligible Applicants

The medical information of the Assessment must be obtained from the physician or physician's staff if the physician is unavailable, when the applicant is determined to be medically ineligible. The **Nurse Consultant** adds the source of the medical information in the Phoenix Source of Information/Level of Care section. A pre-signed Physician's Input Letter from the CLTC medical consultant is available and may be sent to the applicant's attending physician to obtain medical information. A copy of the consent form (Form 121) signed at the time of assessment, should be routed with the CLTC Physician's Input Letter. No other form should be sent to the attending physician for this purpose.

The **Nurse Consultant** should consult with Central Office on difficult cases that cannot be resolved in the local CLTC office or on cases where efforts to verify medical information from the physician or physician's staff have been unsuccessful.

02.29 Pre-Admission Review for Waiver Enrollment

Pre-admission review is completed by a **Nurse Consultant** for an applicant who applies for waiver enrollment. Policy and procedure must be followed for intake, assessment, level of care, and Medicaid financial eligibility.

The pre-admission review information must provide accurate and comprehensive information for the **Case Manager** to develop a service plan. The Assessment must present a clear picture of the applicant's medical, skin/nutrition, functional abilities, and communication/psycho-behavioral status. In addition, the following information must be addressed and documented in the applicant record by the **Nurse Consultant**:

- Setting during interview process, including persons present, applicant involvement in assessment process and explanation of CLTC program;
- Support systems presently serving the applicant must be completed in Caregiver Supports section (names and phone numbers) and the Non-Waiver Supports section of Phoenix;
- Special Alerts section of Phoenix must be completed.

During the interview process, the **Nurse Consultant** must explore with the applicant, primary contact and/or other permitted caregiver supports, the status of Third Party Liability, i.e., private insurance, Tri-Care, and completes Premium Payment Project Referral Form (1-95), if appropriate.

The **Nurse Consultant** is responsible for providing assistance to the applicant who is Medicaid eligible with Payment Category 32 (ABD) with the completion of the Medicaid Eligibility Form 3400B as needed.

For Category 32 (ABD) applicants, the **Nurse Consultant** must complete the Statement of Transfer of Assets (Medicaid Eligibility Form 3400D). The completed and signed form should be forwarded to SCDHHS Central Mail Center, Post Office Box 100101, Columbia, SC 20202-3101. When the assessment is completed via a telephone interview, the Statement of Transfer of Assets (Medicaid Eligibility Form 3400D) should be explained and completed verbally. The form should be witnessed by the person receiving the information and one other witness. (A Statement of Transfer of Assets (Medicaid Eligibility Form 3400D will be obtained at the Initial Visit by the on-going **Case Manager**.)

Applicants who indicate that a transfer of assets below market value has occurred will not be enrolled in the waiver. The application will not be terminated until a response is received from Medicaid Eligibility regarding financial eligibility.

Waiver applicants who are eligible for SSI (Categories 16, 54, 80, 81, 85, or 86) and ABD (Category 32) Medicaid and are 55 years of age or older will be provided an Estate Recovery Brochure by the **Nurse Consultant.** The **Nurse Consultant** will obtain a signed Estate Recovery Notification Form DHHS 1296ER. The copy of the form will be left with the applicant. The original will be scanned into Phoenix and routed to the Division of Estate Recovery. If the participant refuses to sign the form, notate refusal on the 1296ER and route as above. The **Nurse Consultant** should narrate the reason for refusal. CLTC application may continue even if participant refuses to sign 1296ER form.

When the assessment is completed via telephone interview, the Estate Recovery Notification Form DHHS 1296ER should be explained and completed verbally. The form should be witnessed by the person receiving the information and one other witness. (The Estate Recovery Notification, Form DHHS 1296ER will be obtained at the Initial Visit by the on-going **Case Manager**.)

If the applicant has Medicare coverage, the Medicare number must be recorded in the Participant Information section of Phoenix.

During the assessment process, the **Nurse Consultant** must identify the applicant

who could be **at-risk for missed PCII visits** and **priority for emergencies/disasters**. The recommendation, based on information obtained from the applicant, primary contact, and/or primary caregiver during the initial assessment, must be keyed into the appropriate sections of Phoenix by the **Nurse Consultant**. Evaluation of the participant who would be vulnerable during an emergency, disaster or at-risk for missed PCII visits will be continued by the **Case Manager** during the monitoring process. The assessment should identify the applicant with special needs and/or support situations whose health and safety would be impacted by the absence of an authorized PCII. (Example: Applicant who is bedbound and would rely on the PCII to get up in the morning and there are no other reliable support systems to perform this duty.)

The emergency/disaster priority status is determined by evaluating the applicant's support system, advanced medical needs, and other special needs. (Examples: Applicant lives alone and has no one available to evacuate him/her or can only be transported by ambulance or has special communication needs.) The **Nurse Consultant** requests permission from the applicant, primary contact, and/or permitted primary caregiver to share the name of the applicant who has been identified as priority for emergencies/disasters with the Emergency Management Office, American Red Cross, or other emergency agencies. This choice for notification to emergency agencies must be recorded in Phoenix by the **Nurse Consultant**.

- In order to receive services through CLTC, the participant/ primary contact must select a case management provider.

- The participant/ primary contact should be given the "Choosing a Case Manager" brochure.

- The **Nurse Consultant** should review/read the brochure to the participant/ primary contact.

- If a selection is made at the **Nurse Consultant** visit, the signed Provider Choice must be scanned in the Phoenix record. This choice will be reconfirmed upon entry into the waiver.

- **If a selection is NOT made at the Nurse Consultant visit, Case Management Provider Choice Form is left with the participant/primary contact.** The **Nurse Consultant** should instruct the participant/primary contact to choose at least 5 case management providers (if available) in order of preference. A self-addressed envelope should be left with the applicant. The **Nurse Consultant** should instruct the participant/primary contact to mail the completed and signed form to the local CLTC office. (The envelopes can be metered at the office prior to visit).

Note: If this is not received by waiver enrollment date, the **Case Manager II** may obtain verbal provider choices.

- A CLTC brochure will be provided informing the applicant/primary contact of available waivered services.

- The CLTC Area Office and Nurse Consultant contact information will be provided

- Referrals should be made to other agencies for the immediate needs of the applicant as appropriate, i.e., Adult Protective Services.

If the applicant does not enroll in the waiver **within thirty (30) calendar days** of the initial assessment, a new assessment must be completed. The **Nurse Consultant** must contact the applicant and/or primary contact, if possible, or other permitted caregiver supports to confirm the information obtained in the assessment and document this contact in the narrative. (It may be necessary to re-verify Medicaid financial eligibility depending on the amount of time the case has been pending.) This contact must be made before the case is transferred to the **Case Manager II** for waiver entry and service plan development.

If the initial assessment was completed **within the past 180 days**, a re-evaluation may be completed per phone or visit. A new assessment should be completed in Phoenix and a new level of care determined.

If the initial assessment is **over 180 days old**, then a visit must be made to complete the Assessment. A new assessment must be completed in Phoenix and a new level of care determined.

If the applicant appears to be medically ineligible at any time while the case is pending, a visit must be made to the applicant to re-determine the level of care.

The date the applicant is determined to be eligible (level of care, locus of care, Medicaid financially eligible, wants to participate in the waiver, and slot available) to enter the waiver must be documented in the Narrative by the **Nurse Consultant**.

The **Nurse Consultant** must call to confirm the participant's location prior to the transfer conference and enrollment.

The Nurse Consultant and the Case Manager II must team staff the assessment information for service plan development and to enter the case into the waiver within five (5) business days of the applicant becoming

eligible.

The **Nurse Consultant** will make a recommendation concerning the applicant's risk factor in relation to the Emergency Preparedness Plan and at risk for missed PCII visits. The **Nurse Consultant** completes a narrative entry documenting the team conference with the Case Manager II was completed.

If it is determined during the team conference that the assessment information does not provide a clear and comprehensive picture of the applicant, it is the responsibility of the **Nurse Consultant** to contact the applicant and/or primary contact, if possible, or other permitted caregiver support to obtain additional information for the service plan development.

Note: The applicant must be enrolled in the waiver by the **Case Manager II** on the same day of the Nurse Consultant/Case Manager conference.

The enrolling **Case Manager II** must complete the following tasks on the date of enrollment which is the same date of the transfer conference:

- Narrate the transfer conference with the Nurse Consultant,
- Change the Participant Status to "participating" in Phoenix,
- Send a CLTC Notification Form to the participant, primary contact, and /or permitted caregiver supports notifying of the waiver enrollment,
- Notifies the designated CLTC Support Staff for RSP indicator entry. The RSP entry must be completed within four (4) calendar days of the waiver enrollment date.

For all applicants pursuing the Nursing Home Transition service, refer to the Chapter 7 Nursing Home Transition addendum for details and complete instructions.

02.29.10 Transfer of Pending Waiver Applicant to Another CLTC Region

When a pending waiver applicant, who has been assessed by a **Nurse Consultant**, moves to another CLTC region, the transfer conference may be accomplished by telephone between the transferring region **Nurse Consultant** and the receiving region **Case Manager II**. **This policy applies to an eligible applicant (level of care, locus of care, Medicaid financially eligible, wants to participate and waiver slot available.)**

Note: If dis-enrollment from a non-compatible waiver or managed

care plan is necessary, this must be completed online by the transferring **Nurse Consultant** prior to the transfer**.**

The **Nurse Consultant** will initiate the Phoenix transfer process and will remain assigned to the applicant in pending waiver status, until the transfer telephone conference is completed with the receiving CLTC Area Office.

The **Nurse Consultant** will send a CLTC Notification Form to the applicant/primary contact and involved agencies confirming the transfer.

The **designated Support Staff** makes the appropriate copies as directed, routes to the designated persons/agencies, and files in the individual‘s correspondence file.