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| ADMINISTRATIVE DIRECTIVE |
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TRANSMITTAL: 92 ADM-27

TO: Commissioners of
Social Services

DIVISION: Medical
Assistance

DATE: June 25, 1992

SUBJECT: Home Care Assessment Instrument Process and
Notification Procedures

SUGGESTED

DISTRIBUTION: | Home Care Services Staff
| Medical Assistance Staff
| Adult Services Staff
| Director of Social Services
| Staff Development Coordinators

CONTACT

PERSON: | See Appendix A for contact persons

ATTACHMENTS: | See Attachment 1 for listing of Appendices

FILING REFERENCES

Previous | Releases | Dept. Regs. | Soc. Serv. | Manual Ref. | Misc. Ref.
ADMs/INFs | Cancelled | | Law & Other | |
| | | Legal Ref. | |
80 ADM-9 | | 505.14(b) & | Article 5 | |
89 ADM-21 | | (g) | Title 11 | |
| | | 367-o | |
DSS-296EL (REV. 9/89)

1.0 INTRODUCTION

This directive transmits a new home care assessment instrument and the instructions for completing the instrument. The directive also includes the implementation schedule, the procedures for reassessing certain personal care services recipients, and the letters for notifying recipients of the reassessment requirements and the outcome of the reassessment. A separate directive will discuss the use of the new home care assessment instrument by certified home health agencies.

These policies and procedural changes are required by Social Services Law 367-o (Chapter 41 of the Laws of 1992). The statute is attached as Appendix B.

1.1 EFFECTIVE DATE

The effective date of this directive is July 1, 1992.

2.0 BACKGROUND

On July 1, 1992, the Department of Social Services and the Department of Health must implement a home care assessment instrument for use in assessing home care applicants/recipients (A/Rs). The home care assessment instrument was developed using the results from two field tests of proposed instruments from social services districts, licensed home care agencies and certified home health agencies throughout the state; input from an advisory committee which was convened twice to discuss the instrument; and comments from provider agencies and social services districts.

The implementation of a new assessment instrument is part of the new cost containment policies and procedures mandated by recent statutory changes. Effective July 1, 1992, social services districts and certified home health agencies must also incorporate efficiency reviews and fiscal assessments when authorizing or reauthorizing personal care and home health services. These new policies are described in the administrative directives, entitled "Fiscal Assessment and Management of Personal Care Services", and "Fiscal Assessment and Management of Home Health Services" which will be issued in the near future.

3.0 SUMMARY OF POLICY AND PROCEDURE

The amendments to Section 367-0 of the Social Services Law and 18 NYCRR 505.14(b) and (g) require social services districts to use the new home care assessment instrument to reassess certain recipients and when

authorizing or reauthorizing personal care services. The regulations are attached as Appendix C. The home care assessment instrument, entitled "Home Assessment Resource Review Instrument" (HARRI), is attached as Appendix D. The instructions for the HARRI are attached as Appendix E.

The HARRI must be used to assess all personal care services A/Rs, whether they receive services from a licensed home care services agency, an exempt agency, a certified home health care agency, a long term home health care program, an individual provider, or an employee of the social services district. The HARRI must be used to assess personal care services A/Rs who are residents of adult care facilities.

3.1 The Home Care Assessment Instrument (HARRI)

3.1.1 Description of the Instrument

The HARRI enables the assessor to evaluate the A/R's health, social and environmental needs to determine if home care services are appropriate and refers the A/R to the most appropriate and cost-effective home care services or to other long-term care services.

The factors considered are the A/R's ability to perform activities of daily living, health and rehabilitation needs, the ability to direct care and summon assistance and health and safety factors.

The HARRI includes the following:

Section I Home Care Appropriateness Determination:

1. Health and Safety Determination;
- 2.& 3. Residence Determination; and
4. Home Care Program Determination.

Section II Determination of Paraprofessional Activities/Hours:

- A. Level of Assistance;
- B. Paraprofessional Activities; and
- C. Estimating Maximum and Actual Hours of Care.

Section III Instructions for Adjusting the Hours Authorization:

- A. Actual Hours of Care Required;
- B. Review of Efficiencies; and

C. Adjusted Authorized Hours.

The HARRI directs the A/R to the appropriate home care program, specifies the maximum number of hours per month that will be paid by the Medical Assistance program, and serves as a basis for the A/R's plan of care.

3.1.2 Assessor Who May Complete the HARRI

The HARRI may be completed by the professional staff of the social services district, a nurse employed by a certified home health agency, a nurse employed by a long term home health care program, a nurse employed by the social service district or its designee, a nurse employed by a voluntary or proprietary agency under contract to the social services district, or a hospital discharge planner. The hospital discharge planner may complete Section I of the HARRI and make the appropriate referral to the home care program selected or if necessary to other long term care services, or may complete the entire HARRI. If the hospital discharge planner completes the entire HARRI, the social services district or the certified home health agency may complete another HARRI in its discretion.

The assessor must be one of the professionals identified above or a combination of the professionals identified above, depending on the social services district's personal care services program structure.

3.1.3 Relationship to Other Assessment Forms and Procedures

The HARRI is not a substitute for the "Home Care Assessment Abstract" (DSS 3139) and "Long Term Care Placement Form Medical Assessment Abstract" (DMS-1) or approved local equivalent forms. The home care assessment instrument must be used in conjunction with existing Department-approved forms and procedures for authorizations expected to exceed 60 days duration.

The HARRI should be completed as part of the nursing and social assessments and incorporates the review of the efficiencies as mandated by Chapter 165 of the Laws of 1991. After completing the nursing and social assessments and the HARRI, the social services district must complete the fiscal assessment. A flowchart is attached as Appendix F demonstrating the relationship of the HARRI to the fiscal assessment.

The Department is working toward the integration and automation of all assessment forms.

3.2 Initial Implementation of New Assessment Procedures and Instrument

The social services districts must complete the HARRI for the following A/Rs:

3.2.1 Recipients Currently Receiving Over 156 Hours per Month of Personal Care Services

The social services districts must notify all personal care services recipients currently authorized to receive over 156 hours per month of services that their need for services will be reassessed using the HARRI.

If a recipient or a recipient's representative fails to comply with the reassessment requirements, the recipient's authorization for personal care services may be reduced to 156 hours per month. Failure to comply is defined as failure to cooperate with the scheduling and completion of the home care reassessment. However, if the health and safety of a recipient would be jeopardized by a reduction in services, the social services district must continue current services and give priority to the reassessment of this recipient. Standards for health and safety are found in 18 NYCRR 505.14(a)(4) and are described in the administrative directive, "Fiscal Assessment and Management of Personal Care Services" which will be released in the near future.

3.2.2 Recipients Currently Receiving Less than 156 Hours per Month of Personal Care Services

Effective July 1, 1992, the social services districts must use the HARRI to assess all recipients who are currently authorized to receive personal care services for less than 156 hours per month. The reassessment must occur during the social services district's periodic reassessment of a recipient's need for personal care services.

3.2.3 Applicants Seeking an Initial Authorization for Personal Care Services

Effective July 1, 1992, the social services districts must use the HARRI as part of the assessment of all applicants initially applying for personal care services who the districts expect will require services for over 60 continuous days. For initial assessments, the social services district is not required to complete Section 14 and 16 from the DSS-3139.

3.3 Continued Use of the Assessment Instrument

The social services districts must continue to use the HARRI as part of all reassessments conducted on or after July 1, 1992.

3.4 Discontinuation of the Use of 156 Hour Classification

There will be no further use of the 156 hours per month classification after the social services districts reassess all recipients who currently receive more than 156 hours of services per month. The 156 hours per month is not a cap on the hours of services to be authorized.

The HARRI will indicate the maximum number of hours of services that may be authorized under the Medical Assistance program.

4.0 REQUIRED ACTIONS

4.1 Review Recipient Lists

The social services districts were sent Department-generated lists of recipients who currently receive over 156 hours per month of personal care services. These lists were produced from the Medicaid Management Information System (MMIS) Prior Approval File. The social services districts must review the lists for accuracy and must:

- 4.1.1 Identify any errors in the authorizations appearing on the prior approval file and make the necessary corrections;
- 4.1.2 Remove all closed cases;
- 4.1.3 Determine if cases can be removed from the list because extra hours had been approved only to accommodate unexpected changes in the authorization; and
- 4.1.4 Add to the lists newly opened cases that exceed 156 hours per month which received prior approvals after the Department produced the lists.

4.2 Provide Corrected List to Department

The social services districts must notify the Department of any deletions or additions of cases that exceed 156 hours per month. Failure to provide these deletions or additions to the Department may result in automatic reductions of all current authorizations to 156 hours per month.

4.3 Notify Recipients on the List of Reassessment Requirement

The social services districts must send letters to all recipients on the lists described in 4.2 above and to all recipients receiving services over 156 hours per month from individual providers or employees of the social services districts on the Department-approved form attached as Appendix G.

Appendix G illustrates the six items the social services district must add to the letter: (No. 1) letterhead; (No. 2) recipient's name and address;

(No. 3) date; (No. 4) phone number; (No. 5) Commissioner's signature; and (No. 6) name of district.

The letter provides notice to the recipient that personal care services will be reassessed using the HARRI and that failure to comply with the reassessment requirements may result in a reduction of his or her hours to 156 hours per month.

Appendix G-1 is a prototype ready for reproduction.

4.4 Schedule Reassessment Visits

The social services districts must schedule reassessment visit appointments for all recipients notified pursuant to 4.3 above.

4.5 Identify Recipients Who Fail to Comply

The social services districts must determine which recipients or recipients' representatives failed to comply with the reassessment requirements by failing to cooperate with the scheduling of the appointment or the completion of the reassessment.

The social services districts must send each recipient who fails to comply with the reassessment, and whose health and safety would not be jeopardized by a reduction in services to 156 hours per month, a written notice which is attached as Appendix H. Social services districts must photocopy this notice and issue the notice as a two-sided notice, not a two-paged notice. This notice informs the recipient that the personal care services authorization will be reduced to 156 hours per month provided that the recipient's health and safety would not be jeopardized by this reduction. According to 18 NYCRR 358, this notice must be timely and adequate. Therefore, this notice must be mailed to the recipient at least ten days prior to the date of the intended action, and the effective date must be at least ten days after the notice date.

If the recipient's health and safety would be jeopardized by the reduction, the social services district must reenter the existing prior approval using a special indicator code described in 5.4 below. The reassessment of this recipient would be prioritized as described in 4.6.2 below.

4.6 Reassess Recipients whose Personal Care Services Authorization Exceeds 156 hours per Month

The social services districts must reassess recipients using the HARRI and enter new prior approvals using a special indicator code as described in 5.4 below. The social services district must photocopy the HARRI (Appendix D). No copies will be available from the Department's Forms and Publications Office. The new prior approval period will end on the date of the previous prior approval period.

4.6.1 Planning the Reassessment Visit Schedule

The reassessments must be based on actual visits to the recipients' homes, not on paper reviews. New nursing and social assessments are not required for these recipients. However, existing case record documentation supporting the current authorization should be consulted. The current personal care services authorization must be revised as directed by the outcome of the HARRI. A flowchart attached as Appendix I demonstrates the steps for reassessment of cases exceeding 156 hours per month.

The Department will reduce the prior approvals for recipients whose personal care services authorizations exceed 156 hours per month on the MMIS Prior Approval system to 156 hours per month as of July 1, 1992.

Because the Prior Approval File will authorize a number of hours equal to 156 hours per month multiplied by the number of months remaining in the recipient's authorization period, some recipients will have an adequate number of hours to cover their current hours of authorization for several months. For these recipients, the districts will have more time to complete reassessments using the HARRI.

However, all reassessments must be completed by September 1, 1992.

Two examples are given below. In the first example, the social services district has many weeks to complete the reassessment. The second example allows significantly less time for reassessment.

Example No. 1:

A recipient is authorized for 49 hours per week or 196 hours per month. The recipient's six month authorization is from 4/1/92 to 9/30/92. When authorized, the total amount of hours entered on the prior approval file was 1,274 hours (49 hours a week X 26 weeks).

If the existing authorization is reduced on 7/1/92 to 156 hours per month, the total amount of hours authorized will be 468 hours (156 hours per month X the 3 months remaining in the authorization period). This recipient could be reassessed in the seventh week of the reassessment visit schedule because 468 hours would provide approximately 9 weeks of 49 hours per week of services (49 hours per week X 9 weeks = 441 hours, remainder of 27 hours), allowing time for continued service throughout any ten day notice period.

Example No. 2:

A recipient is currently authorized for 24 hour continuous care which is 168 hours per week or 672 hours per month. The recipient's authorization is from 6/1/92-12/1/92. When authorized, the total amount of hours entered on the prior approval file was 4,368 hours (168 hours a week X 26 weeks).

If the existing authorization is reduced on 7/1/92 to 156 hours per month, the total amount of hours authorized will be 780 hours (156 hours per month X the 5 months remaining in the authorization period).

This recipient would need to be reassessed within the first 3 weeks of the reassessment visit schedule because 780 hours would provide approximately 4 weeks and 4 days of 24 hour continuous care (168 hours per week X 4 weeks = 672 hours, remainder 108 hours), allowing time for continued service throughout any ten day notice period.

4.6.2 Prioritizing Reassessments

The social services districts must prioritize reassessments to assure that personal care services recipients have an adequate total number of hours to cover their current authorizations until any 10 day notices of reduction or discontinuation become effective. Top priority for reassessment should be given to recipients whose current authorizations:

- a. expire within the next month; or
- b. are for 24 hour continuous care; or
- c. are for live-in services or any amount between 24 hour continuous care and live-in services; or
- d. are for recipients whose health and safety needs may be jeopardized by the reduction in hours as described in 3.2.1 above.

Prioritizing reassessments and completing new prior approvals must assure that recipients continue to receive necessary services and providers are paid for the services provided. However, all reassessments must be completed by September 1, 1992.

A provider may not reduce or discontinue services required under a recipient's plan of care until the recipient is notified either of the outcome of the home care reassessment or a reduction based on the recipient's failure to comply with the home care reassessment as required in this directive.

4.7 Notify Recipients Described in 4.6 of the Outcomes of the Reassessment

The social services districts must notify the personal care services recipients whose personal care services authorizations exceeded 156 hours per month and who were reassessed using the HARRI, of the outcomes of the reassessments using written notices such as the one

attached as Appendix J. The social services districts must photocopy this notice and issue the notice as a two-sided notice, not a two-paged notice. The outcomes must include one of the following actions:

- 4.7.1 authorize the personal care services at the same level; or
- 4.7.2 reduce the personal care services to the indicated level; or
- 4.7.3 increase the personal care services to the indicated level; or
- 4.7.4 discontinue the personal care services with a referral made to a certified home health agency (CHHA), a long term home health care program (LTHHCP), a residential health care facility (RHCf), a hospice, an intermediate care facility for the mentally retarded (ICF-MR), an acute care hospital, an Assisted Living Program (ALP), an Adult Care Facility (ACF) or Protective Services for Adults (PSA); and
- 4.7.5 in addition, the social services districts must notify personal care services recipients about their fair hearing rights under 18 NYCRR 358. The actions specified in section 4.7.1 and 4.7.3 which authorize or increase services require adequate notices. The notice date and the effective date can be the same. The actions specified in sections 4.7.2 and 4.7.4 which reduce or discontinue services require a timely and adequate notices. The effective date must be at least ten days after the notice date. When services are to be discontinued, the actual discontinuation date is contingent on the availability of the alternative long term care services.

4.8 Assess All Initial Cases with the Assessment Instrument

Effective July 1, 1992, all initial personal care services cases that are expected to require services for more than 60 continuous days must be assessed using the HARRI.

The applicant must be notified of his or her initial personal care services authorization using the written notification letter DSS-4007, "Notice of Decision of Initial Authorization/Reauthorization/or Denial Personal Care Services" or its successor. These notices are contained in 89 ADM-21, "Mandatory Client Notices".

4.9 Reassess All Personal Care Services Recipients with Current Authorizations at the Time of the Periodic Reassessment With the Assessment Instrument

Effective July 1, 1992, all recipients requiring periodic reassessments must be reassessed using the HARRI. The recipient must be notified of the outcome of his or her personal care services reassessment by the mandated client notices: "Notice of Decision of Initial Authorization/Reauthorization/or Denial Personal Care Services" (DSS-

4007) and "Notice of Intent to Increase, Reduce or Discontinue Personal Care Services" (DSS-4008) or their successors. These notices are contained in 89 ADM-21, "Mandatory Client Notices".

4.10 Maintain Copies of Completed Home Care Assessment Instruments

The social services districts must maintain copies of all completed HARRIs in case records of the A/Rs.

4.11 Exclusions

An A/R who receives personal care services from a long term home health care program (LTHHCP) must be assessed using the HARRI but will not be subject to the maximum hours per month limitation imposed by the new home care assessment instrument.

4.12 Exemptions

An A/R who receives personal care services from a model waiver program (The Care At Home I, II, III) authorized in accordance with Section 366(6) or (7) of the Social Services Law is exempt from the use of the HARRI.

4.13 Claiming Implications

The administrative costs for these procedures for social services districts which exceed their Administrative Caps for SFY 92-93 may be submitted as an exemption under cost containment.

5.0 SYSTEM IMPLICATIONS

5.1 Production of Lists of Recipients

The MMIS Prior Approval File has produced lists of recipients whose personal care services authorizations exceed 156 hours per month.

5.2 Establishment of a Indicator Code

A HARRI indicator code has been established to identify prior approvals for recipients whose needs have been reassessed using the HARRI or whose health and safety would be jeopardized by the reduction in services.

5.3 Reduction of Prior Approvals

On June 30, 1992, all prior approvals on the MMIS Prior Approval File for personal care services authorizations over 156 hours per month will be reduced to 156 hours per month over the remaining authorization periods, except cases that have been reapproved with a HARRI indicator code or cases whose health and safety would be jeopardized by the reduction.

5.4 Using the HARRI Indicator Code

The social services districts must use the MMIS Prior Approval File to enter a new prior approval using a HARRI indicator code.

When a reassessment is completed, the social services district must place a "Y" in the Secondary Diagnosis Code field on the DSS 2832-H. Upon data entering this form, the "Y" will be entered in the field "Assess. Ind." (Assessment Indicated). If a "Y" is not entered in this field on the data entry screen, the prior approval will be rejected when the Expiration Date is 7/1/92 or later. For prior approvals with an Expiration Date prior to 7/1/92, no indicator needs to be entered.

If the recipient's health and safety would be jeopardized, the social services district must place a "Y" in the Secondary Diagnosis Code field as described in the paragraph above.

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

ATTACHMENT 1

LIST OF APPENDICES

- APPENDIX A Contact Persons for Administrative Directive
(Available on-line)
- APPENDIX B Social Services Law 367-o, Chapter 41 of the Laws of 1992
(Not available on-line)
- APPENDIX C Regulations 18 NYCRR 505.14(b) and (g)
(Available on-line)
- APPENDIX D Home Care Assessment Instrument, "Home Assessment
Resource Review Instrument", HARRI
(Not available on-line)
- APPENDIX E HARRI Instructions
(Not available on-line)
- APPENDIX F Flowchart-Home Care Assessment Instrument Relationship to
Fiscal Assessment
(Not available on-line)
- APPENDIX G Letter to Patients who Currently Receive over 156 hours
per Month of Personal Care Services Notifying Them of
Reassessment Requirements (with instructional numbers)
(Available on-line)
- APPENDIX G-1 Letter to Patients (Prototype for Reproduction)
- APPENDIX H Notice of Reduction of Personal Care Services Under the
Medical Assistance Program for Failure to Comply with
Reassessment Requirements
(Available on-line)
- APPENDIX I Flowchart-Steps for Reassessing Cases Exceeding 156 hours
per Month
(Not available on-line)
- APPENDIX J Notice of Outcome of Personal Care Services under the
Medical Assistance Program due to Reassessment Using the
Home Care Assessment Instrument
(Available on-line)

APPENDIX A

CONTACT PERSONS

For information regarding MMIS Prior Approval File, Richard Alexander, Division of Medical Assistance, Bureau of Long Term Care by telephoning (800) 342-3715, extension 3-5653 or directly at (518) 473-5654, on-line DMA037.

For information pertaining to Home Care Assessment Instrument, Mary Jane Conroy, Division of Medical Assistance, Bureau of Long Term Care, by telephoning (800) 342-3715, extension 3-5653 or directly at (518) 473-5653, on-line 89A808.

For information pertaining to the process and notification procedures, call your Personal Care Services Field Representative, Division of Medical Assistance, Bureau of Long Term Care:

New York City, Erie, Monroe, Nassau, Suffolk and Westchester:

Marcia Anderson, by telephoning (800) 342-3715, extension 3-5490, or directly at (518) 473-5490, on-line number 0LT130.

Cayuga, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Lewis, Madison, Oneida, Onondaga, Otsego, Saratoga, Schoharie, Warren, and Washington:

Margaret Willard, by telephoning (800) 342-3715, extension 6-7480, or directly at (518) 486-7480, on-line number 0LT130.

Allegany, Cattaraugus, Chautauqua, Chemung, Genesee, Livingston, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming and Yates:

Patricia Vickery, by telephoning (800) 342-3715, extension 6-7479 or directly at (518) 486-7479, on-line number 0LT130.

Albany, Broome, Chenango, Columbia, Dutchess, Jefferson, Montgomery, Orange, Oswego, Putnam, Rensselaer, Rockland, St. Lawrence, Schenectady, Sullivan and Ulster:

Priscilla Ferry, by telephoning (800) 432-3715, extension 6-7479 or directly at (518) 486-7479, on-line number 0LT130.

APPENDIX C

Regulations 18 NYCRR 505.14(b) and (g)

June 17, 1992

Subparagraphs (iv) through (vi) of paragraph (2) of subdivision (b) of Section 505.14 are relettered subparagraphs (v) through (vii); such relettered subparagraphs are amended; and a new subparagraph (iv) is added to read as follows:

(iv) a home care assessment instrument that meets the requirements of subparagraph (3)(iv) of this subdivision;

[(iv)] (v) an assessment of the patient's [eligibility] appropriateness for hospice services and assessments of the appropriateness and cost-effectiveness of the services specified in subparagraph [(3)(iv)] (3)(v) of this subdivision;

[(v)] (vi) a fiscal assessment that meets the requirements of subparagraph [(3)(v)] (3)(vi) of this subdivision for a patient described in clause (b) of such subparagraph; and

[(vi)] (vii) such other factors as may be required by paragraph (4) of this subdivision.

Subparagraphs (iv) through (vi) of paragraph (3) of subdivision (b) of such section are relettered subparagraphs (v) through (vii) and a new subparagraph (iv) is added to read as follows:

(iv) Home care assessment instrument.

(a) For patients authorized to receive more than 156 hours of personal care services per month prior to July 1, 1992:

(1) The social services district must notify each patient, or the patient's representative, on a form required by the department that the district must reassess the patient and if the patient or the patient's representative does not cooperate with the scheduling and completion of the reassessment, and if a reduction in authorized services hours will not jeopardize the patient's health or safety, the district must reduce the patient's authorized services hours to not more than 156 hours of personal care services per month.

(2) The social services district must use the home care assessment instrument developed by the department to reassess each patient.

(b) For patients authorized to receive 156 hours, or less, of personal care services per month prior to July 1, 1992, the social services district must use the home care assessment instrument to determine whether to reauthorize personal care services.

(c) For patients initially authorized for personal care services on or after July 1, 1992, who the district reasonably expects will require personal care services for more than 60 continuous days

during the initial authorization period, the social services district must use the home care assessment instrument to determine initially whether to authorize personal care services.

(d) The social services district may include such assessment instrument in the social or nursing assessment.

(e) Exemptions:

(1) A patient who receives personal care services from a model waiver program authorized in accordance with subdivision (6) or (7) of Section 366 of the Social Services Law is exempt from the requirements of this subparagraph.

(2) A patient who receives personal care services from a long-term home health care program is exempt from any maximum hours per month limitation that would otherwise be imposed as a result of the use of the home care assessment instrument.

(f) Notice. (1) If a social services district determines to reduce the personal care services hours authorized for a patient because the patient or the patient's representative did not cooperate with the scheduling and completion of the required reassessment, the district must provide the patient with a timely and adequate notice that informs the patient of the patient's right to request a fair hearing and to have services continue unchanged until the fair hearing decision is issued (aid-continuing) in accordance with Part 358 of this Title. This timely and adequate notice must be provided on a form required by the department.

(2) If a social services district determines to deny, or reduce or discontinue the personal care services hours authorized for a patient because an assessment or reassessment indicates that personal care services are inappropriate or that the personal care services hours authorized must be reduced or discontinued, the district must provide the patient with a timely and adequate notice that informs the patient of the patient's right to request a fair hearing and to have services continue unchanged until the fair hearing decision is issued (aid-continuing) in accordance with Part 358 of this Title. This timely and adequate notice must be provided on a form required by the department.

(3) If a social services district determines to increase or leave unchanged the personal care services hours authorized for a patient because a reassessment indicates that the personal care services hours authorized must be increased or remain unchanged, the district must provide the patient with an adequate notice that informs the patient of the patient's right to request a fair hearing in accordance with Part 358 of this Title. This adequate notice must be provided on a form required by the department.

Subparagraphs (iii) through (xxi) of paragraph (3) of subdivision (g) of such section are renumbered subparagraphs (iv) through (xxii) and new subparagraph (iii) is added to read as follows:

(iii) completing the home care assessment instrument for the patient, as required by this section;

Subparagraphs (ii) through (xii) of paragraph (4) of subdivision (g) of such section are renumbered subparagraphs (iii) through (xiii) and new subparagraph (ii) is added to read as follows:

(ii) the home care assessment instrument completed for the patient, as required by this section;

Paragraphs (2) through (4) of subdivision (b) of Section 505.23 are renumbered paragraphs (3) through (5) and a new paragraph (2) is added to read as follows:

(2) As part of the comprehensive assessment or reassessment that a certified home health agency must conduct for each recipient in accordance with the regulations of the Department of Health, a certified home health agency must complete the home care assessment instrument required by this department.

(i) (a) For recipients provided with more than 156 hours of home health services per month prior to July 1, 1992:

(1) The certified home health agency must notify each recipient, or the recipient's representative, and the recipient's physician that the certified home health agency must reassess the recipient and if the recipient or the recipient's representative does

not cooperate with the scheduling and completion of the reassessment, and if a reduction in authorized services hours will not jeopardize the patient's health or safety, the certified home health agency must reduce the recipient's home health services hours to not more than 156 hours of home health services per month.

(2) The certified home health agency must use the home care assessment instrument to reassess each recipient.

(b) For recipients provided with 156 hours, or less, of home health services per month prior to July 1, 1992, the certified home health agency must use the home care assessment instrument to reassess each recipient to determine whether to continue to provide home health services to the recipient; and

(c) For recipients initially provided with home health services on or after July 1, 1992, who the agency reasonably expects will require home health services for more than 60 continuous days, the certified home health agency must use the home care assessment instrument to determine initially whether to provide home health services.

(d) Exemptions:

(1) A recipient who receives home health services from a model waiver program authorized in accordance with subdivision (6) or (7) of Section 366 of the Social Services Law is exempt from the requirements of this paragraph.

(2) A recipient who receives home health services from a long-term home health care program is exempt from any maximum hours

per month limitation that would otherwise be imposed as a result of the use of the home care assessment instrument.

Paragraph (3) of subdivision (j) of such section is repealed and a new paragraph (3) is added to read as follows:

(3) The department may monitor and audit certified home health agencies' compliance with the home care assessment instrument procedure, notice requirements and fiscal assessment procedure set forth in this section. When the department has determined that any certified home health agency has submitted claims for home health services provided to recipients for whom home care assessment instruments or fiscal assessments are required, but the agency has failed to use the home care assessment instrument, has failed to provide the notices required by this section, or has failed to conduct fiscal assessments, the department may require repayment of the full amount expended for home health services provided on and after the 60th day of services.

NEW YORK STATE DEPARTMENT OF HEALTH
NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

Home Assessment Resource Review Instrument
(HARRI)
Instructions

1. Patient's Name. Enter the patient's last name, then first name.
2. Social Security Number. Enter the patient's Social Security Number.
3. Medicaid Client ID Number (CIN). Enter the patient's Medicaid identification number. If the patient is not currently Medicaid eligible, enter zeros. Do not leave item blank.
4. Assessor's Name. Enter your last name, then first name and your title at the agency/facility where you are employed.
5. Enter the name of the agency/facility where you are employed.
6. Enter date of the assessment.

INSTRUCTIONS FOR SECTION I:
HOME CARE APPROPRIATENESS DETERMINATION

This section may be completed by the social services district, the CASA, the CHHA, or the discharge planner.

Determine whether the person should be referred to home care and the most appropriate home care program by completing Page 1 as follows:

1. Health and Safety Determination

Determine whether the person is appropriate for home care by checking any or all of the patient's characteristics which apply. These characteristics are defined as follows:

A self-directing patient is one who is capable of making choices about his/her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice, OR has informal supports willing and able and available to provide direction on behalf of the patient.

A patient who is able to summon help is an individual who is physically, mentally and cognitively capable of initiating effective communication to individuals outside the immediate presence of the patient, regardless of the present availability of a phone or PERS.

A patient who can be left alone is an individual who, based on his/her

physical, mental and cognitive capability does not require the continuous presence of another individual to meet his/her minimal ongoing health and safety requirements.

Informal supports refer to friends, relatives or associates of the patient, or other community resources unaffiliated with the agency, who are able, available and willing to provide needed care, support and other services to the patient during the periods agency staff are not present.

Able, Available and Willing to give direction or provide needed care is defined as follows:

- Able: Has sufficient intellect to provide direction and has a general sense of the patient's needs and desires.
- Available: Can be easily contacted and will promptly respond. Will periodically be present in patient's home to ascertain whether care provided is consistent with patient's needs and desires.
- Willing: Communicates agreement and intention to oversee caregiving and to make decisions for patient; AND accepts responsibility by choice and without reluctance; AND has customarily provided direction and participated in decisions for the patient in the past, if needed.

If ALL characteristics apply and are checked:

- o if patient is currently receiving home care services, refer for PRI completion and proceed to question 4.
- o the patient is not appropriate for home care and should be referred for a PRI/SCREEN for possible facility placement.

If NONE or SOME characteristics apply and are checked:

- o if patient is awaiting discharge from a facility, proceed to question 2.
- o if patient is currently receiving home care or residing at home proceed to question 4.

2&3. Residence Determination

Determine whether the person has a home or a reasonable expectation of obtaining a home in the near future; or can be placed in an Adult Care Facility (ACF) in order to receive home care services. It should be noted that the Assisted Living Program is included as a residential/home care choice, but is not yet available in the State.

4. Home Care Program Determination

Review the program eligibility description provided and enter on the line provided the letter which corresponds to the program which appears to be most appropriate for the person. Although the program choices may not be mutually exclusive, SELECT THE ONE THAT BEST APPLIES ACCORDING TO THE FOLLOWING CRITERIA:

A. Personal Care/Home Attendant Only

- o patient is self-directing, or has informal supports able, willing and available to direct care;
- o patient has a stable medical condition, that is, there is no recent history of threatening changes in health status;
- o patient needs some or total assistance with at least one paraprofessional health-related task (e.g. assistance with medications or simple dressing changes); one activity of daily living (ADL) (e.g. bathing, eating, dressing, toileting and transferring); or one instrumental activities of daily living (IADL); (e.g. transportation, shopping, laundry, meal preparation);
- o patient does not require skilled nursing or therapy.

B. Personal Care/Home Attendant Combined with Home Health Aide (HHA)

For MA recipients only, the criteria for the PCA program are met and:

- patient requires at least one HHA level, health-related tasks; and
- patient requires four (4) or more hours of paraprofessional care per day.

C. Home Health Aide Services

For Medicare beneficiaries only, all the criteria for the PCA program are met except the patient requires nursing care and the Medicare eligibility criteria found in Chapter 11 of the Home Health Agency Manual (HCFA Transmittal 222) are met. These criteria include, but are not limited to, the following:

- the patient is confined to the home;
- services are provided under a physician's plan of care;
- skilled nursing is required on a part-time, intermittent basis, which could include the following:

- o observation and assessment of patient's condition when only the specialized skills of a medical professional can determine a patient's status;
- o management and evaluation of a patient care plan
- o teaching and training activities; or
- o administration of medications or other treatments.

For Medicaid patients only, the criteria for the PCA program are met, except:

- patient does not have a stable medical condition;
- patient requires four or fewer hours of aide-level care per day.

D. Long Term Home Health Care Program

- patient is medically eligible for a residential health care facility (RHCF);
- the annual cost of care is not expected to exceed 75 percent of the annual cost of RHCF care;
- the patient requires coordination of a complex care plan of skilled and paraprofessional services for at least 120 days, OR requires at least one skilled service and at least one waived service. Waivered services include:
 - o Home Maintenance Tasks
 - o Housing Improvement
 - o Social Transportation (non-medical)
 - o Congregate/Home Delivered Meals
 - o Respite Care
 - o Social Day Care
 - o Personal Emergency Response System (PERS)
 - o Moving Assistance
 - o Medical Social Services
 - o Respiratory Therapy
 - o Nutritional Counseling/Educational Services

E. AIDS Home Care Program

The patient meets the criteria of eligibility to the LTHHCP, except:

- patient has AIDS or an HIV-related illness;
- the annualized cost of care could exceed 75 percent of the cost of RHCF care;

F. Certified Home Health Agency Services

- patient requires at least one skilled treatment or intervention which must be provided by a skilled nurse or therapist; or requires skilled care in combination with paraprofessional services;
- patient requires part-time, intermittent care;
- patient is expected to be discharged from the agency within 120 days;
- for a patient medically eligible for the LTHHCP, the annualized cost of care exceeds 75 percent of the RHCFC cost.

G. Certified Home Health Agency Services and Personal Care/Home Attendant Services

For Medicaid clients only, the criteria for CHHA services are met and:

- the patient requires four or more hours of paraprofessional care a day some or all of which may be performed by a personal care aide.

H. Private Duty Nursing

- A nursing assessment and written documentation is completed by a CHHA indicating that the patient requires continuous skilled LPN or RN nursing care which cannot be provided by the CHHA or intermittent nursing care is currently not available from the CHHA.

Exceptions:

As an alternative to the above programs, the following programs should be considered if available in the community:

I. Patient Managed Home Care Program

- Patient has a physical disability and requires paraprofessional services and is willing, able and chooses to direct his/her own care.

J. Care at Home Program

- A child who because of physical disability or illness would otherwise require institutional care if home care services were not available, and who qualifies for MA regardless of parental income.

K. Hospice

- The patient is terminally ill and has a life expectancy of six months or less;
- The patient desires palliative care rather than curative care.

5. If the person has actually been referred or admitted to a home care program which is different from the program determination made in question 4, indicate to which program the patient has actually been referred or admitted. Briefly explain why the HARRI program determination and the person's program referral or admission are different. For example, the program determined by the HARRI may not be available in the community in which the patient resides.

INSTRUCTIONS FOR SECTION II:

DETERMINATION OF PARAPROFESSIONAL ACTIVITIES/HOURS

This section may be completed by the social services district, the CASA, the CHHA or the discharge planner.

Section II of the Home Assessment Resource Review Instrument (HARRI) is used to determine the activities which must be performed by the paraprofessional workers and the number of hours in a week required to complete these activities for each patient. The assessor will be required to identify whether the patient requires assistance with each activity listed, the level of assistance required, and the amount of assistance to be provided by informal supports.

A. Level of Assistance

The number of hours per week of paraprofessional services required to complete each activity is based on the type and amount of assistance needed by the patient. The level of assistance for each activity is generally described as follows:

- o The patient is independent or independent with an assistive device, or regardless of the patient's level of independence, informal supports are able, available, and willing to provide the activity all of the time. This level of assistance always requires zero (0) hours of paraprofessional care.
- o The patient requires another individual to assist with or supervise, part of, but not the entire activity.
- o The patient requires another individual to assist with, supervise, or provide the entire activity.

In addition, the level of assistance for some activities are further operationally defined in the HARRI.

B. Paraprofessional Activities

The activities to be assessed are listed on the instrument. You will note that the activities are separated into two categories:

1. Activities which require a span of time to complete:

The instrument lists five paraprofessional activities which must be provided intermittently throughout the day over a span of time. The time needed to actually complete the activity and the span of time are not the same. These activities include:

a. Eating and Drinking is defined as:

the process of getting food and fluids, by any means, from a receptacle into the body (including a gastrostomy tube). It is assumed that a person requires food and fluids throughout the day, but may go for one 12-hour period in a 24-hour period without food or fluids unless medically contraindicated. Therefore, assistance with eating or drinking generally spans a 12-hour period of time with some exceptions, as noted on the HARRI.

b. Bladder toileting is defined as:

the process of getting to and from a toilet or commode, getting on and off a toilet or commode, cleaning self after toileting and adjusting clothing. It is assumed that a person needs toileting every four hours throughout a 24-hour period of time. Therefore, assistance with bladder toileting spans a 24-hour period of time.

c. Turning and Positioning is defined as:

the process of moving in bed from side to back or shifting body weight to relieve pressure, prevent skin breakdown, or prevent respiratory complications. It is assumed that some persons with a stable medical condition and no known medical history of recurrent skin breakdown or respiratory complication may go for one eight-hour period in a 24-hour period without being turned or positioned if pressure relieving equipment is also used. Such persons are usually not bedfast. Therefore, for such persons, assistance with turning and positioning would span a 16-hour period of time.

It is further assumed that a person who needs assistance with turning and positioning and is not at high risk for skin breakdown, and has an alternation pressure relieving device, requires turning and positioning every four hours throughout a 24-hour period. Therefore, this activity would span a 24-hour period of time.

Persons at high risk for skin breakdown or respiratory complications must be turned at least every two hours and automatically require 24-hours of paraprofessional care.

d. Mobility is defined as:

the process of ambulating or wheeling in the home. It is assumed that a person should not be left in one place for more than 12 hours in 24-hour period. Therefore, assistance with this activity spans a 12-hour period of time.

e. Transfer is defined as:

the process of moving between positions, to and from bed, chair and standing (exclude transfers to and from bath and toilet). It is assumed that a person should not be left in one place for more than 12 hours in a 24-hour period. Therefore, this activity spans a 12-hour period of time.

2. Personal care activities or health related activities:

These activities require a discrete amount of time and may be required to be completed at a specific time of day, but are not necessarily completed within a specific span of time. Personal care activities include ADLs (e.g. bathing, grooming, dressing and bowel toileting) and IADLs (e.g. meal preparation, cleaning, laundry and shopping/errands). Health related activities include paraprofessional assistance with simple procedures and treatments (e.g. assistance with medication, simple dressing changes, range of motion, application of hot and cold compresses, assistance with ostomy care, taking vital signs and preparing complex diets).

This section of activities also includes accompanying the patient to medical appointments, if necessary and applicable.

C. Estimating Maximum and Actual Hours of Care Per Week

Each activity requires the assessor to determine the maximum hours and actual hours of assistance per week needed by the patient to complete the activity.

"Maximum hours" (MH) is defined as the upper limit of paraprofessional hour per week which may be required by the patient in order to complete each activity. Each activity has been assigned one or more maximum hour allocations based on level of assistance required by the patient.

"Informal Supports" (IF) is defined as family members, friends, and community supports able, available and willing to provide assistance to the patient.

"Actual Hours" (AH) is defined as the number of paraprofessional hours per week of assistance required by the patient. Actual hours is

calculated by subtracting the hours of assistance provided by informal supports from the Maximum Hours of assistance attributed to each activity. (AH= MH-IF)

- o Instructions for computing the maximum hours and actual hours of care are as follows:

1. Eating and Drinking

- Zero (0) hours of care per week are needed if the patient is independent with or without adaptive devices or equipment OR regardless of level of independence, assistance with the activity is provided by informal supports all of the time. Generally, the patient is able to feed self without supervision or physical assistance but requires an assistive device such as padded utensils, suction plate or cup, or spill-proof cup.
- Seven (7) hours of care per week are needed if the patient requires intermittent encouragement or guidance or minimal physical assistance with some parts of eating, such as cutting food or opening milk carton.
- Twenty-one (21) hours of care per week are needed if the patient is totally fed by hand or needs continual cuing or physical assistance with eating; or needs gastrostomy tube feedings.

Based on the patient's medical condition and care needs, an additional 2-4 hours of care per week may be added to the maximum hours allowed, if the patient cannot go 12 hours without food or fluids. Persons who may require more frequent food or fluids include persons at high risk for urinary tract infections, persons whose dietary needs or medical conditions requires small frequent meals, such as persons with AIDS, gastric ulcers, and other gastrointestinal disorders.

2. Toileting: Bladder

- Zero (0) hours of care are needed if the patient is independent with or without an adaptive device OR assistance with bladder toileting is provided by informal supports all the time. Generally, the patient requires no supervision or physical assistance and may use a bedpan, commode, fracture pan, urinal, raised toilet seat, grab bar; or has an indwelling bladder catheter, external catheter, cystostomy, urostomy, or ureterostomy.
- Three and one half (3.5) hours of care are needed if the patient is continent of urine and requires intermittent

supervision or minimal physical assistance with some parts of toileting; or uses adaptive equipment.

- Ten and one half (10.5) hours of care are needed if the patient is continent of urine, but requires constant supervision or physical assistance with most or all parts of toileting; including the use of adaptive equipment; OR is incontinent of urine and is not toileted and requires changing of clothes and/or protective padding/incontinence pads or is toileted every four hours.

3. Turning and Positioning

- Zero (0) hours of care are needed if the person is independent with or without adaptive equipment such as a trapeze or side rails OR assistance is provided by informal supports all of the time.
- Nine (9) hours of care are required if the person needs assistance to move about in bed, is not high risk for skin breakdown or respiratory complications; is known to be medically stable with no known history of recurrent skin breakdown or respiratory complications and uses an alternation air pressure mattress, or other pressure relief device. This assumes the patient needs to be turned or positioned every four hours but the person is not bedfast and may go for one eight hour period without being turned or re-positioned.
- Twenty-one (21) hours of care are required if the patient requires total assistance to move about in bed, is not at high risk for skin breakdown or respiratory complications and may use an alternation air pressure mattress or other pressure relief device. This assumes the person needs assistance with turning and positioning every four hours.
- Zero (0) hours of care are accrued at this point if the person requires total assistance to move in bed and is at high risk for skin breakdown or respiratory complications. Persons meeting this criteria will accrue hours in the override section of HARRI.

4. Mobility

- Zero (0) hours of care are needed if the patient is independent with or without adaptive equipment OR assistance is provided all of the time by informal supports. Generally, the patient walks or wheels with no supervision or human assistance or may require an assistive device such as a walker, cane, crutches or wheelchair.
- Three and a half (3.5) hours of care are required if the person walks with physical assistance or supervision OR is

wheeled by someone else to move about. It is assumed that regardless of the level of assistance the paraprofessional is continually present throughout the activity.

5. Transfer:

- Zero(0) hours are required if the patient transfers with or without adaptive equipment such as a slide board or grab bar; OR assistance is provided by informal supports all the time.
 - Three and a half(3.5) hours are required if the patient requires intermittent or constant supervision or assistance with the transfer. It is assumed that regardless of the level of assistance the paraprofessional is continually present throughout the activity.
 - Five (5) hours are required if the patient requires total assistance with the use of lifting equipment to transfer.
- o Identify the level of assistance required by the patient for each activity, and enter the appropriate number of hours in the maximum hours (MH) column to the left of the activity. If the patient does not require any assistance from a paraprofessional, this number will always be zero. For example, if the patient requires some assistance in eating and drinking you would enter 7 in column MH. Column MH represents the maximum paraprofessional hours/week possibly needed to assist with this activity.
 - o Consider the availability of informal supports (e.g. family members, friends, and other community organizations) to assist the patient with each activity and enter the number of hours the informal supports will be able to assist in column IF. For example, if family members are available seven-days-a-week to assist the patient with breakfast, you might estimate two hours of care will be provided by supports and enter "2" into column IF.
 - o For each activity subtract the number of hours of care which will be provided by informal supports (column IF) from the maximum number of hours/week required to complete the activity (column MH) in order to determine the actual number of paraprofessional hours of care required by the patient (AH). Enter the actual number of hours into column AH. For example, if the patient requires seven hours of care per week for assistance with eating and drinking and family members are providing two of these seven hours per week then the actual number of paraprofessional hours of care required would be seven minus two or five hours.
 - o After completing this process for each of the activities which span a period of time, subtotal AH on page 4. This subtotal indicates the number of paraprofessional hours per week required by the patient to assist with these activities which span a period of time.

- o Based on the care activities required by the patient, identify the highest span of time needed to complete the activities and enter it on the span of time line. Your answer will be either a 12, 16 or 24-hour span of time for each patient. Entering the span of time reminds the assessor that despite the actual number of hours of care required, the hours of care must be provided or spread over a daily span of time. Span of time does not change the number of actual hours of care needed or authorized. The home care agency is responsible for assuring that the service is delivered over the span of time necessary to meet the patient's needs.

2. Personal Care and Health Related Activities

Determine the maximum hours/week required by the patient to complete the personal care and health related activities (column MH) the number of hours which will be covered by informal supports (column IF); and the actual number of hours required by the patient (column AH). You will note that for each task there are three levels of assistance.

No assistance or zero hours of assistance means that the patient does not require paraprofessional assistance with the activity or assistance is provided by informal supports all of the time.

Partial assistance means another individual is required to assist with or supervise, part of, but not the entire activity.

Total assistance means another individual is required to assist with, supervise or provide the entire activity.

- o When determining the maximum number of hours/week needed by the patient to complete the required health-related activity, the HARRI does not ask you to identify the level of worker needed to complete the task. This decision has already been made by the assessor, in the Home Care Program Determination (Section I). Patients requiring paraprofessional assistance with 1-3 different health related tasks weekly may receive from three to six hours per week depending on the level of assistance needed. These tasks may be provided less frequently than daily, daily and/or several times a day and include such activities as monitoring vital signs, assistance with medications, special skin care, or range of motion exercise. If the patient requires four or more health related tasks, you will note the number of hours required to assist with the health related tasks is increased.
- o Enter the maximum number of hours required to complete the health related tasks in column MH, the number of hours which will be provided by informal supports in column IF, and the

actual number of hours of paraprofessional care required in column AH.

- o On page 4, total column AH for the personal care and health related activities. Then total column AH for all activities (span of time activities, personal care and health related activities) to come to a total actual hours per week.

3. Override Activity

Override activities are those patient circumstances which may necessitate a maximum hour allocation of 24 hours of care, regardless of the actual number of hours of personal and health related care required by the patient. In order to be eligible for the 24 hour override, the patient must :

- be unable to recognize an emergency or urgent situation and subsequently summon help, OR is able to recognize an emergent situation ,BUT the PERS is not available in the patient's community; and/or
- exhibit behavior which creates an actual danger for himself/herself or others. Such behaviors include but are not limited to: self inflicted physical injuries, wandering which leads to being lost or injured; behaviors which lead to fire; behaviors which lead to asphyxiation; and/or
- require turning and positioning every two hours and be high risk for skin breakdown or respiratory complications. High risk includes but is not limited to:
 - o present or history of decubitus ulcer, stage 1,2,3 or 4;
 - o less than normal body weight (-10%);
 - o greater than normal body weight (+10%);
 - o diagnosed iron deficiency anemia;
 - o diagnosed negative nitrogen balance;
 - o diagnosed respiratory disease;
 - o vascular or venous stasis ulcer;
 - o terminal disease
- If any of the above criteria are met, consider whether the patient's safety supervision and care needs can be met by a live-in aide or continuous aide services. Enter the local billable hours for live-in aides in your social services district or 168 hours in column MH, as appropriate. Subtract the number of hours which may be covered by informal supports (column IF) and indicate the actual hours of care per week required by the patient in column AH.
- The actual hours of care per week which may be authorized for the patient is the total score in column AH or the override hours in column AH whichever is greater.

INSTRUCTIONS FOR ADJUSTING THE HOURS AUTHORIZATION

Based on consideration of additional efficiencies as required by Chapter 165 of the Laws of 1991, this section adjusts the actual hours per week which may be authorized.

- o Enter the actual hours of care which may be authorized for the patient on Line A which is the total actual hours in Column AH or the override score in column AH, whichever is greater.
- o Consider the additional efficiencies or economies which could reduce the actual number of hours required per week. At a minimum, the efficiencies which must be considered, include but are not limited to: PERS, patient managed home care, shared aide, enriched housing, assisted living program, specialized medical equipment and adult day care program. In addition, the maximum hours allocation may be lowered by the assessor based on patient specific circumstances and the assessors professional judgement, provided such action can be supported by relevant and appropriate documentation. Estimate the number of hours which, as a result of the efficiencies could be subtracted from the actual hours and enter this estimate on line B.
- o Subtract line B from Line A to determine the patient's adjusted authorized hours and enter the adjusted hours on Line C.
- o Line C represents the number of paraprofessional hours of home care per week which will be paid for by the Medical Assistance program.

APPENDIX F

Home Care Assessment Instrument Relationship to Fiscal Assessment

```
+-----+
|Social Services|
|District Receives|
|Request for Personal|
|Care Services|
+-----+
```

```
+-----+
|Nursing & Social &|
|Home Care Assessment|
|Instrument Including|
|Review of Efficiencies|
|Completed|
+-----+
```

Are
Personal Care
Services Medically
Necessary?

No

```
+-----+
|Personal Care|
|Services Denied|
|Refer to|
|Appropriate|
|Services|
+-----+
```

Yes

Can
Health &
Safety be
Maintained?

No

```
+-----+
|Personal Care|
|Services Denied|
|Refer to|
|Appropriate|
|Services|
+-----+
```

Yes

```
+-----+
|Care Plan Developed|
+-----+
```

Are
Care Needs
Likely to
Exceed 60 Days?

No

```
+-----+
|Personal Care|
|Services|
|Provided in the|
|Usual Manner|
+-----+
```

Yes

```
+-----+
|Local District|
|Conducts Fiscal|
|Assessment|
+-----+
```

Costs Exceed 90% of RHCFCosts?	No	+-----+ Personal Care Services Provided in the Usual Manner +-----+
Yes		
+-----+ Social Services District Reviews Case Against Exception Criteria +-----+		
Case Meets at Least One Exception Criteria?	No	+-----+ Social Services District Makes Referrals to Other Appropriate Care. District Provides Personal Care Services in the Interim for Current Recipients of Personal Care Services Pending Availability of Other Appropriate Care. +-----+
Yes		
+-----+ Personal Care Services Provided in the Usual Manner +-----+		+-----+ No Personal Care Services are provided on an Interim Basis for Initial Applicants +-----+

Dear Home Care Recipient:

A new State law, Social Services Law Section 367-o requires that all Medical Assistance recipients currently authorized to receive over 156 hours a month, which is equivalent to an average of 36 hours per week, of Personal Care Services/Home Attendant Services have their need for home care services reassessed using a new State required assessment instrument.

You will be contacted by your caseworker/provider agency representative to schedule a reassessment visit. You will receive a separate notice advising you of the outcome of the reassessment. A new physician's order for Personal Care Services/Home Attendant Services is not needed at this time unless your regularly scheduled reauthorization for services falls within the next 30 days.

If you fail to cooperate with the scheduling and completion of the home care reassessment, your Personal Care Services/Home Attendant Services may automatically be reduced to 156 hours a month, which is equivalent to 36 hours of week, on July 1, 1992.

If you have any questions about the reassessment, please call your caseworker/agency representative at _____.

Sincerely,

Commissioner
_____ Department of
Social Services

APPENDIX G

(No.1) (Social Services District Letterhead)

Name of Home Care Recipient(No.2)

Recipient Address

(Date) (No.3)

Dear Home Care Recipient:

A new State law, Social Services Law Section 367-o requires that all Medical Assistance recipients currently authorized to receive over 156 hours a month, which is equivalent to an average of 36 hours per week, of Personal Care Services/Home Attendant Services have their need for home care services reassessed using a new State required assessment instrument.

You will be contacted by your caseworker/provider agency representative to schedule a reassessment visit. You will receive a separate notice advising you of the outcome of the reassessment. A new physician's order for Personal Care Services/Home Attendant Services is not needed at this time unless your regularly scheduled reauthorization for services falls within the next 30 days.

If you fail to cooperate with the scheduling and completion of the home care reassessment, your Personal Care Services/Home Attendant Services may automatically be reduced to 156 hours a month, which is equivalent to an average of 36 hours per week, on July 1, 1992.

If you have any questions about the reassessment, please call your caseworker/agency representative at _(No.4)____(phone number)_____.

Sincerely,

Commissioner (No.5)

Department of
Social Services (No.6)

Complete Reassessment During Home Visit	Continue Current Authorization Pending Use of Assessment Instrument
---	---

Will Authorization Continue as Presently Authorized?

No

Authorization is:
Increased, Reduced,
Discontinued. Send
(APPENDIX J) Notice
of Outcome

Yes

Continue PCS Authorization at Same Level Send (APPENDIX J) Notice of Outcome	Reassess at the end of Authorization Period Using Assessment Instrument Use of DSS-4007 or DSS-4008 to Notify Recipient
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