Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
FAX (501) 682-1197

TO: **Arkansas Medicaid Health Care Provider - Children's Services Respite Care**

DATE:

SUBJECT: **PROPOSED - Provider Manual Update Transmittal No. 5**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
200.000 - 262.400	10-13-03	200.000 - 262.400	11-01-04
DMS-661	11/02	DMS-661	11/04
DMS-666	11/02	DMS-666	11/04
DMS-667	11/02	DMS-667	11/04
DMS-669	11/02	DMS-669	11/04
DMS-851	11/02	DMS-851	11/04
DMS-852	11/02	DMS-852	11/04

Explanation of Updates

The Respite Care provider manual and necessary forms are being updated to reflect the name change from Children's Medical Services (CMS) to Children's Services

Section 214.000 is being updated to make a clarification in the Children's Services Respite Care Eligibility Criteria.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

_____
Roy Jeffus, Director

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: **www.medicaid.state.ar.us**.

"The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act."

SECTION II CHILDREN'S SERVICES RESPITE CARE

CONTENTS

200.000 CHILDREN'S SEVICES RESPITE CARE GENERAL INFORMATION
201.000 Arkansas Medicaid Participation Requirements for Children's Services Respite Care Providers
201.100 Children's Services Certification Responsibilities
201.110 Additional Certification Requirements of the Individual Children's Services Respite Caregiver
202.000 Providers of Children's Services Respite Care Services in Arkansas and Bordering States
203.000 Providers in Non-Bordering States
204.000 Records Requirement
204.100 Retention of Records

210.000 PROGRAM COVERAGE
210.100 Introduction
211.000 Scope
212.000 Exclusions
213.000 Benefit Limits
213.100 Extension of Children's Services Respite Care Benefits
214.000 Children's Services Respite Care Eligibility Criteria
214.100 Application for Children's Services Respite Care Services
214.200 Medicaid Aid Category
214.300 Age Eligibility Determination
214.400 Level of Care Determination
214.410 Children's Services Eligibility Committee
214.500 Children's Services Respite Plan of Care
214.600 Client's Notification of Freedom of Choice and Fair Hearing
214.700 Service Agreement and Certification/Delegation of Children's Services Respite Caregiver
214.800 Approval of Children's Services Respite Care Services
215.000 Reporting Changes
216.000 Description of Children's Services Respite Care
216.100 Allowed Units of Service
217.000 Quality Assurance
218.000 Appeal Process for Medicaid Recipients

240.000 PRIOR AUTHORIZATION

250.000 REIMBURSEMENT
251.000 Method of Reimbursement
252.000 Rate Appeal Process

260.000 BILLING PROCEDURES
261.000 Introduction to Billing
262.000 CMS-1500 (formerly HCFA-1500) Billing Procedures
262.100 Children's Services Respite Care Procedure Code
262.200 Place of Service and Type of Service Codes
262.300 Billing Instructions - Paper Only
262.310 Completion of CMS-1500 (formerly HCFA-1500) Claim Form
262.400 Special Billing Procedures

200.000 CHILDREN'S SEVICES RESPITE CARE GENERAL INFORMATION

11-1-04

201.000 Arkansas Medicaid Participation Requirements for Children's Services Respite Care Providers 11-1-04

Individual Children's Services respite caregivers, Division of Developmental Disabilities Services (DDS) licensed community-based providers and child care facilities that meet the participation requirements may be enrolled as Children's Services respite care providers.

The provider enrollment requirements listed below must be met to participate in the Arkansas Medicaid Program as a Children's Services respite care provider:

A. Individual Children's Services respite caregivers must meet the following requirements:

1. Complete a provider application (Form DMS-652), a Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (Form DMS-652), Medicaid contract (Form DMS-653) and Request for Taxpayer Identification Number and Certification (W-9)**.
2. Be certified by Children's Services of the Arkansas Department of Human Services, Division of Developmental Disabilities Services. (See Sections 201.100 and 201.110.)
3. The provider application (DMS-652) and the Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

B. DDS licensed community-based providers must meet the following requirements:

1. Complete a provider application (Form DMS-652), a Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (Form DMS-652), Medicaid contract (Form DMS-653) and Request for Taxpayer Identification Number and Certification (W-9)**.
2. Be licensed by the Division of Developmental Disabilities Services (DDS) of the Arkansas Department of Human Services. A copy of the current license must be submitted to Children's Services. Subsequent license renewals must be submitted to Children's Services when issued.
3. Be certified by Children's Services of the Arkansas Department of Human Services, Division of Developmental Disabilities Services. (See Section 201.100.)
4. The provider application (DMS-652) and the Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

C. Child care facilities must meet the following requirements:

1. Complete a provider application (Form DMS-652), a Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (Form DMS-652), Medicaid contract (Form DMS-653) and Request for Taxpayer Identification Number and Certification (W-9)**.
2. Be licensed by the Division of Child Care and Early Childhood Education (DCCECE) of the Arkansas Department of Human Services. A copy of the current license must be submitted to Children's Services. Subsequent license renewals must be submitted to Children's Services when issued.
3. Be certified by Children's Services of the Arkansas Department of Human Services, Division of Developmental Disabilities Services. (See Section 201.100.)
4. The provider application (DMS-652) and the Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

201.100 Children's Services Certification Responsibilities 11-1-04

Children's Services, Division of Developmental Disabilities Services (DDS) is responsible for certifying **all** providers of Children's Services respite care services.

The Service Agreement and Certification/Delegation of Children's Services Respite Caregiver (DMS-852) certifies that the provider has met the requirements and qualifications to be a Children's Services respite care provider. **View or print form DMS-852.** Form DMS-852 must be signed by the Children's Services respite care provider, parent or legal guardian, and a registered nurse (unless the Children's Services respite care provider is a registered nurse). Children's Services will review the DMS-852 and, if the certification criteria are met, will certify the provider by signing the DMS-852. Children's Services will retain a copy of the signed certification statement on all certified Children's Services respite care providers. The original, signed certification will be sent to the provider. (See Section 214.700.)

Children's Services is responsible for furnishing the Division of Medical Services (DMS) Provider Enrollment Unit with written notification of the certification status of Children's Services respite care providers. Children's Services certifications must be renewed by the providers annually.

201.110 Additional Certification Requirements of the Individual Children's Services Respite Caregiver 11-1-04

In addition to the certification requirement in Section 201.100, the individual Children's Services respite caregiver must also meet the following criteria:

A. Must be age 18 years or older.

B. Must be a U.S. citizen or legal alien authorized to work in the U.S.

C. Must be free from evidence of:

1. Abuse or fraud in any setting;
2. Violations in the care of a dependent population;
3. Conviction of a crime related to a dependent population and
4. Conviction of a violent crime. (A criminal background check will be required and paid for by the Arkansas Medicaid Program.)

D. Must be able to read and write at a level sufficient to follow written instructions and maintain records.

E. Must be able to perform the essential job functions required (which will vary depending on the type and severity of the client's condition, but basically the Children's Services respite caregiver is to assist the client in the activities of daily living).

F. Must have a valid driver's license and a good driving record if transportation is to be provided for the client during Children's Services respite care services.

G. Must be a registered nurse (RN) or a health care paraprofessional as defined under the scope of the Arkansas State Board of Nursing School Nurse Roles and Responsibilities Practice Guidelines.

To meet the criterion for a health care paraprofessional, the DMS-852 must be signed and dated by an RN (unless no nursing duties are involved in taking care of the child. The RN's signature certifies that the Children's Services respite caregiver meets the health care paraprofessional requirement specified in the School Nurse Roles and Responsibilities Practice Guidelines, is properly trained to perform the duties that are necessary to take care of the client and these duties (listed on the DMS-852) are appropriate to be delegated to the individual Children's Services respite caregiver.

H. A spouse, parent or legal guardian of the client who receives Children's Services respite care services cannot be the Children's Services respite caregiver.

I. A relative (excluding a spouse, parent or legal guardian) of the client may be the Children's Services respite caregiver if:

1. The relative does not reside in the same home as the client;
2. The relative meets the above certification and participation requirements and
3. The family provides adequate justification as to why the relative is the provider of care (e.g., lack of other qualified providers in the area of residency).

202.000 Providers of Children's Services Respite Care Services in Arkansas and Bordering States 11-1-04

Children's Services respite care providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet all Arkansas Medicaid participation requirements as outlined in Section 201.000.

A. Routine services providers may furnish and claim reimbursement for Children's Services respite care services subject to the benefit limitations and coverage restrictions set forth in this manual.

B. Claims must be filed according to this manual.

203.000 Providers in Non-Bordering States 11-1-04

Providers in non-bordering states are not eligible to participate in the Children's Services Respite Care Program.

204.000 Records Requirement 11-1-04

Children's Services respite care providers must develop and maintain sufficient written records to corroborate that the services provided are of the type, frequency, duration and scope outlined in the Children's Services respite plan of care and confirm that the services were actually furnished.

Children's Services respite care providers must maintain records of the following:

A. The Service Agreement and Certification/Delegation of Children's Services Respite Caregiver (DMS-852) signed and dated by an RN (unless no nursing duties are involved), Children's Services respite caregiver, parent or legal guardian and Children's Services representative;

B. A copy of the client's approved Children's Services respite plan of care and

C. A copy of the completed billing forms (CMS-1500, formerly HCFA-1500) documenting the following information:

1. The date, actual time and duration for which the service(s) were provided;
2. The signature of the individual providing the service(s) and
3. The signature of the parent or legal guardian receiving the service(s).

204.100 Retention of Records 11-1-04

Children's Services respite care providers must maintain all records for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer. The records must be made available to authorized representatives of the Arkansas Department of Human Services, Division of Medical Services,

Children's Services, the state Medicaid Fraud Unit, and representatives of the Department of Health and Human Services and its authorized agents or officials. Failure to furnish records upon request will result in sanctions being imposed.

All documentation must be made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business during normal business hours. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

210.000 PROGRAM COVERAGE 10-13-03

210.100 Introduction 11-1-04

The Children's Services Respite Care Program is administered by Children's Services of the Arkansas Department of Human Services, Division of Developmental Disabilities Services. The Children's Services Respite Care Program operates under the authority of a home and community-based waiver authorized under Section 1915(c) of the Social Security Act.

211.000 Scope 11-1-04

The Arkansas Medicaid Program offers certain home and community-based services to recipients to decrease the likelihood of institutionalization. The purpose of the Children's Services Respite Care Program is to provide temporary physical and emotional relief to families who are caring for clients with disabilities. This relief promotes continued care in the home, thereby reducing the likelihood of institutionalization of the client.

Children's Services respite care services are available only to Medicaid-eligible Children's Services clients who meet the Children's Services respite care eligibility criteria (see Sections 214.000 through 214.700).

Children's Services is responsible for determining the client's eligibility for Children's Services respite care services. No primary care physician (PCP) referral is necessary to receive Children's Services respite care services.

212.000 Exclusions 11-1-04

The following individuals or services are not covered under the Children's Services Respite Care Program:

A. Inpatients of nursing facilities, hospitals or other inpatient institutions in accordance with 42 CFR 441.301(b)(1)(ii).

B. Foster care children.

C. Clients with solely a mental health diagnosis.

D. Room and board expenses.

E. DDS Waiver clients.

213.000 Benefit Limits 11-1-04

The following benefit limits apply to Children's Services respite care services:

A. Children's Services respite care services are limited to $1000 per client per twelve (12) calendar months, beginning with the month of approval. This amount may be extended in

an emergency situation. See Section 213.100, Extension of Children's Services Respite Care Benefits, for information about exceeding this limit.

B. The cost of Children's Services respite care services cannot exceed the following amounts:

1. $10.00 per hour or $2.50 per unit (one unit is equivalent to 15 minutes).
2. $160.00 daily maximum limit for 24 consecutive hours.

213.100 Extension of Children's Services Respite Care Benefits 11-1-04

In an emergency situation and subject to the availability of funds, additional Children's Services respite care services may be provided to families who have met the $1000 per client per twelve (12) months limit. A parent or legal guardian may request an extension of Children's Services respite care benefits by contacting the Children's Services respite care coordinator.

If the client is determined to be eligible for the extended Children's Services respite care benefits, the amount granted will be determined on a case-by-case basis.

214.000 Children's Services Respite Care Eligibility Criteria 11-1-04

Children's Services respite care services are limited to Children's Services clients who meet the Children's Services respite care eligibility criteria. The Children's Services respite care eligibility criteria consist of the following process:

A. The parent or legal guardian must complete a Children's Services respite care application through Children's Services;

B. The Children's Services client must be Medicaid eligible in certain aid categories (see Section 214.200);

C. The Children's Services client must be under age 19;

D. The Children's Services client must meet the institutional level of care;

E. The Children's Services client must have an approved Children's Services respite plan of care;

F. Children's Services must advise the family of the freedom of choice between home and community-based services and institutional services and

G. There must be a completed and signed Service Agreement and Certification/Delegation of Children's Services Respite Caregiver (DMS-852).

NOTE: Eligibility for the Children's Services Respite Program depends not solely on whether the client meets the specific institutional level of care, but also on an assessment of the family's need for respite care as expressed in the respite application.

The eligibility evaluation criteria for Children's Services respite care services are discussed in detail in Sections 214.100 through 214.700.

214.100 Application for Children's Services Respite Care Services 11-1-04

The parent or legal guardian must complete the application packet for Children's Services respite care services. The application packet will include:

A. Application Form for Families (DMS-851). **View or print form DMS-851.**

B. Level of Functioning Survey for the Mentally Retarded/Developmentally Disabled (DMS-666). This form is completed by a Children's Services nurse or social worker in cooperation with the parent(s). **View or print form DMS-666.**

C. Level of Functioning Survey for the Physically Disabled (DMS-667). This form is completed by a Children's Services nurse or social worker in cooperation with the parent(s). **View or print form DMS-667.**

D. Family Friends Children's Services Respite Care Waiver Plan of Care (DMS-661). **View or print form DMS-661.**

E. Freedom of Choice and Fair Hearing (DMS-669). **View or print form DMS-669.**

F. Service Agreement and Certification/Delegation of Children's Services Respite Caregiver (DMS-852). **View or print form DMS-852.**

The family may request the Children's Services respite care application by telephone or by writing to the Arkansas Department of Human Services Children's Services Family Friends Children's Services Respite Care. **View or print Family Friends Children's Services Respite Care contact information.**

A Children's Services respite care coordinator is available by telephone as a resource for families and Children's Services respite care providers to resolve any questions or problems they may encounter during the application process and after approval of Children's Services respite care services.

214.200 Medicaid Aid Category 11-1-04

Children's Services clients must be Medicaid eligible in one of the following aid categories:

A. Supplemental Security Income (SSI) or

B. Tax Equity and Fiscal Responsibility Act (TEFRA).

Current Medicaid and categorical eligibility must be verified as part of the eligibility evaluation process. SSI eligibility is determined by the Social Security Administration. TEFRA eligibility is determined by the Department of Human Services, Division of County Operations.

214.300 Age Eligibility Determination 11-1-04

Children's Services respite care services are available to Medicaid-eligible Children's Services clients from birth to age 19.

NOTE: After age 16, SSI and TEFRA clients who have a diagnosis of mental retardation and/or developmental delay will require an additional Children's Services-eligible diagnosis to remain eligible for Children's Services and Children's Services respite care services.

214.400 Level of Care Determination 11-1-04

The client must meet **one** (1) of the levels of care listed below:

A. Physically disabled requiring a nursing facility (NF) level of care or

B. Mentally retarded and/or developmentally disabled requiring an intermediate care facility for mentally retarded (ICF/MR) or persons with related conditions level of care. Mentally retarded and/or developmentally disabled also include:

1. Autism,
2. Epilepsy,
3. Cerebral palsy or
4. Any other condition of a person found to be closely related to mental retardation because it results in an impairment of general intellectual functioning or adaptive

behavior similar to those of mentally retarded persons; or requires treatment and services to those similarly required for such persons; or is attributable to dyslexia resulting from a disability described above.

NOTE: After age 16, a diagnosis of mental retardation and/or developmental delay requires an additional Children's Services-eligible diagnosis in order to remain eligible for Children's Services and Children's Services respite care services.

214.410 Children's Services Eligibility Committee 11-1-04

The level of care determination is performed by the Children's Services Eligibility Committee. This committee consists of three (3) members:

A. Physician (M.D. or D.O.), licensed by the State of Arkansas;

B. Registered Nurse, licensed by the State of Arkansas and/or

C. Social Worker, licensed by the State of Arkansas with at least two years of experience as a social worker.

The Children's Services Eligibility Committee is responsible for the following:

1. Evaluating the client's need for a NF or ICF/MR level of care using the Level of Functioning Survey form (DMS-666 or DMS-667, depending on the specific medical condition of the client). **View or print form DMS-666.** **View or print form DMS-667.**
2. Notifying the parent(s) or legal guardian, in writing, if the client is determined to be eligible (or ineligible) for the appropriate level of care.
3. Approving or denying the Children's Services respite plan of care.
4. Re-evaluating the institutional level of care and Children's Services respite plan of care annually.

214.500 Children's Services Respite Plan of Care 11-1-04

Each eligible client must have an approved individualized Children's Services respite plan of care before Children's Services respite care services are approved. Children's Services will send the family a Children's Services Respite Care Waiver Plan of Care (DMS-661) for completion. **View or print form DMS-661.**

The Children's Services respite plan of care is the fundamental tool used to ensure that the services to be furnished are appropriate to and adequate for the nature and severity of the individual's disability. The parent(s) or legal guardian(s) of the client will complete, sign and submit the Children's Services respite plan of care form to Children's Services for approval.

The parent or legal guardian may contact the Children's Services respite care coordinator for assistance in completing the Children's Services respite plan of care.

The Children's Services respite plan of care must include the following information:

A. Why Children's Services respite care services are needed;

B. How and when the Children's Services respite care services will be used;

C. The frequency and duration of the Children's Services respite care services;

D. The rate of pay to the Children's Services respite care provider(s);

E. The name(s) and address(es) of the Children's Services respite care provider(s) and

F. The signature(s) of the parent(s) or legal guardian, including the date signed.

Children's Services must approve, recommend changes or deny the plan of care. If the plan is denied, the Children's Services respite care coordinator will work with the family to design an acceptable plan of care and to make revisions during the year, if necessary. Families may appeal any denied plan of care. See Section 218.000 for the appeal process for Medicaid recipients.

Children's Services will furnish a copy of the approved Children's Services respite plan of care to the parent or legal guardian and to each Children's Services respite care provider. Children's Services will retain the original plan of care. Children's Services will review the Children's Services respite plan of care annually.

214.600 Client's Notification of Freedom of Choice and Fair Hearing 11-1-04

The parent(s) or legal guardian will be given freedom of choice to receive services in an institution or in a home and community-based setting.

Children's Services will mail the Freedom of Choice and Fair Hearing form (DMS-669) to the parent or legal guardian. **View or print form DMS-669.** The parent, legal guardian or Children's Services client (if 18 years old) must indicate, in writing, the choice selected by completing and signing the form. Children's Services respite care services cannot be authorized until Children's Services receives the completed form.

In addition, the Freedom of Choice and Fair Hearing form advises the parent or legal guardian of their right to a fair hearing if they are denied their choice of services or providers. Also, the instructions for filing a request for a fair hearing are provided.

Children's Services will retain the completed form for documentation of freedom of choice and fair hearing opportunity.

214.700 Service Agreement and Certification/Delegation of Children's Services Respite Caregiver 11-1-04

The Service Agreement and Certification/Delegation of Children's Services Respite Caregiver form DMS-852 initially must be completed by the parent or legal guardian and approved by an RN (unless no nursing duties are involved in taking care of the child). **View or print form DMS-852.** The parent or legal guardian will list on the DMS-852 the duties and/or tasks to be performed by the Children's Services respite caregiver while caring for the client. Only those duties listed on the DMS-852 will be performed by the Children's Services respite caregiver.

In accordance with the Arkansas State Board of Nursing School Nurse Roles and Responsibilities Practice Guidelines, a registered nurse (RN) may delegate certain tasks to the Children's Services respite caregiver by approving and signing the DMS-852. The RN must assess and train, if necessary, the Children's Services respite caregiver in performing the duties that may be delegated. If the RN determines that the Children's Services respite caregiver is capable of performing the duties, he or she must complete and sign DMS-852 certifying that the duties are appropriate to delegate to the Children's Services respite caregiver and the Children's Services respite caregiver is qualified to perform the duties.

In order for the Children's Services respite care provider to meet the certification requirement (see Sections 201.100 and 201.110), the DMS-852 must be signed and dated by the individuals listed below:

A. The Children's Services respite care provider (also referred to as Children's Services respite caregiver) certifying that:

   1. He or she is qualified and properly trained to perform the duties listed on DMS-852; and

   2. He or she meets all certification requirements as specified in Sections 201.100 and 201.110.

B. The parent or legal guardian certifying that:

1. He or she agrees that the Children's Services respite caregiver is qualified and properly trained to perform the duties listed on DMS-852 and
2. He or she accepts full responsibility for placing the client in the care of said Children's Services respite caregiver.

C. An RN certifying that:

1. The Children's Services respite caregiver is qualified and properly trained to perform the duties listed for the client and
2. Delegation of the duties to the Children's Services respite caregiver is appropriate for this client.

NOTE: If the Children's Services respite caregiver is an RN, the signature of a registered nurse is not required on DMS-852. If the Children's Services respite caregiver is a licensed DDS or child care facility, the RN's signature is also not required.

D. The Children's Services respite care coordinator certifying that the Children's Services respite caregiver meets the Children's Services respite care requirements.

Children's Services will mail the DMS-852 to each family. The parent or legal guardian is responsible for returning the completed form to Children's Services with all required signatures. The signed DMS-852 must be on file with Children's Services before services may begin. Children's Services will retain a copy of the signed DMS-852 and mail the original form to the Children's Services respite caregiver.

A DMS-852 must be completed and signed annually. If the family changes providers or obtains additional providers, an additional DMS-852 must be completed for each new Children's Services respite care provider, signed by the required individuals and forwarded to Children's Services before payment can begin to the new providers.

Also, if changes in the client's condition result in additional or different duties and/or tasks, the family must obtain a new DMS-852, signed by all required individuals, to ensure that delegation of the new duties is appropriate and the Children's Services respite caregiver is trained and qualified to perform the duties.

The Children's Services respite caregiver must retain a copy of the DMS-852 for his or her records. (See Section 204.000 for records requirements.)

214.800 Approval of Children's Services Respite Care Services 11-1-04

After the client's Children's Services respite care services application is approved, Children's Services will furnish billing forms (CMS-1500, formerly HCFA-1500) to the family for completion by the Children's Services respite caregiver as services are provided.

215.000 Reporting Changes 10-13-03

It is the parent or legal guardian's responsibility to notify the Children's Services respite care provider at least twenty-four hours prior to an appointment for Children's Services respite care services if the appointment must be cancelled.

If the client is expected to be out of the home for 30 days or longer, the parent or legal guardian must notify Children's Services.

216.000 Description of Children's Services Respite Care 11-1-04

Children's Services respite care services allow temporary physical and emotional relief to a family that is caring for a client with disabilities.

DMS-852 will list specific duties the Children's Services respite caregiver must provide while the client is in his or her care. The duty areas are communication, feeding, mobility assistance, toileting, dressing, administering certain medications and other duties that will be defined by the parent or legal guardian and RN, depending on the client's needs.

It is the parent or legal guardian's responsibility to provide clear and precise written instructions to the Children's Services respite caregiver regarding the client's needs. It is the Children's Services respite caregiver's responsibility to ensure that all instructions are performed as stated.

216.100 Allowed Units of Service 11-1-04

One (1) unit of Children's Services respite care service equals 15 minutes; e.g., if the duration of the service is one hour and 30 minutes, Medicaid will cover 6 units.

Services of less than one hour's duration per date of service are not covered; e.g., 50 minutes of service on a given date are not covered.

Services of less than fifteen minutes in duration are not covered; e.g., if the service lasts one hour and 20 minutes, Medicaid will cover only one hour and 15 minutes (5 units).

Odd minutes may not be saved to add to minutes from a previous date of service.

(See Section 213.000 for benefit limits and Section 262.100 for the procedure code.)

217.000 Quality Assurance 11-1-04

To ensure that the Children's Services Respite Care Program requirements are being met, the Medicaid agency will perform annual reviews of a random sampling of client records. Also, an annual client satisfaction and program evaluation survey of the total Children's Services respite care client population will be conducted to determine whether quality standards are met. Appropriate action(s) (e.g., recommendation for training, disqualification of provider, etc.) will be taken if an investigation of negative allegations reveals that quality standards are not met.

218.000 Appeal Process for Medicaid Recipients 11-1-04

When an adverse decision (e.g., application denied, case closed, choice of providers denied, plan of care denied, etc.) is received from Children's Services, the Medicaid recipient may request a fair hearing from the Department of Human Services for reconsideration of the denied services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Arkansas Department of Human Services within thirty (30) days of the date of the denial or adverse action notice. **View or print the Arkansas Department of Human Services Appeals and Hearings Section contact information.**

240.000 PRIOR AUTHORIZATION 11-1-04

Children's Services respite care services do not require prior authorization but must be provided in accordance with the approved Children's Services respite plan of care. If emergency respite care is approved, this will require a prior authorization by Children's Services.

250.000 REIMBURSEMENT 11-1-04

251.000 Method of Reimbursement 11-1-04

Reimbursement in the Children's Services Respite Care Program is by fee schedule. Payment is the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable amount for each service.

252.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate.

Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity of a conference, for a full explanation of the factors involved and the Program decision.

Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the provider disagrees with the decision made by the Assistant Director, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The Rate Review Panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director.

260.000 BILLING PROCEDURES 11-1-04

261.000 Introduction to Billing 11-1-04

Children's Services respite care providers use the CMS-1500 (formerly HCFA-1500) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim may contain charges for only one recipient.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claims submission.

262.000 CMS-1500 (formerly HCFA-1500) Billing Procedures 11-1-04

262.100 Children's Services Respite Care Procedure Code 11-1-04

Use the following procedure code for Children's Services respite care services:

National Code	Description
T1005	Children's Services Respite Care Services 1 unit = 15 minutes minimum of 4 units per day maximum of 64 units per day

262.200 Place of Service and Type of Service Codes 10-13-03

Place of Service	Paper Claims	Electronic Claims
Patient's Home	4	12
Day Care Facility	5	52
Day Treatment Centers	I	99
Respite Care Facility	J	99

Type of Service (paper only)
9 - Other Medical Service

262.300 Billing Instructions - Paper Only 11-1-04

The Children's Services respite care provider must complete the CMS-1500 (formerly HCFA-1500) claim form for each recipient of Children's Services respite care services. The provider's signature is required in field 31 of the form. **View a CMS-1500 sample form.**

It is the provider's responsibility to obtain the parent's or legal guardian's signature on the claim form. The parent or legal guardian must sign in field 13 to certify that the information reported on the form (e.g., dates of service, units of service) is correct.

The provider **must** retain a copy of the completed form (with both signatures) for his or her records. (See Section 204.000 of this manual for documentation requirements.)

To complete the billing process, the parent or provider must send the completed CMS-1500 claim form to the Children's Services respite care coordinator at the Arkansas Department of Human Services Children's Services. **View or print Children's Services contact information.**

The Children's Services respite care coordinator will review the CMS-1500 claim form to check for:

A. Signatures of both the person legally responsible for the child and the provider;

B. Compliance with the respite plan of care;

C. Medicaid eligibility of the child during the dates of service and

D. Accuracy.

All discrepancies must be resolved prior to authorizing Medicaid payment.

The Children's Services respite care coordinator's staff will bill Medicaid on behalf of the provider. Payment will be sent directly to the provider who rendered the services.

262.310 Completion of CMS-1500 (formerly HCFA-1500) Claim Form 11-1-04

Field Name and Number	Instructions for Completion
1. Type of Coverage	This field is not required for Medicaid.
1a. Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2. Patient's Name	Enter the patient's <u>last</u> name and <u>first</u> name.
3. Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.

	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
	b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
	c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.

d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12. Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13. Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14. Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15. If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16. Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17. Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is not required for Children's Services Respite Care. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18. Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19. Reserved for Local Use	Not applicable to Children's Services Respite Care.
20. Outside Lab?	This field is not required for Medicaid.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 262.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 262.200 for codes.

	D. Procedures, Services or Supplies	
	CPT/HCPCS	Enter the correct CPT or HCPCS procedure code.
	Modifier	Not applicable to Children's Services Respite Care claims.
	E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only one diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
	F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
	G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
	H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
	I. EMG	Emergency - This field is not required for Medicaid.
	J. COB	Coordination of Benefit - This field is not required for Medicaid.
	K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)

29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the recipient, unless the recipient has an insurer that requires co-pay. In such a case, enter the sum of the insurer's payment and the recipient's co-pay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

262.400 Special Billing Procedures 10-13-03

Not applicable to this program.

CHILDREN'S SERVICES RESPITE CARE WAIVER

LEVEL OF FUNCTIONING SURVEY
FOR THE PHYSICALLY DISABLED

SUMMARY SHEET

Client's Name: _____
Medicaid # _____

NOTE: *The individual must meet the indicated dependency level in 2 or more of the following categories (except he or she may meet only one of the categories if it is the Health Status category) to justify need for services in a Medicaid-certified Nursing Facility for individuals with disabilities or to meet level of care eligibility requirement for the Physically Disabled Respite Waiver.*

Date:		Date:		Date:		
MET	NOT MET	MET	NOT MET	MET	NOT MET	See qualifying option in each category below:
						Category 1: Health Status 2 or more questions answered with a 4
						Category 2: Communication Three or more questions answered with a 3 or 4
						Category 3: Task Learning Skills Three or more questions answered with a 3 or 4
						Category 4: Personal/Self Care Question "a" answered with a 4 or 5 Or Question "b" answered with a 4 or 5 Or Questions "c" and "d" answered with a 4 or 5
						Category 5: Mobility Any one question answered with a 4 or 5
						Category 6: Behavior: Any question answered with a 3 or 4
						Category 7: Community Living Skills Any two of questions "b", "e", or "g" answered With a 4 or 5; Or Three or more questions answered with a 4 or 5
						Category 8: Current Support Situation Any two questions answered With a 4

Date:_____ Evaluators Signature:_____
Title/Affiliation:_____

Children's Services Respite Care Waiver

Level of Functioning Survey
For the Physically Disabled

Instructions for Completing

For determining level of care eligibility for Physically Disabled Respite Waiver services, consider the individual's functioning in community environments. Complete the attached survey presuming the needed services and supports are not in place for the individual. Please note that, for items in the Health Status section, needed care or supervision may be provided by caregivers other than a licensed nurse.

DEFINITIONS:

"No Assistance" means no help is needed.

"Prompting/Structuring" means prior to the functioning, some verbal direction and/or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the functioning and provide only verbal direction, gestural prompts, and/or guidance.

"Some Direct Assistance" means that a helper must be present and provide some physical guidance/support (with or without verbal direction).

"Total Care" means that a helper must perform all or nearly all of the functions.

"Rarely" means that the behavior occurs quarterly or less.

"Sometimes" means that a behavior occurs once a month or less.

"Often" means that a behavior occurs 2-3 times a month.

"Regularly" means that a behavior occurs weekly or more.

Client's Name:_____ Medicaid No._____

LEVEL OF FUNCTIONING SURVEY

1. HEALTH STATUS
   How often is nursing care or nursing supervision by a licensed nurse required for the following?

   Please put appropriate number in the box under year of assessment.
   (Key: 1= Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

	Date:	Date:	Date:
a.) Medication administration and/or evaluation for effectiveness of a medication regimen			
b.) Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)			
c.) Seizure Control			
d.) Teaching diagnosed disease control and care, including diabetes			
e.) Management of care of diagnosed circulatory or respiratory problems			
f.) Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc.			
g.) Observation for choking/aspiration while eating, drinking			
h.) Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.			
i.) Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)			
j.) Oxygen dependency, tracheostomy care, and/or ventilator-dependent			

Client's Name:_____ Medicaid No._____

2. COMMUNICATION
How often does this person:

Please put appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Indicate wants by pointing, vocal noises, or signs?			
b.) Use simple words, phrases, short sentences?			
c.) Ask for at least 10 things using appropriate names?			
d.) Understand simple words, phrases or instructions containing prepositions: i.e., "on", "in", "behind" ?			
e.) Speak in an easily understood manner?			
f.) Identify self, place or residence, and significant others?			

3. TASK LEARNING SKILLS
How often does this person perform the following activities?

Please put the appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Pay attention to purposeful activities for 5 minutes?			
b.) Stay with a 3-step task for more than 15 minutes?			
c.) Tell time to the hour and understand time intervals?			
d.) Count more than 10 objects?			
e.) Do simple addition, subtraction?			
f.) Write or print 10 words?			
g.) Discriminate shapes, sizes or colors?			
h.) Name people or objects when describing pictures?			
i.) Discriminate between "one", "many", "lot"?			

Client's Name:_____ Medicaid No._____

4. PERSONAL/SELF-CARE
   With what type of assistance can this person currently:

   Please put appropriate number in the box under year of assessment
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.?			
b.) Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc.?			
c.) Perform bathing function: i.e., bathe, run bath, dry self, etc.?			
d.) Dress self completely, i.e., including fastening and putting on clothes?			

5. MOBILITY
   With what type of assistance can this person currently:

   Please put appropriate number in the box under the year of assessment.
   Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Move (walking, wheeling) around environment?			
b.) Rise from lying down to sitting positions, sit without support?			
c.) Turn and position in bed, roll over?			

Client's Name:_____ Medicaid No._____

6. BEHAVIOR
   How often does this person:
   Please put appropriate number in the box under the year of assessment.
   (Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

	Date:	Date:	Date:
a.) Engage in self-destructive behavior?			
b.) Threaten or do physical violence to others?			
c.) Throw things or damage property, have temper outbursts?			
d.) Respond to others in a socially unacceptable manner (without undue anger, frustration or hostility)?			

7. COMMUNITY LIVING SKILLS
   With what type of assistance would this person currently be able to:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Prepare simple foods requiring no mixing or cooking?			
b.) Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?			
c.) Add coins of various denominations up to one dollar?			
d.) Use telephone to call home, doctor, fire, police?			
e.) Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.?			
f.) Refrain from exhibiting unacceptable sexual behavior in public?			
g.) Go around cottage, ward, building, without running away, wandering off, or becoming lost?			
h.) Make minor purchases, i.e., candy, soft drinks, etc.?			

Client's Name:_____ Medicaid No._____

8. CURRENT SUPPORT SITUATION

Please put appropriate number in the box under the year of assessment
(Key: 1=Over 12 hours daily, 2=4-8 hours daily (5 days or more a week), 3=Less than 20 hours a week, 4=None

	Date	Date	Date
a.) How many hours per day is the child out of home during a week – e.g. At school, in a day treatment center?			
b.) How many hours per day of in-home care from a personal care aide or nurse does the child receive during a week?			

Please put appropriate number in the box under the year of assessment
(Key: 2=More than two caregivers, 3=Two caregivers, 4=One caregiver)

	Date	Date	Date
c.) How many caregivers are available in the household to take care of the child – e.g., mother, father, grandparent, nurse, etc.?			

Please put appropriate number in the box under the year of assessment
(Key: 2=Less than one year, 3=Over one year, 4=From birth)

	Date	Date	Date
d.) How long has the child had this physically handicapping condition or chronic illness?			

Addendum to LOF Survey

Client Name: _____ SSN: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____Birthdate: _____ Sex: _____

Primary Caregiver: _____

Address: _____

Relationship: _____Phone: _____

Presenting Problem/Diagnosis: _____

Medications: _____

_____

Is the Individual Oriented to:

Person: ____ Place: ____ Time: ____

Describe any problems with caregiving:

Assessment completed by:

Assessor's Name	Signature	Provider Name	Provider Number

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
FAMILY FRIENDS CHILDREN'S SERVICES RESPITE CARE WAIVER
FREEDOM OF CHOICE AND FAIR HEARING

_____ _____
Name of Child Medicaid Number

Your family has been approved for $1,000.00 per year of respite care services under the Family Friends Respite Care Waiver from _____ until _____ pending approval of your plan of care and your acceptance of these community-based respite services below.

It has been determined that the child named above is eligible for services in an institution. If you wish for your child to be institutionalized, please indicate below that you want your child to receive services in an institution. If you wish your child to stay within your community and receive services there, please indicate below that you want your child to receive services in the community. Specifically, in order to qualify for respite services outside an institution, the parent or legal guardian of the child (or the child him/herself if 18 years of age or older) must certify below that he/she desires services "in a community setting." Please read the statement below and **answer the following question and sign with the signature of the parent or legal guardian (or by the child him/herself if 18 years of age or older)**.

"I understand I may choose (for my child) to be provided services in an institution or a community setting. If denied my choice, I understand I am entitled to a fair hearing under 42 CFR Part 431, Subpart E. See reverse side for instructions on how to request a fair hearing.

I CHOOSE (FOR MY CHILD) TO RECEIVE SERVICES: IN AN INSTITUTION_____ IN A COMMUNITY SETTING_____.

Additionally, I understand I am entitled to a fair hearing if I am denied my choice of services or I am denied my choice of providers."

_____
Signature of Parent or Legal Guardian Date

_____
Signature of Child if 18 years of age or older Date
(If unable to sign, make an "X" with two witnesses' signatures)

HOW TO FILE FOR A FAIR HEARING

If you are not satisfied with the decision on your case, you may request a Hearing by writing the Appeals and Hearings Section, P.O. Box 1437, Little Rock, AR 72203-1437. Any request for a Hearing must be received within thirty (30) days from the date on the notice of the decision.

YOUR RIGHT TO REPRESENTATION

If you request a Hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. If you wish to have a lawyer, you may ask the local County Human Services Office to help you arrange for one. If free legal services are available where you live, you may ask your County Office for their address and phone number.

FAMILY FRIENDS RESPITE CARE

APPLICATION FORM FOR FAMILIES

Name of child (last name, first name, middle name) Date of birth

Child's Medicaid number Child's Social Security number

Parents/guardians names Home phone Business phone

Mailing Street address City Zip code County

What is your child's disability?

What are his/her strengths and needs in the following areas:

Communication

Feeding

Mobility

Toileting

Dressing

Sleeping

Other

If your child is receiving any type of medication, please specify below:

Name of medication	How often given	Route given (mouth, tube, rectal, injection)

Do you have friends or relatives who take care of your child with special needs? _____

Please explain why you need respite care (what kind of stress is your family under). _____
_____
_____
_____
_____
_____
_____
_____
_____

Is your child in school or day treatment center program? _____

If so, how many hours per day? _____

Does your child receive personal care? (paid for by Medicaid or DDS) _____

If so, how many hours per month? _____

Does your child receive private duty nursing care? _____

If so, how many hours per week? _____

Does your child receive any respite care from another agency? _____

If so, how many hours per week? _____

What is the number in your immediate family household under 18? _____

Are there any other persons with disabilities in your household?_____
Who?_____

I certify that they above information is correct.

_____
Parent/Legal Guardian Signature **Date**

Please return respite application to the address below.

Children's Services
PO Box 1437, Slot S380
Little Rock, Arkansas 72203

CHILDREN'S SERVICES RESPITE CARE WAIVER

LEVEL OF FUNCTIONING SURVEY
FOR THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED

SUMMARY SHEET

Client's Name:_____
Medicaid #_____

NOTE: *The individual must meet the indicated dependency level in 2 or more of the following categories to justify need for services in a Medicaid-certified Intermediate Care Facility for individuals with Mental Retardation or to meet level of care eligibility requirement for the MR/DD Respite Waiver.*

Date:		Date:		Date:		
MET	NOT MET	MET	NOT MET	MET	NOT MET	See qualifying option in each category below:
						Category 1: Health Status 2 or more questions answered with a 4
						Category 2: Communication Three or more questions answered with a 3 or 4
						Category 3: Task Learning Skills Three or more questions answered with a 3 or 4
						Category 4: Personal/Self Care Question "a" answered with a 4 or 5 Or Question "b" answered with a 4 or 5 Or Questions "c" and "d" answered with a 4 or 5
						Category 5: Mobility Any one question answered with a 4 or 5
						Category 6: Behavior: Any question answered with a 3 or 4
						Category 7: Community Living Skills Any two of questions "b", "e", or "g" answered With a 4 or 5; Or Three or more questions answered with a 4 or 5

Date:_____ Evaluators Signature:_____
Title/Affiliation: _____

Date:_____ Evaluators Signature:_____
Title/Affiliation:_____

Children's Services Respite Care Waiver

Level of Functioning Survey
For the Mentally Retarded/Developmentally Disabled

Instructions for Completing

For determining level of care eligibility for MR/DD Respite Waiver services, consider the individual's functioning in community environments. Complete the attached survey presuming the needed services and supports are not in place for the individual. Please note that, for items in the Health Status section, needed care or supervision may be provided by caregivers other than a licensed nurse.

DEFINITIONS:

"No Assistance" means no help is needed.

"Prompting/Structuring" means prior to the functioning, some verbal direction and/or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the functioning and provide only verbal direction, gestural prompts, and/or guidance.

"Some Direct Assistance" means that a helper must be present and provide some physical guidance/support (with or without verbal direction).

"Total Care" means that a helper must perform all or nearly all of the functions.

"Rarely" means that the behavior occurs quarterly or less.

"Sometimes" means that a behavior occurs once a month or less.

"Often" means that a behavior occurs 2-3 times a month.

"Regularly" means that a behavior occurs weekly or more.

Client's Name:_____ Medicaid No._____

LEVEL OF FUNCTIONING SURVEY

1. HEALTH STATUS
   How often is nursing care or nursing supervision by a licensed nurse required for the following?

   Please put appropriate number in the box under year of assessment.
   (Key: 1= Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

	Date:	Date:	Date:
a.) Medication administration and/or evaluation for effectiveness of a medication regimen			
b.) Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)			
c.) Seizure Control			
d.) Teaching diagnosed disease control and care, including diabetes			
e.) Management of care of diagnosed circulatory or respiratory problems			
f.) Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc.			
g.) Observation for choking/aspiration while eating, drinking			
h.) Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.			
i.) Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)			

Client's Name:_____ Medicaid No._____

2. COMMUNICATION
   How often does this person:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Indicate wants by pointing, vocal noises, or signs?			
b.) Use simple words, phrases, short sentences?			
c.) Ask for at least 10 things using appropriate names?			
d.) Understand simple words, phrases or instructions containing prepositions: i.e., "on", "in", "behind" ?			
e.) Speak in an easily understood manner?			
f.) Identify self, place or residence, and significant others?			

3. TASK LEARNING SKILLS
   How often does this person perform the following activities?

   Please put the appropriate number in the box under the year of assessment.
   (Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Pay attention to purposeful activities for 5 minutes?			
b.) Stay with a 3-step task for more than 15 minutes?			
c.) Tell time to the hour and understand time intervals?			
d.) Count more than 10 objects?			
e.) Do simple addition, subtraction?			
f.) Write or print 10 words?			
g.) Discriminate shapes, sizes or colors?			
h.) Name people or objects when describing pictures?			
i.) Discriminate between "one", "many", "lot"?			

Client's Name:_____ Medicaid No._____

4. PERSONAL/SELF-CARE
   With what type of assistance can this person currently:

   Please put appropriate number in the box under year of assessment
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.?			
b.) Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc.?			
c.) Perform bathing function: i.e., bathe, run bath, dry self, etc.?			
d.) Dress self completely, i.e., including fastening and putting on clothes?			

5. MOBILITY
   With what type of assistance can this person currently:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Move (walking, wheeling) around environment?			
b.) Rise from lying down to sitting positions, sit without support?			
c.) Turn and position in bed, roll over?			

Client's Name:_____ Medicaid No._____

6. BEHAVIOR
   How often does this person:
   Please put appropriate number in the box under the year of assessment.
   (Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

	Date:	Date:	Date:
a.) Engage in self-destructive behavior?			
b.) Threaten or do physical violence to others?			
c.) Throw things or damage property, have temper outbursts?			
d.) Respond to others in a socially unacceptable manner (without undue anger, frustration or hostility)?			

7. COMMUNITY LIVING SKILLS
   With what type of assistance would this person currently be able to:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Prepare simple foods requiring no mixing or cooking?			
b.) Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?			
c.) Add coins of various denominations up to one dollar?			
d.) Use telephone to call home, doctor, fire, police?			
e.) Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.?			
f.) Refrain from exhibiting unacceptable sexual behavior in public?			
g.) Go around cottage, ward, building, without running away, wandering off, or becoming lost?			
h.) Make minor purchases, i.e., candy, soft drinks, etc.?			

Addendum to LOF Survey

Client Name: _____ SSN: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____Birthdate: _____ Sex: _____

Primary Caregiver: _____

Address: _____

Relationship: _____Phone: _____

Presenting Problem/Diagnosis: _____

Medications: _____

_____

Is the Individual Oriented to:

Person: ____ Place: ____ Time: ____

Describe any problems with caregiving:

Assessment completed by:

Assessor's Name	Signature	Provider Name	Provider Number

Arkansas Department of Human Services
Family Friends Respite Waiver Program

SERVICE AGREEMENT AND CERTIFICATION/DELEGATION OF CHILDREN'S SERVICES RESPITE CAREGIVER

Client's Name_____ Medicaid #_____

Client's Address_____

Children's Services Respite Caregiver's Name_____ Relationship to Client_____

(Items 1-8 are to be completed by the parent(s) or legal guardian.)

Please list duties of Children's Services Respite Caregiver in the following areas:

1. Communication

2. Feeding

3. Mobility

4. Toileting

5. Dressing

6. Sleeping

7. Medication

NAME OF MEDICATION	DOSAGE	HOW OFTEN GIVEN	ROUTE (GIVEN BY MOUTH OR GASTRIC TUBE, ETC)*

(*Note – Only a registered nurse may administer rectal or injectible medications)

8. Other

By signing below, the CHILDREN'S SERVICES RESPITE CAREGIVER certifies that he or she is in fact qualified and properly trained to perform the tasks listed on page 1 and meets all requirements as specified in Section 201.110 of the Medicaid Provider Manual for providing Children's Services Respite Care under the Children's Services Respite Care Waiver program. The respite caregiver also agrees to Children's Services conducting a criminal background check on him or her. Please circle if you are an R.N., L.P.N. or L.P.T.N. and give your license number _____.

_____

Signature of Children's Services Respite Caregiver Date

_____

By signing below, the PARENT or LEGAL GUARDIAN certifies that he or she agrees that the Children's Services respite caregiver is qualified and properly trained to perform the tasks listed on page 1 and accepts full responsibility for placing his or her child in the care of said Children's Services respite caregiver.

_____

Signature of Parent or Legal Guardian Date

By signing below, the REGISTERED NURSE licensed in the State of Arkansas certifies that he or she has assessed the client listed on page 1 and agrees that the Children's Services respite caregiver is qualified and properly trained to perform the tasks listed on page 1 for the client and that delegation of these tasks is appropriate for this client and this Children's Services respite caregiver. License #_____.

(Note This signature is NOT required if the Children's Services respite caregiver is a registered nurse).

_____

Signature of Registered Nurse Date

By signing below, the CHILDREN'S SERVICES RESPITE CARE COORDINATOR certifies that the Children's Services Respite Caregiver meets the Children's Services respite care requirements.

_____

Signature of Children's Services Respite Care Coordinator Date

Name of Client_____

Medicaid #_____

FAMILY FRIENDS CHILDREN'S SERVICES RESPITE CARE WAIVER PLAN OF CARE

Your family may be eligible for $1,000.00 worth of respite care services under the Children's Services Family Friends Respite Care Waiver from _____ until _____ pending approval of your respite application and plan of care and your acceptance of community-based respite services. Respite is the act of providing physical and emotional relief to families who are responsible for day-to-day care of children with disabilities. It is TEMPORARY respite care for families of children with disabilities and may not be used for day care while the parent goes to work.

Please indicate below your plan of care for using the total dollar amount of respite services listed above. If you have any questions regarding this form, please call toll-free the Children's Services Respite Coordinator at 1-800-482-5850, extension 22277.

How much will you pay per hour (or day for respite)? (Remember that the maximum hourly rate allowed is $10.00 per hour and the maximum daily [24 consecutive hours] rate is $160.00)._____(If you think the rate will vary (for example from $6 to $8), give an estimated average (for example $7).

At this rate, how many total hours or days of respite will you use during your approved respite period?_____(For example, if you paid the maximum of $10 an hour and no daily rates, you would have 100 hours of respite available during the year; on the other hand, if you paid the maximum of $160.00 per day and no hourly rates, you would have six days and six hours of respite available for the year.)

Describe below as best you can how and when you plan to use your respite dollar allocation and for what purpose throughout the respite period for which you are approved - for example, half-a-day once a month to go shopping, or six days in July to take a vacation, or 2-3 hours a week to do family business. To illustrate, you might use 3 days (@ $160.00 day maximum) for vacation at $480 and one hour a week (@ $10.00 an hour maximum) for family business at $520. We realize situations change but try to predict as accurately as possible how you plan to use your respite. Note that after the $1,000 is used up, all payment for respite waiver services will terminate (with the exception that in crisis/emergency situations, depending on the availability of funding, various funding sources may be utilized to provide emergency respite based on the urgency of the family's need for respite.

I plan to use my respite care as follows:

____ Vacation _____ # of hours/days (circle either hours or days) $_____

____ Shopping _____ # of hours/days $_____
____ Family business _____ # of hours/days $_____
____ Going Out for Dinner/Movie/etc. _____ # of hours/days $_____
____ Recreational Activities of Siblings _____ # of hours/days $_____
____ Obtaining Medical Care _____ # of hours/days $_____
____ Other (Explain)_____#hours/days

I plan to use my respite care according to the following approximate monthly schedule:

____ # of hours/days in October (circle either hours or days) $_____
____ # of hours/days in November $_____
____ # of hours/days in December $_____
____ # of hours/days in January $_____
____ # of hours/days in February $_____
____ # of hours/days in March $_____
____ # of hours/days in April $_____
____ # of hours/days in May $_____
____ # of hours/days in June $_____
____ # of hours/days in July $_____
____ # of hours/days in August $_____
____ # of hours/days in September $_____

The name(s) and address(es) of my respite provider(s) are:

(1)_____
(2)_____
_____ _____
_____ _____

(3)_____ (4)_____
_____ _____
_____ _____
_____ _____

I certify that the above information is correct to the best of my knowledge at this time.

_____
Signature of Children's Services Parent/Legal Guardian Date

_____
Approval of Children's Services Eligibility Committee Representative Date

Children's Services Contact Information:

In-State WATS:	1-800-482-5850 (501) 682-2277 (501) 682-2270 extension 22277
Direct:	(501) 682-2270 (501) 682-2277
Fax:	(501) 682-8247
Mailing Address:	Arkansas Department of Human Services Children's Services P.O. Box 1437, Slot S380 Little Rock, Arkansas 72203-1437