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 | ADMINISTRATIVE DIRECTIVE |
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TRANSMITTAL: 90 ADM-20

TO: Commissioners of
 Social Services

DIVISION: Medical
 Assistance

DATE: 5/30/90

SUBJECT: Care At Home (Model Waiver) Case Management:
 Guidelines and Procedures

SUGGESTED
 DISTRIBUTION:

Medical Assistance Staff
 Care At Home Coordinator
 Services Staff
 Staff Development Coordinators

CONTACT
 PERSON:

Any questions concerning this release may be di-
 rected to: Linda Reese - 1-800-342-4100, ext. 35491
 Janice Tricarico - ext. 35454

ATTACHMENTS:

- I - Case Management Services Application (On-line)
- II - Case Management Plan Outline (On-line)
- III - Budget Sheet (Not on-line)
- IV - Time Account (On-line)
- V - Recruiting Letter (On-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
86 ADM 4		NYSCRR 18 505.16	SSL 366.6		90 LCM-57 89 LCM 129 89 LCM 106

I. Purpose:

This directive transmits basic information concerning coverage and billing related to the provision of case management services to participants in the Care At Home Medicaid model waivers. It includes guidelines, application and billing procedures related to Care At Home Program Case Management services.

II. Background:

A. CARE AT HOME Case Management Expansion

Model waiver guidelines now allow for expansion of the types of agencies which may provide case management services to this population. Local Social Services districts (LDSS) will be responsible for recruitment of Care At Home case management providers.

B. Overview of CARE AT HOME Case Management Guidelines

As an alternative to institutionalization, home care for children involves a fundamental shift in both the site and focus of care, returning primary responsibility to the family and community. Family values and participation play a central role in the delivery of services in the home setting.

Regardless of the specific medical diagnosis or the necessary care and services required, the serious on-going illness of a child creates burdens on any family. Most families need assistance in integrating their child's special needs with the regular functioning of their household. The move from hospital to home also involves a major cost shifting to the family. Difficulties in cash flow due to slow reimbursement from insurers often compound a situation where many additional expenses (increased utility bills, housing modifications, certain supplies) are not reimbursed. Families must also spend significant amounts of time arranging schedules, balancing finances and providing direct skilled care for their child when professional care givers are unavailable.

The multiplicity of needs and problems faced by these children and their families often cannot be addressed by any single agency or resource. Services and coverage frequently need to be requested from a number of different providers and programs many of which lack experience and understanding of the complexity of delivering home-based care to children with special health care needs. The success of the home care plan is dependent upon building that understanding and on the effective coordination and delivery of services. The case manager is the key to these activities and the impetus to the cooperative provision of services to each child.

While technically the child is the individual whose care is being managed, the child cannot be viewed as separate and apart from the family, particularly in the home care setting which relies on parental involvement and support. Seen from this perspective, case management for the Care At Home Program must be family-centered.

For purposes of the Care At Home Program, case management is defined as the activities carried out by a case manager to assist and enable a child and family to access the full range of services and resources for which they are eligible. "Enable" means to build on and strengthen the family's ability to participate in discussions and carry out functions related to case management. It connotes an active role for the family. The case manager and family will engage in a collaborative effort in seeking the best interests, and meeting the needs, of the child.

Case management functions and responsibilities extend beyond "medical case management" to include other pertinent aspects of the child and family's situation e.g. participation in the development of the child's educational plan which may include subsequent transfer of payment responsibilities for certain therapies and equipment. Case management is a discrete service which will assist the child and family to gain access to a full range of health, medical, social, educational and support services for which they are eligible. Case management goals are established for each child and family and contained in a written case management plan mutually agreed to and signed by both the case manager and the parent/guardian of the child.

As noted, problems faced by many Care At Home participants and their families require interdisciplinary expertise and efforts to achieve resolution. The Care At Home case manager is the key to effective coordination and delivery of services across disciplines, agency programs and payors. While each provider and program administrator will be acting within his/her respective service system, the case manager will serve as the pivotal person encouraging and supporting the cooperative effort required to meet the child's needs. At the same time, the case manager's overall responsibility for the child's service needs requires that she/he keep other service providers informed of changes. Such coordination not only benefits the child in treatment but is a learning process for interdisciplinary consultants.

Care At Home case managers do not perform a "gate-keeping" function. However, they are responsible for on-going review of expenditures to ensure that the child has a payor for each necessary service and that those services billable to Medicaid

stay within the predetermined monthly budget. As needs and available resources fluctuate, the case manager will be responsible for adjusting the corresponding plan of care as well as negotiating coverage with potential payors.

Effective case managers must:

1. be able to develop a strong, supportive working relationship with the child and family;
2. be able to communicate and build mutual respect with the family and other service providers as well as program administrators, equipment vendors and insurers to promote cooperation and continuity of services/coverage;
3. possess thorough knowledge of individual and institutional services (medical, social, educational and other support services) available in the community;
4. possess a thorough knowledge of entitlement programs and funding sources (both public and private) as well as applicable eligibility criteria;
5. be proactive in their approach to problem identification and resolution; and
6. demonstrate advocacy and brokering ability.

III. Program Implications:

Case management services may now be directly reimbursed under the Care At Home Program in accordance with the procedures outlined in this directive.

The current approved case management fees are listed below:

* Downstate/Metropolitan (New York City, Nassau County, Suffolk County, Westchester County, Rockland County, Putnam County)	\$50 per hour
* REST OF STATE	\$32 per hour
* OMRDD	\$22 per hour

These fees are billable in 1/4 hour units.

IV. Required Action:

A. Obtaining Case Management Services for Care At Home Children

1. Disseminating Application

Local districts are responsible for recruitment of case management providers. This will include disseminating the attached Care At Home Waiver Program Case Management Services Application (Attachment I) to current case management providers as well as to those who express interest in the program. Completed applications must be submitted to the New York State Department of Social Services for approval as Care at Home case management providers. The estimated number of hours of case management will vary from case to case. All case management costs must be reflected as a component of the monthly expenditure cap.

2. Submission of Applications to SDSS

The completed application should be sent to:

Mr. Stuart Lefkowich, Assistant Commissioner
New York State Department of Social Services
Division of Medical Assistance
40 North Pearl Street
Albany, New York 12243
Attention: Care At Home Program

B. Components of Case Management

Case management is a coordinated, problem solving approach to meeting the needs of Care At Home children and their families. It consists of a number of separate stages aimed at identifying, assessing, planning and monitoring a comprehensive plan of care. These stages include:

1. Case Management Screening and Intake

During initial screening the concept and functions of case management are discussed with the family. If the family is interested in using the agency or individual as a case manager, a determination of need for case management services is made. This function includes:

- a. the initial contact with the child and family. This should be made as soon as possible subsequent to referral for services to allow for an assessment within 15 days. (This time frame may be waived at the Department's discretion. Any variance from this 15 day requirement must be specified and agreed to by the LDSS.),

- b. providing information concerning case management, and
- c. identifying potential entitlement/payors for services.

2. Case Management Assessment and Reassessment

During this process information is gathered about both the child and family and the available resources upon which a plan may be developed.

The case management process must be initiated by a written assessment of the child and family's need for case management of medical, social, psychosocial, educational, financial and other services.

The case management assessment takes into account the current level of functioning and the continuing need for services. It defines case management service priorities and provides an evaluation of the child and family's ability to benefit from such services.

An initial assessment must be completed by a case manager within 15 days of the date of the referral. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management assessment.

As part of the initial case management assessment, the case manager must develop or secure with the family's permission:

- a. a comprehensive medical evaluation of the child or, if necessary, arrange to have such an evaluation completed;
- b. information from other agencies/individuals to identify the barriers to care and existing gaps in service to the child; and
- c. a comprehensive assessment of the child's service needs including, medical, social, psychosocial, educational, financial and other services.

3. Case Management Planning and Coordination

Attachment II gives the general outline for a Case Management Plan for Care At Home. The outline is used in conjunction with this Directive to complete a case management plan. Attachment III gives the Budget Sheet for Care At Home.

At this point, the case manager, with the child's family, identifies the course(s) of action to be followed, the informal and formal sources that can be used to provide services, and the frequency, duration and amount of service that will satisfy the child/family's needs. All of these are incorporated into the initial written case management plan which must be completed within 45 days of the date of referral. Planning includes, but is not limited to, the following activities:

- a. identification of the nature, amount, frequency, duration and costs of the services required by a particular child including the amount and cost of case management services as well as the applicable Medicaid expenditure cap;
- b. identification of services to be provided to the child/family;
- c. identification of the child/family's informal support network as well as providers of services;
- d. specification of the short-term and long-term objectives to be achieved through the case management process. While there may be several goals appropriate to each child and family, a primary goal should be chosen. Intermediate objectives leading toward the primary goal must be identified with a time frame of no more than one year. The objectives and tasks required for the child/family to achieve the stated goal should be listed in the plan. Case management objectives with anticipated dates of completion, must be established in the initial case management plan consistent with service needs and assessment; and
- e. collaboration with health care providers and other formal and informal service providers including discharge planners and others as appropriate.

This activity may occur through case conferences or other means and is intended to encourage exchange of clinical information and to assure:

- (1) integration of clinical care plans throughout the case management process;
- (2) continuity of service;
- (3) avoidance of duplication of service (including case management services);
- (4) establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the recipient.

The case management plan must be reviewed and updated by the case manager as required by changes in the child/family condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed, the objectives established in the initial case management plan must be maintained or revised, and/or new objectives and new time frames established with the participation of the child/family.

The case management plan must specify:

- o those activities which the child/family is expected to undertake within a given period of time toward the accomplishment of each case management objective;
- o the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- o the type of treatment program or service providers to which the individual will be referred;
- o the method of provision and those activities to be performed by a a service provider or other person to achieve the individual's related objectives;
- o the type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed. Attachment III gives the Budget Sheet for this purpose.

4. Implementation of the Case Management Plan

Implementation means marshalling available resources for translating the plan into action. This includes:

- a. securing the services determined in the case management plan to be appropriate for a particular child and family through referral to those agencies or persons who are qualified to provide the identified services;
- b. assisting the family with referral and/or application forms required for the acquisition of services;
- c. acting as an advocate with providers of service when necessary to obtain/maintain fulfillment of the child and family's service needs; and

- d. developing alternative services to assure continuity in the event of service disruption.

5. Crisis Intervention

A case manager may be required to coordinate case management and other services in the event of a crisis. Crisis intervention includes:

- a. assessment of the nature of the child and family's circumstances;
- b. determination of the emergency service needs; and
- c. revision of the case management plan, including any changes in activities or objectives required to achieve the established goal. (Emergency services are defined as those services required to ameliorate/alleviate or eliminate a crisis.)

6. Monitoring and Follow-Up of Case Management Services

Monitoring the acquisition/provision of services and following up with clients guarantees continuity of service. Monitoring and follow-up includes:

- a. verifying that quality services, as identified in the case management plan, are being received by the child and are being delivered by providers in a cost-conscious fashion;
- b. assuring that the family is adhering to the case management plan and ascertaining the reason for any deviation or decision not to follow the agreed upon plan;
- c. ascertaining the family's satisfaction with the services provided;
- d. collecting data and documenting in the case record the progress of the child/family (this includes documenting contacts made to or on behalf of the child/family);
- e. making necessary revisions to the case management plan;
- f. making alternate arrangements when services have been denied or are unavailable to the child or family, or when the child can no longer participate in the waiver; and
- g. assisting the family and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

7. Counseling and Exit Planning

Counseling in Care At Home case management enables family members to cooperate with the case manager in carrying out the objectives and tasks required to achieve the service goals. It is not the provision of an actual service such as employment counseling or medical social work.

Counseling as a function of case management includes the following:

- a. assuring that the child and family obtain, on an ongoing basis, the maximum benefit from the services received;
- b. developing support groups for the child, the family and informal providers of services;
- c. mediating among the family network and/or other informal providers of services to resolve problems with service provision;
- d. facilitating access to other appropriate care if and when eligibility for the targeted services ceases; and
- e. assisting families to anticipate the difficulties which may be encountered subsequent to admission to or discharge from facilities or other programs.

D. Essential Processes in the Provision of Case Management:
The Case Record

1. Documentation of Case Management Services

A separate case record must be established for each case management client and must document each case management function provided. The case record should reflect progress toward the individual's case management goals and objectives and the tasks necessary to accomplish these objectives. Each case record must, at minimum, contain information as follows:

- o name of child; parents/guardian;
- o name of provider agency and person providing the service;
- o dates of service;
- o place of service; and
- o a statement of how the service supports/advances the child/family in a particular task, objective or goal described in the case management plan.

2. Continuity of Service

Case management services must be ongoing from the time the client enters into case management to the time when:

- a. the child/family moves beyond the service area of the provider;
- b. the long-term goal has been reached;
- c. the family requests that the case be closed;
- d. the child is no longer eligible for services; or
- e. the child's case is appropriately transferred to another case manager.

3. Required Contact

Direct contact with the child and family must be made by the case manager at least monthly, or more frequently as specified in the case management plan.

This time frame may be waived at the discretion of the local district and only contingent upon the needs of a particular individual. Any variation from the monthly contact requirement must be specified by agreement between the local district and the provider. However, the case manager is expected to participate in each scheduled 120 day reassessment beginning with the child's initial Care At Home program assessment.

E. Relationship of Local Districts and Case Managers

Local district staff have a primary role in the oversight and management of Care At Home children. A local district designee must be assigned to be in contact with Care At Home case managers on a regular basis to discuss progress toward case management goals and to assist in the development and modification of case management plans as necessary. The local district must receive a copy of each case management plan and insure that all case management plans are up-dated every 6 months.

F. Provider Qualifications and Participation Guidelines

1. Provider Entities

Case management services may be provided by social services agencies, facilities, persons and groups possessing the capability to provide such services who are approved by the State Commissioner of Social Services. Prospective providers of case management services may include, but are not limited to:

- a. facilities licensed or certified under New York State law or regulations;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. State and local government agencies; and
- d. home health agencies certified under New York State law.

2. Case Management Staff

Individual case management staff must meet the educational and experience qualifications outlined in 18 NYCRR 505.16. The individual providing case management must have two years of experience in a substantial number of activities outlined in this Directive, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a prorated basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human service field;
- b. one year of case management experience and an additional year of experience in other activities with the target population;
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined in this Directive, including the performance of assessments and development of case management plans; or
- d. meeting the regulatory case management requirements of another State agency.

V. Systems Implications:

1. Provider Enrollment in the Medicaid Management Information System (MMIS)

The MMIS provider enrollment package will be sent to prospective case management providers by the Department. Completion and return of the enrollment material will result in the assignment of a unique provider identification number for approved applicants to be used in service authorization and billing activities. Currently enrolled MMIS providers (i.e., those providing Medical Assistance services in addition to case management) must also be enrolled in the case management category of service and receive a separate case management provider identification number. Billing instructions and claim forms for case management providers will be sent subsequent to the provider's

return of the enrollment package.

2. Billing and Payment for Case Management Services

Payment for case management services will be through the MMIS fiscal agent. Payment will be rendered on a client specific, unit of service basis. Case management providers will bill for services on preprinted MMIS claim forms according to instructions provided to them upon enrollment by the Department.

The forms designated in Attachment IV should be used to document case contacts and time spent on case management functions. They will also assist in the completion of the billing claim forms. The designated forms are required in addition to the case record and are subject to audit by State, federal or local authorities.

VI. Additional Information:

Attachment I is the Care At Home Waiver Program Case Management Services Application and related instructions. Districts must copy this material for potential case managers. Attachment V gives a suggested letter for recruitment of case management providers.

VII. Effective Date:

June 15, 1990

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

CARE AT HOME WAIVER PROGRAM
CASE MANAGEMENT SERVICES APPLICATION

SECTION A - IDENTIFYING INFORMATION

1. Title Care At Home Case Management Application
2. Organization _____
3. Address _____
City _____ State _____ Zip Code _____
4. Type of Organization _____
5. License or Certification _____

6. Chief Executive Officer _____
7. Application Contact Person _____
Title _____
8. Contact's Telephone _____
9. Parent Organization _____
Address _____
City _____ State _____ Zip Code _____
Type of Organization _____
License or Certification _____

Chief Executive Officer _____
10. Medicaid Provider Enrollment Information
Medicaid Provider I.D. Number(s) _____

Categories of Service _____

11. Other Case Management Services _____

12. Start Date of Services:	<u>CAH I</u>	<u>CAH II</u>
	_____	_____

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| CARE AT HOME I Effective 12/01/88 - 11/30/93 |
| CARE AT HOME II Effective 07/01/89 - 06/30/92 |
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SECTION B - PROGRAM INFORMATION

1. Local Social Services District(s) _____

2. Target Population: (check one)

- Care At Home I (CAH I) - SNF Level
- Care At Home II (CAH II)-Tech-Dependent at Hospital Level
- Care At Home I AND II

Geographic Area Served _____

Average Monthly Caseload CAH I _____

CAH II _____

3. Case Manager Qualifications

- a. 2 years of Case Management experience _____
- b. A Bachelors or Masters Degree which includes a practicum with Case Management experience _____
- c. Meets regulatory requirements of a State agency _____
Please describe below.
- d. One year of Case Management experience and one year of other experience with the target group _____
- e. One year of Case Management experience and a Degree in a Health or Human Services field _____

SECTION C - FINANCIAL INFORMATION

1. Personnel Services Costs

Title	Annual Salary	% of Program	Annual Cost

Total Cost Salaries _____
% of Fringe Benefits _____
Total Personnel Services Cost _____

2. Case Management Hours

a. Total Annual Case Manager Hours _____
Other Necessary Activities _____ Hours
Training _____
Leave Time _____
Meetings _____
Group Activities _____
Administrative Work _____

b. Total Annual Other Activities _____

c. Annual Available Case Manager Hours _____
(2a minus 2b)

SECTION D - ASSURANCES

1. We assure the quality of the case management services provided under this application are in accordance with 18 NYCRR Section 505.16.
2. We assure the timely submittal of quarterly financial reports as required by the Care At Home Waiver Program.
3. We assure the case management client's right to choose the provider of case management services and any other services to be provided under the Medical Assistance Program.
4. We assure the case management client's right to refuse services and to refuse any portion of the case management plan.
5. We assure the participation of the client and other persons of the clients choice in the case management plan and solicit the client's signature to signify assent with its contents.
6. We assure that the client is informed of the right to a fair hearing.
7. We assure that the client will be afforded the right to review the case management record upon request.
8. We assure the confidentiality of all client-specific information and assure that a signed release will be obtained from the client prior to the release of client-specific information and that a copy will be retained in the case management record.
9. We assure that case management records, financial and claiming information, client assessments and the case management plans will be available for inspection by the Health Care Financing Administration, the New York State Department of Social Services and appropriate social services districts or their agents at the following location(s)

(list all agency offices where case management is provided)

10. We assure that the case management services provided will include the activities of intake and screening, assessment, planning, implementation of plan, coordination of services, crisis intervention, monitoring, counseling and discharge planning, some of which may be accomplished by referral to medical, social, educational, psychosocial, habilitation and/or rehabilitation services. We assure that case management services to Care At Home clients will include home visits.

11. Signature _____

12. Title _____

13. Date _____

(Note: When the client is non self-directing, the assurance of client rights should be directed to the parent or guardian.)

INSTRUCTIONS FOR COMPLETION OF CASE MANAGEMENT APPLICATION
CARE AT HOME WAIVER PROGRAM

SECTION A - IDENTIFYING INFORMATION

1. Title - The name by which the case management application will be known, we will refer to this title when corresponding with you.
2. Organization - The organization which will conduct the case management project.
3. Address, City, State, Zip Code - The address at which you wish to receive mail.
4. Type of organization - Enter whether the organization is proprietary, not-for-profit, or public. If the type is proprietary, attach a separate page stating the ownership. If the type is not-for-profit, attach a separate page listing the board of directors names and occupations. If the type is public, attach a separate page stating the relationship to the Medicaid program, if any.
5. License or Certification - If the organization is licensed or certified under a federal, state or local government's jurisdiction, please enter the name of the licensing or certifying authority and the law or regulation under which it is certified. If none, enter none. For example, a home health agency is certified by the New York State Health Department under Article 36 of the Public Health Law.
- 6 Chief Executive Officer - The individual in overall charge of the organization.
7. Application Contact Person - The individual who should be contacted for additional information on the application. Include the contact person's title.
8. Contact's Telephone - The telephone number of the contact person.
9. Parent Organization - If the organization which proposes to provide the case management services is a subsidiary of or is owned by another organization, indicate that here. The instructions are the same as for the responses above which apply to the case management organization.

Do not include affiliations, councils, or fund raising federations, for example United Way.

10. Medicaid Provider Enrollment Information

a. Medicaid Provider ID Number(s) - If the organization or parent organization is now an enrolled Medicaid provider, enter provider ID number(s) here.

b. Categories of Service - Enter the categories of service in which the provider is now enrolled to provide service.

11. Other Case Management Services - If the organization provides case management services to other target groups, list those groups and the funding sources which provide payments.

12. Start Date of Services - The earliest date of the first waiver year on which the organization will provide or has provided case management services to any participant of Care at Home I or Care at Home II Waiver programs.

SECTION B - PROGRAM INFORMATION

1. Local Social Services District(s) - The local district(s) that will be receiving this application and will be referring and authorizing Medicaid eligibles for this program.

2. Target Population

a. The population to be served - Check the appropriate box. There are two Care At Home Waivers. Waiver one (CAH I) serves children who, if institutionalized, would require care in a skilled nursing facility: Waiver two (CAH II) serves children who are technology-dependent as defined by the waiver and who, if institutionalized, would require inpatient hospital care.

b. Geographic Area Served - Enter the area that the agency will serve. This can be statewide, one or more counties, a city, borough, minor civil division or one or a number of zip code areas.

c. Average Monthly Caseload - Enter the number of individuals who will be served by this application at any one point in time. The capacity of the program.

3. Case Manager Qualifications

Check each of the education/experience factors that qualify the case manager(s) to provide services. If C is checked, describe such as community health nurse licensed in accordance with NYCRR 700.2(b)(18), etc.

SECTION C - FINANCIAL INFORMATION

1. Personnel Services Costs

List the title, annual salary, percent of time spent on the case management program and the annual cost for each individual in the direct employ of the case management provider.

Provide a job description showing the functions of each title listed.

Attach a table of organization for the case management organization's administrative structure and the relation to the parent organization's structure.

Determine the percent of salaries which constitute fringe benefits. Add this to the total cost of salaries to determine the total annual personnel services cost.

2. Case Manager Hours

- a. The annual number of hours worked by all of the case managers in agency. If staff salaries and time are prorated, include the amount of time which equates with the percent of salaries declared in C-1. Multiply the number of case managers by the number of hours in the agency's work week by 52 weeks.
- b. The Annual Number of Hours Allotted to All Necessary Non-Individual Case Management Activities. List by activity such as training, annual/sick/personal leave, holidays, meetings, group activities, administrative work, etc.
- c. The annual number of hours available for direct case management with individuals.

SECTION D - ASSURANCES

These assurances are required to be eligible to provide case management services to Care At Home Waiver program participants. This document must be signed by an individual with sufficient authority to assure that the activities listed in this document are carried out and that the information herein is correct.

Care At Home Program CASE MANAGEMENT PLANDirections:

1. Use this format as a guide to the case management plan, in conjunction with this Administrative Directive. Additional elements should be added as determined by the case manager.
2. The family must be involved in the development of the case management plan and be given the opportunity to add written comments to the plan. The family verification statement must be incorporated into or attached to the plan. Signature of a family member will indicate both family involvement and agreement with the plan as written.
3. The signed case management plan must be given to the family and local district. Each case management plan is updated every 6 months.
4. The Department will require certain case management plans for review. Case management plans are subject to audit by State, federal and local authorities.

Suggested Format:I. Verification and Timeframes:

- A. Family Verification - The following statement must be signed by a family member:

1. "I VERIFY THAT I HAVE PARTICIPATED IN THE DEVELOPMENT OF THIS PLAN TO THE EXTENT I REQUESTED AND THAT I AGREE WITH THE CONTENT OF THE PLAN."

x		/ /
	Signature of Family Member	date
x		/ /
	Signature of Case Manager/ Affiliation	date

2. Family Comments: (if any)

- B. Case Management Plan Period: From/to dates, not to exceed 6 months.

II. Family and Other Contacts:

- A. Family Information: Names, addresses, phone numbrs, etc.
- B. Care At Home Client Information: Name, Medicaid number, medical condition/diagnosis,
- C. Care At Home Coordinator: Name, address, phone, etc.
- D. Medical Contacts: Hosptials, physicians, phone numbers, etc.
- E. Service/Equipment Contacts: Service suppliers, equipment repair etc.

III. Case Management Plan:A. Child and Family Needs: Include information on the following kinds of needs:

- o Medical/social;
- o psychosocial;
- o educational;
- o financial;
- o other

B. Case Management Goals:

1. Develop a Primary Goal, with intermediate objectives and timeframes. Develop activity/tasks of child/family needed to reach goal.
2. Develop Secondary Goals as needed with intermediate objectives and timeframes. Develop activity/tasks of child/family needed to reach goal.

IV. Budget Information: Attach the current Budget Sheet (Attachment III) showing type, frequency, duration, cost. Case management goals should be reasonably related to the service needs.V. Additional Significant Information: Determined by the family and case manager.

Case Management for Care At Home Program
TIME ACCOUNT

Directions:

1. Keep this record for each child case managed;
2. This record will be used by local, state and federal agencies for audit purposes:
3. 1/4 hours may be billed.

Suggested Format:

CASE MANAGEMENT TIME ACCOUNT

Childs Name:_____

Medicaid Number:_____

Date of Service

Purpose: give specific detail

Hours Billed

Dear Program Administrator and Social Service/
Health Care Administrator:

We wish to inform you that we are currently recruiting agencies to provide case management services for clients in the Medicaid Model Waiver Programs Care At Home I and Care At Home II.

The Care At Home programs are designed to make Medicaid reimbursement available for home and community-based services for certain physically disabled children. These children must be under 18 years of age, meet SSI disability criteria, apply while they are being cared for in an institutional setting and be capable of being cared for in the community safely and at no greater cost than in the appropriate institutional setting. These children may become eligible for Medicaid without regard to their parents' income or resources.

The Care At Home programs offer case management as a discrete service in addition to all other services available under Medicaid. Recently issued State guidelines have established separate Medicaid case management rates for agencies who provide these services to the Care At Home participants. Enclosed is an Administrative Directive which outlines the components of case management as well as the qualifications and participation guidelines for agencies such as yours.

Should you be interested in participating, we have enclosed an enrollment application with a self-addressed envelope. Further information may be obtained by contacting _____

We strongly urge you to consider participation in this worthwhile program.

Sincerely,