

SOCIAL SERVICES

APPENDIX A

Home Health Aide Services      Personal Care Services      Homemaker Services      Housekeeper/Chore Services

FUNCTIONS OF THE SERVICE

Health Care	X			
Personal Care	X	X	X	
Household Tasks	X	X	X	X
Teaching Home Management		X	X	
Mother Substitute			X	

PROGRAM REQUIREMENTS

Assessment - Nursing - Home Health Agency	X	X		X
Assessment - Social - D.S.S.	X	X	X	
Supervision-Registered Nurse-Home Health Agency	X	X		
Supervision-Registered Nurse-D.S.S.		X		X
Supervision - Services Staff - D.S.S.	X	X*	X	
Trained Personnel Required	X	X		
Doctor's Prescription Required	X	X		
Plan of Treatment Required	X	X		
D.S.S. Responsibility for Case Management-Plan of Service	X	X	X	X

PROVIDER

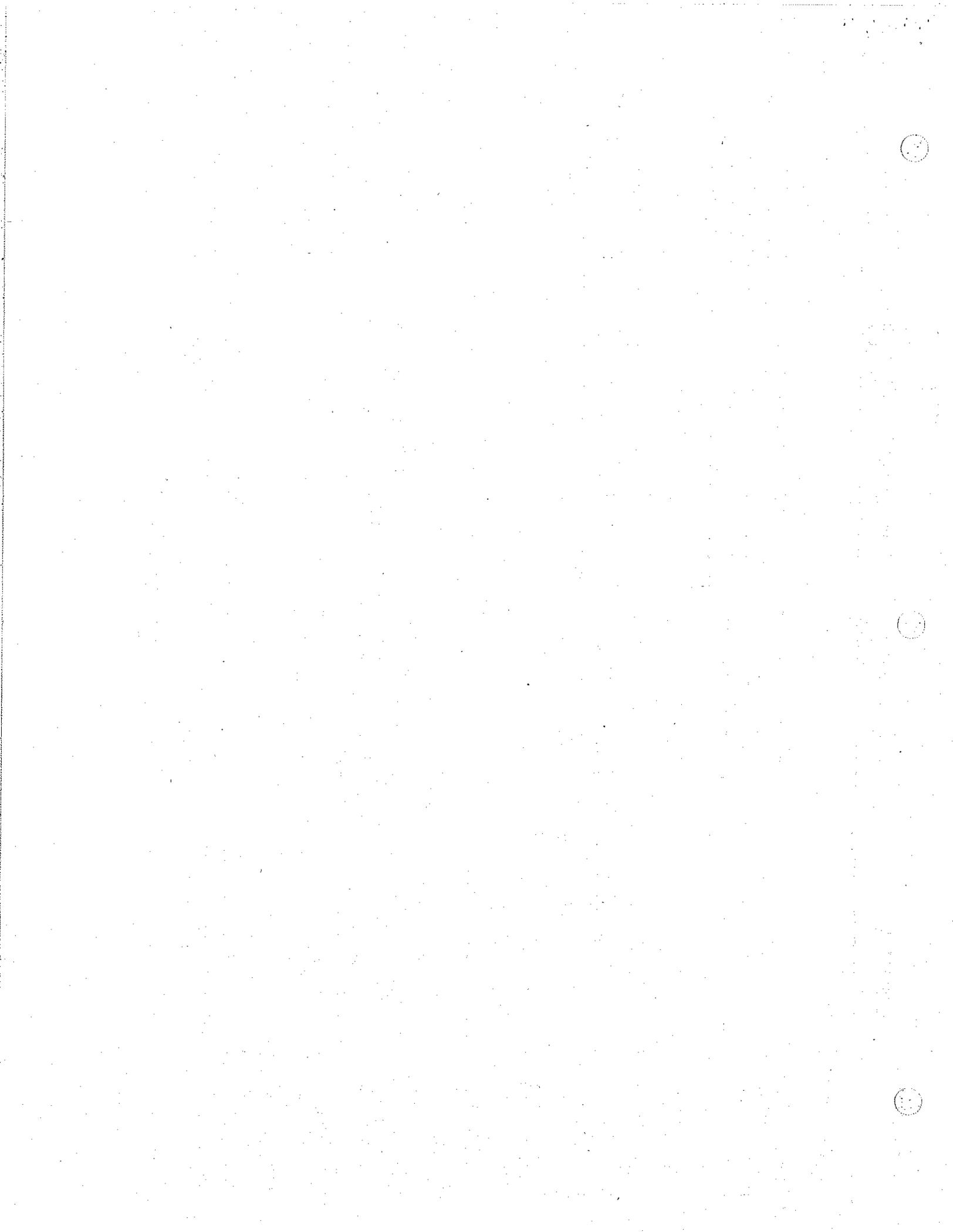
Certified Home Health Agency	X	X		X
Long Term Home Health Care Program	X	X	X	X
D.S.S. Staff		X	X	X
Voluntary Homemaker Agency		X	X	X
Proprietary Homemaker Agency		X**		X
Individual - Unaffiliated Providers		X*		X

METHOD OF CLAIMING

Title XVIII (Medicare)	X			
Title XIX (Medicaid)	X	X		
Title XX (Services)			X	X

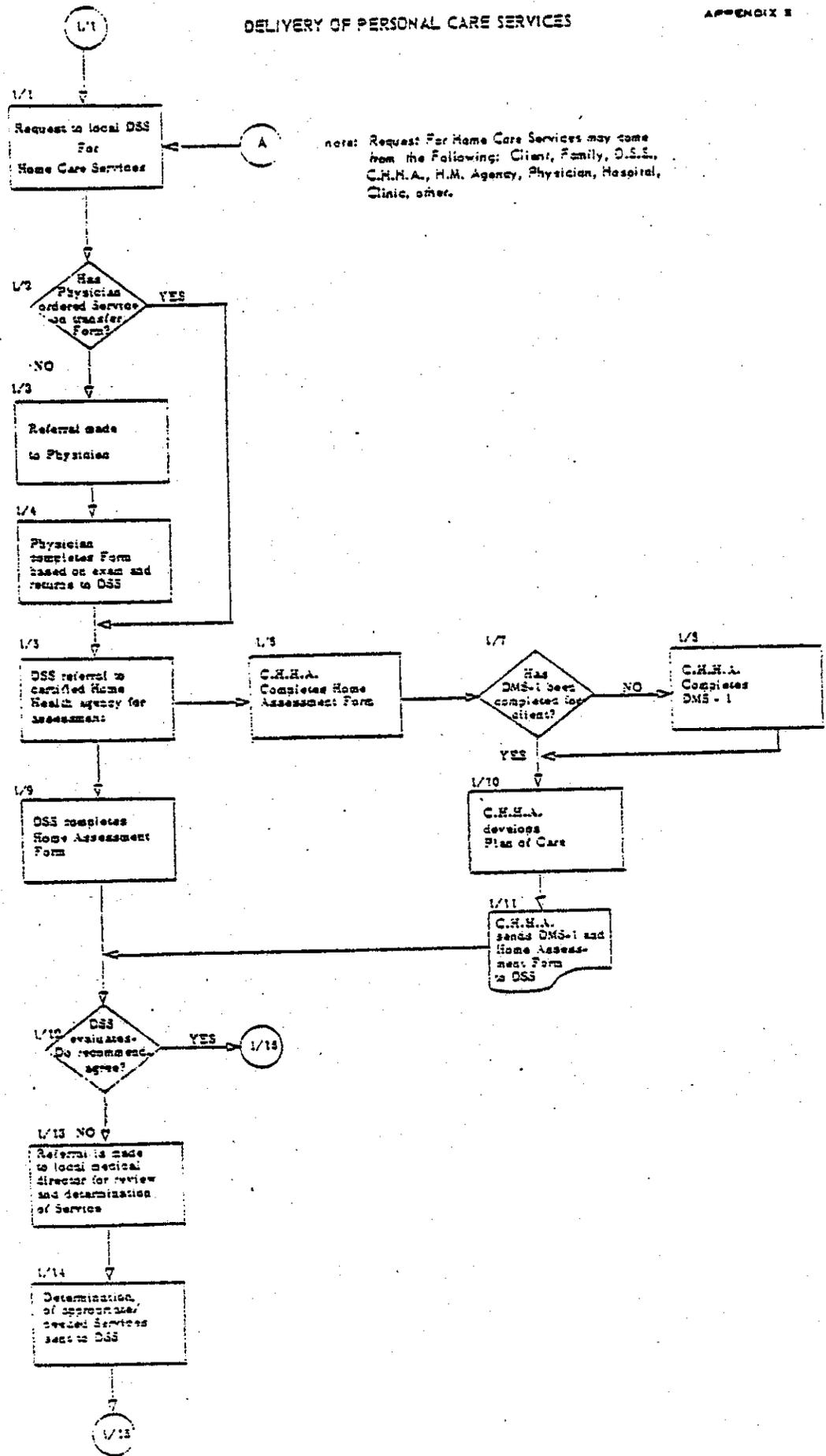
\*When only household tasks are prescribed, untrained, unaffiliated persons may be used.

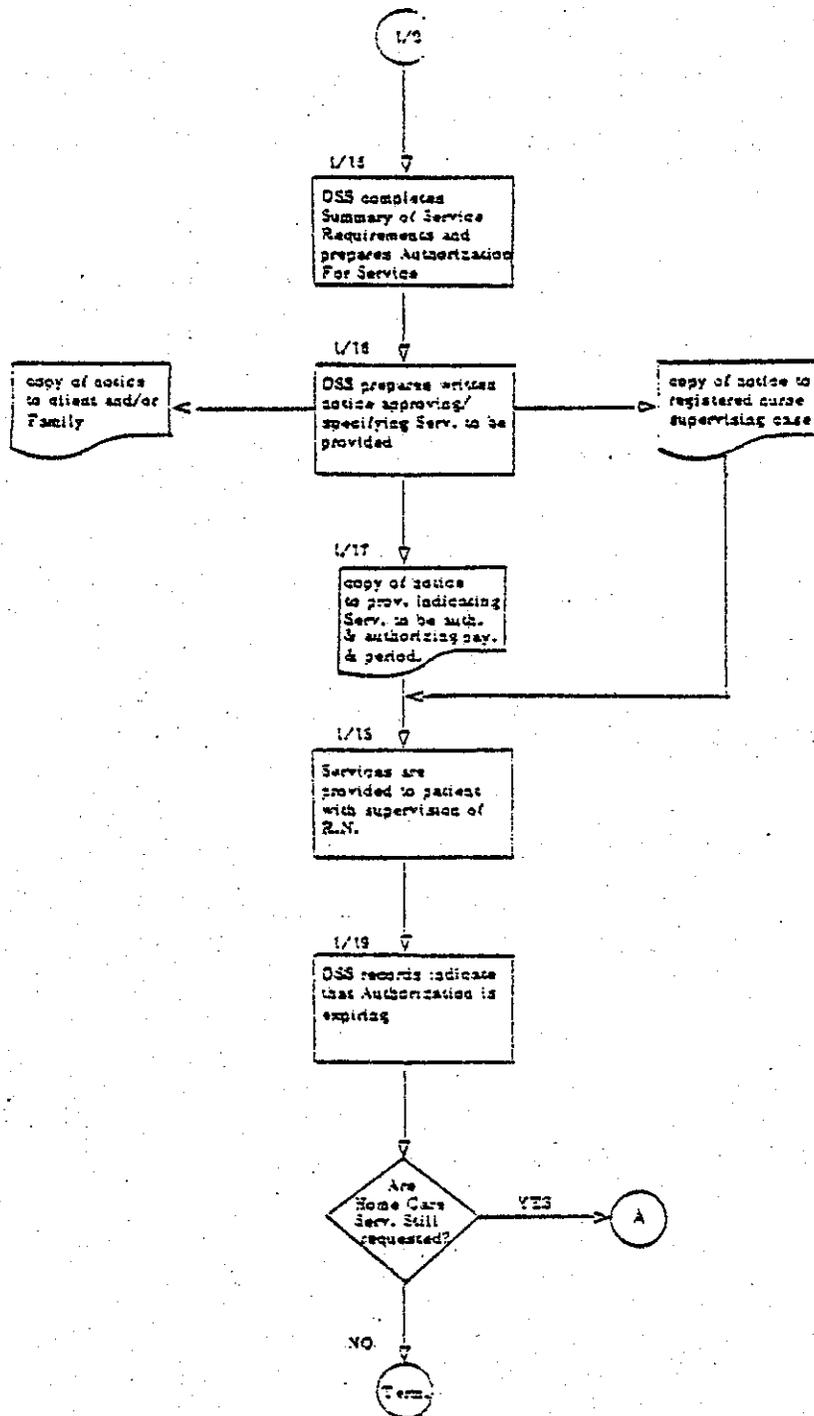
\*\*Only with prior approval of the New York State D.S.S.



# DELIVERY OF PERSONAL CARE SERVICES

APPENDIX B





10/79

NEW YORK STATE DEPARTMENT OF HEALTH-OFFICE OF HEALTH SYSTEMS MANAGEMENT

Appendix C

Transfer Form/Physician Orders

Service Request to: Name	Date of Request: <input checked="" type="checkbox"/> Long Term Home Health Care Program
Address	Tel. No. <input checked="" type="checkbox"/> Home Health Care Services Social Services District

Name of Patient	Date of Birth	Sex	Social Security No.
Patient's Home Address	Tel. No.		Medicare A No.
For Home Services Visit at (address)	Tel. No.		Medicare B No.
Care of (name)			Medicaid No.
Transfer From: Address:	Plan Relates to Condition For Which Patient Institutionalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		Other (specify)
Hospital/RHCF Admission Date	Hospital/RHCF Discharge Date	Case No.	
Contact Person of Referring Agency - Name and Title			Tel. No.
Name and Address of M.D. to Render Care			License No. /STATE

Diagnosis (include surgery and dates) Primary	Code
Secondary	Code

Physicians Certification of Need and Frequency	Physicians Orders - Medications, Diet, Treatments, Equipment and Supplies, Activities, Instructions	
Nursing <input checked="" type="checkbox"/> / x/week or month		
Home Health Aide <input checked="" type="checkbox"/> / x/week or month		
Physical Therapy <input checked="" type="checkbox"/> / x/week or month		
Occupational Therapy <input checked="" type="checkbox"/> / x/week or month		
Speech Pathology <input checked="" type="checkbox"/> / x/week or month		
Medical Social Svs. <input checked="" type="checkbox"/> / x/week or month		
Personal Care <input checked="" type="checkbox"/> / x/week or month		
Other (specify)	Prognosis	Therapeutic Goal(s)
	Is patient essentially homebound? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Estimate of Patients Need for Home Health svcs. ___ wks ___ mos
	M.D. Signature	
	M.D. Name	License No. /STATE

Professional Assessment and Recommendations (functional limitations, psycho-social status, allergies, etc.)

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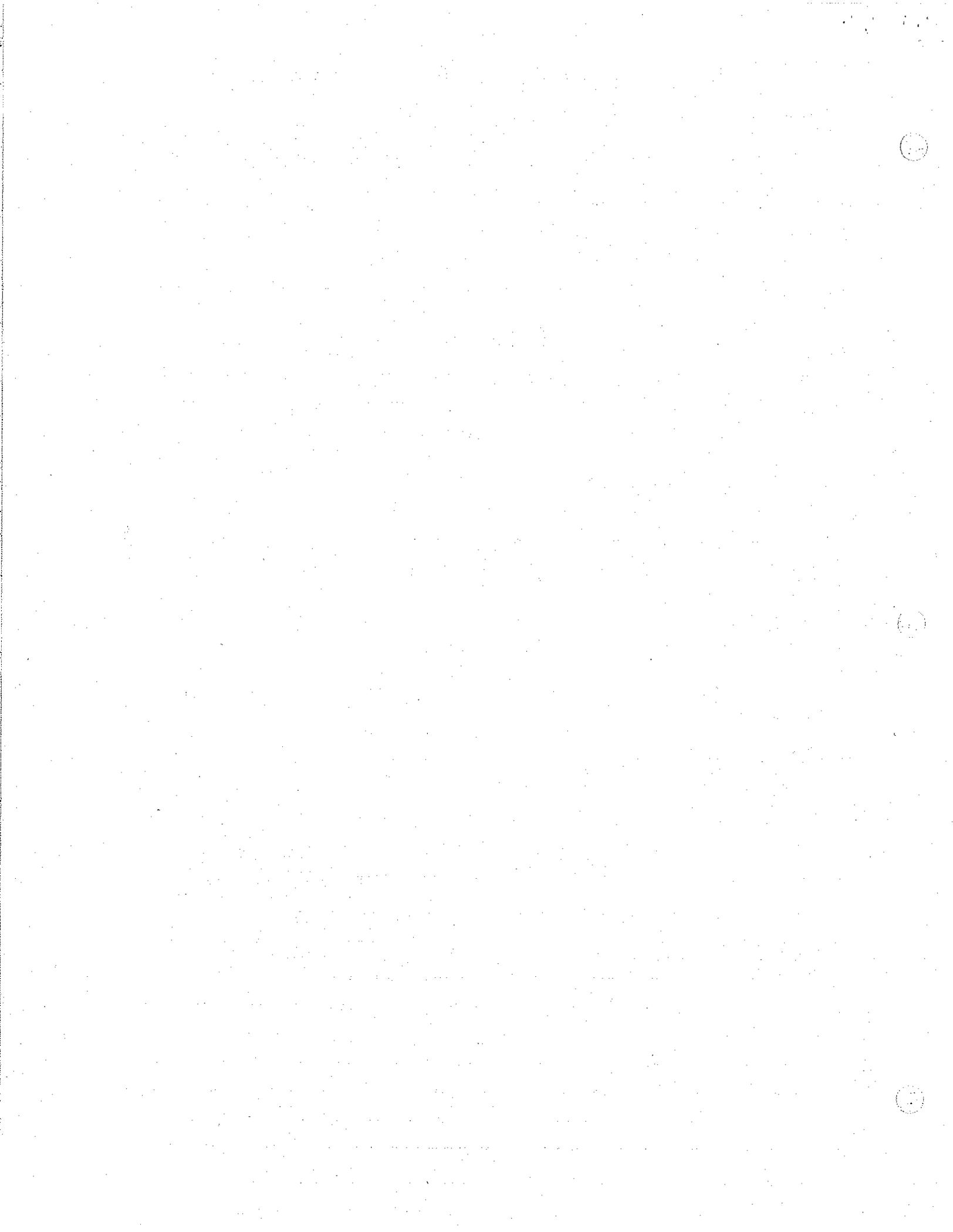


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Signature	Title
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APPENDIX D

DSS 3139-1 (3/79)

OFFICE OF HEALTH SYSTEMS MANAGEMENT  
Instructions  
Home Assessment Abstract

Purpose:

The purpose of the Home Assessment Abstract is to assist in the determination of whether a patient's home environment is the appropriate setting for the patient to receive health and related services. This form is designed to provide a standardized method for all certified home health agencies and social services districts to determine the following questions essential to the delivery of home care services:

1. Is the home the appropriate environment for this patient's needs?
2. What is the functional ability of this patient?
3. What services are necessary to maintain this patient within this home setting?

General Information:

The assessment form includes an outline for the planning for the development of a comprehensive listing of services which the patient requires.

It is required that a common assessment procedure be used for the Long Term Home Health Care Program (LTHHCP), Home Health Aide Services and Personal Care Services. This procedure will apply to both initial assessments and reassessments. The Home Assessment Abstract must be used in conjunction with the physician's orders and the DMS-1 or its successor.

The assessment procedure will differ only in the frequency with which assessments are required. Assessments must be completed at the initial onset of care. Reassessments are required every 120 days for the LTHHCP and Home Health Aide Services. Reassessments for Personal Care Services are required on an as-needed basis, but must be done at least every six (6) months. At any time that a change in the condition of the patient is noted either by staff of the certified home health agency or the local social services district, that agency should immediately inform the other agency so that the procedures for reassessment can be followed.

The form has been designed so that certified home health agencies and local social services districts may complete assessments jointly, a practice which is highly recommended. When it is not possible to undertake assessments jointly, an indication of the person responsible for completing each section has been included on the form. If, while completing the assessment, a nurse or a social services worker believes they have information in one of the other areas of the form, for which they are not responsible, they may include that information.

It is required that the local certified home health agency complete the assessment form within fifteen (15) working days of the request from the local social services district. Completed forms should be forwarded to the local social services district. Differences in opinion on the services required should be forwarded to the local Professional Director, for review and final determination by a physician.

Instructions:Section 1 - Reason for Preparation (RN and SSW)

Check appropriate box depending on whether patient is being considered for admission to an LTHHCP, home health aide service provided by a certified home health agency, or personal care services.

For reassessment, include the dates covered by the reassessment and check whether the reassessment is for an LTHHCP patient, certified home health agency patient, or personal care service patient. If none is appropriate, specify under "other" why form is being completed.

Section 2 - Patient Identification (RN and SSW)

Complete patient's name and place of residence. If the patient is or will be residing at a place other than his home address, give the address where he will be receiving care. Include directions to address where the patient will be receiving care.

The item "Social Services District" requires the name of the Social Services District which is legally responsible for the cost of the care. In large Social Services districts the number or name of the field office should be indicated.

Section 3 - Current Location of Patient (RN and SSW)

Check the current location/diagnosis of the patient. If the patient is in an institution, give name of facility. If he/she is at home and receiving home care, give name of organization providing the service. Complete the "Diagnosis" on all cases.

Section 4 - Next of Kin/Guardian (SSW)

Complete this section with the name of the person who is legally responsible for the patient. This may be a relative or a non-relative who has been designated as power of attorney, conservator or committee for the management of the patient's financial affairs.

Section 5 - Notify in Emergency (SSW)

Complete section with requested information on whom to call in an emergency situation.

Section 6 - Patient Information (SSW)

Complete all information pertinent to the patient. Use N/A if an item is not applicable. Specify the language(s) that the patient speaks and understands.

Check the category of living arrangements that best describes the living arrangements of the patient.

Definitions of Living Arrangements:

One family house - nuclear and extended family

Multi-family house - two or more distinct nuclear families

Furnished room - one room in a private dwelling, with or without cooking facilities

Senior citizen housing - apartments, either in clusters or high-rise

Hotel - a multi-dwelling providing lodging and with or without meals

Apartment - a room(s) with housekeeping facilities and used as a dwelling by a family group or an individual

Boarding House - a lodging house where meals are provided

If walk-up - when the living unit requires walking up stairs, specify number of flights

Lives with - specify with whom the patient lives. Members of household should be detailed in Section 7.

Other Patient Information:

- Social Security Number
- Medicare Numbers
- Medicaid Number
- Blue Cross Number
- Workmens Compensation
- Veterans Claim Number

To obtain correct numbers, the interviewer should ask to see the patient's identification card for each item.

Veterans Spouse - Patient may be eligible for benefits if a veteran's spouse.

Other - Identify insurance company and claim number if the patient has coverage in addition to those listed above.

Source of Income/other benefits - Include all sources of income and benefits. When the patient is receiving Medicaid or if Medicaid is pending, the local social services district will already have all necessary information.

Amount of available funds - Since many elderly people have little money left after payment of rent, taxes and utilities, an effort should be made to determine the amount available after payment of these expenses. This is especially important in evaluating whether or not the patient has adequate funds for food and clothing.

Section 7 - Others in Home/Household (SSW)

Indicate all persons residing in the house with the patient and indicate if and when they will assist in the care of the patient. Indicate in Section 14 what service(s) this person(s) will provide. This information must be specific as it will be used to prepare a summary of service requirements for the individual patient.

Section 8 - Significant Others Outside of Home - (SSW)

A "Significant Other" is an individual who has an interest in the welfare of the patient and may influence the patient. This may be a relative, friend, or neighbor who may be able to provide some assistance in rendering care. Indicate the days/hours that this person will provide assistance.

Section 9 - Community Support - (SSW)

Indicate organizations, agencies or employed individuals, including local social services districts or certified home health agencies who have, or who are presently giving service to the patient; also indicate those services that have been provided in the past six months. Agencies providing home care, home delivered meals, or other services should be included if they have been significant to the care of the patient.

Section 10 - Patient traits - (SSW and RN)

Patient traits should help to determine the degree of independence a patient has and how this will affect care to this patient in the home environment. A patient's safety may be jeopardized if he shows emotional or psychological disturbance or confusion. It is important to determine if the patient is motivated to remain at home, otherwise services provided may not be beneficial.

For all criteria check the "yes" column if the patient meets the standard of the criteria defined. If, in your judgement the patient does not meet the standard as defined, check "no". If you have insufficient evidence to make a positive or negative statement about the patient, check the box marked "?/NA" - unknown or not applicable. If you check a no or ?/NA, please explain the reason in the space to the right. Also indicate source of information used as basis for your judgment.

Definitions:

Appears self directed and/or independent - the patient can manage his own business affairs, household needs, etc., either directly or through instruction to others.

Seems to make appropriate decisions - the patient is capable of making choices consistent with his needs, etc.

Can recall med. routine/recent events - the patient's memory is intact, and patient remembers when to take medication without supervision or assistance. Patient knows medical regimen.

Participates in planning/treatment program - the patient takes an active role in decision making.

Seems to handle crisis well - this means that the patient knows whom to call and what to do in the event of an emergency situation.

Accepts Diagnoses - the patient knows his diagnoses and has a realistic attitude toward his illness.

Motivated to remain at home - the patient wants to remain in his home to receive needed care.

Section 11 - Family Traits (SSW and RN as appropriate)

This section should be used to indicate whether the family is willing and/or able to care for the patient at home. The family may be able to care for the patient if support services are provided, and if required instruction and supervision are given, as appropriate, to the patient and/or family.

Definitions:

- a. Is motivated to keep patient home - this means that the family member(s) is (are) willing to have the patient stay at home to receive the needed care and will provide continuity of care in those intervals when there is no agency person in the home by providing care themselves or arranging for other caretakers.
- b. Is capable of providing care - the family member(s) is (are) physically and emotionally capable of providing care to the patient in the absence of caretaker personnel, and can accept the responsibility for the patient's care.
- c. Will keep patient home if not involved with care - the family member(s) will allow the patient space in the home but will not (or cannot) accept responsibility for providing the necessary services in the absence of Home Care Services.
- d. Will give care if support services given - this means that the family member(s) will accept responsibility for and provide care to the patient as long as some assistance from support personnel is given to the family member(s).
- e. Requires instruction to provide care - this item means that the family is willing and able to keep the patient at home and provide care but will need guidance and teaching in the skills to provide care safely and adequately.

Section 12 - Home/Place where care will be provided -(RN)

In order to care for a person in the home, it is necessary to have an environment which provides adequate supports for the health and safety of the patient. This section of the assessment is to determine if the home environment of the patient is adequate in relation to the patient's physical condition and diagnosis. Input from the patient and family should be considered where pertinent.

Specifically describe the problem, if one exists.

Definitions:

Neighborhood secure/safe - refers to how the patient and/or family perceives the neighborhood, for example, in the assessor's perception, the neighborhood may not be safe or secure but the patient may feel comfortable and safe.

Housing adequate in terms of space - refers to the available space that the patient will be able to have in the home. The space should be in keeping with the patient's home health care needs, without encroaching on other members of the family.

Convenient toilet facilities - refers to the accessibility and availability of toilet facilities in relation to the patient's present infirmities.

Heating adequate and safe - refers to the type of heating that will produce a comfortable environment. Safety and accessibility factors should be considered.

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Laundry facilities - refers to appliances that are available and accessible to the patient and/or family.

Cooking facilities and refrigerator - refers to those appliances that are available and accessible for use by the patient or family.

Tub/shower/hot water - refers to what bathing facilities are available and if the patient is able to use what is available. Modifications may have to be made to make the facilities accessible to the patient.

Elevator - refers to the availability of a working elevator and if the patient is able to use it.

Telephone accessible and usable - refers to whether or not there is a telephone in the home, or if one is available. Specify whether or not the patient is able to reach and use the telephone.

Is patient mobile in house - refers to the ability of the patient to move about in the home setting. Modifications may have to be made to allow mobility, for example, widening doorways and adding ramps for a patient in a wheelchair.

Any discernible hazards - refers to any hazard that could possibly have a negative impact on the patient's health and safety in the home.

Construction adequate - refers to whether or not the building is safe for habitation.

Excess use of alcohol/drugs by patient or caretaker - refers to whether or not the patient or caretaker uses these materials enough to endanger the patient's health and safety because of inadequate judgement, poor reaction time, etc.; smokes carelessly.

Is patient's safety threatened if alone - refers to situations that may cause injury to the patient. This includes situations such as physical incapacitation, impaired judgement to the point where the patient will allow anyone to enter the home, wandering away from home, and possibility of the patient causing harm to himself or others.

Pets - refers to if the patient has a pet(s) and if so, what problems does it present, for example, is the patient able to take care of the pet, is the pet likely to endanger the patient's caretaker, and what plans, if any, must be made for the care of the animal.

Additional Assessment factors - include items that would influence the patient's ability to receive care at home that are not considered previously.

### Section 13 - Recovery Potential (RN)

The anticipated recovery potential is important for short and long range planning.

Full recovery - the patient is expected to regain his optimal state of health.

Recovery with patient managed residual - the patient is expected to recover to his fullest potential with residual problem managed by himself, e.g., a diabetic who self-administers insulin and controls his diet.

Limited recovery managed by others - the patient is expected to be left with a residual problem that necessitates the assistance of another in performing activities of daily living.

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Deterioration - it is expected that the patient's condition will decline with no likelihood of recovery.

Section 14 - Services Required (RN, SSW to complete "D" as appropriate)

This section will serve as the basis for the authorization for service delivery. Fill in all services required, describing type, frequency and duration as pertinent. Specify whether the family or an agency will be providing services and frequency that the agency will be involved. It is necessary to determine the amount of services required to enable the local Social Services district to develop the summary of service requirements and to arrive at a total cost necessary to the Long Term Home Health Care Program. The local Social Services district will make the final budgetary determinations.

- A. This section determines what activities the patient can/cannot do for himself, also the frequency which the patient needs help in performing these activities.
- B. The RN should determine what level of services are needed or anticipated.

Example:

	Yes	No	Type/Freq. Dur.	Agency/Family Agency Freq.
Registered Nurse	X		1 hr/2XW/1mo.	V.N.S.
Physical Therapy		X		
Home Health Aide	X		4 hr/3Xw/1mo.	V.N.S.
Speech Pathology		X		
Occupational Therapy		X		
Personal Care	X		4 hr/5Xw/1mo.	Homemaker Upjohn
Clinic	X		1xwk-Mondays 1 pm	St. Luke's Hospital Surgical

C. Equipment/Supplies

The nurse should determine what medical supplies and equipment are necessary to assist the patient. Consideration should be for the rehabilitation and safety needs of the patient. Circle the specific equipment required and describe in type/freq./dur. column, etc.

Example:

Dressing, cath equipment ---#18 Foley/1xmo/6mo

D. Other Services

The RN should indicate any other health service needed for the total care of the patient. The SSW should complete the balance of the service needs.

Service needs will not be changed by the local social services district without consulting with the nurse. If there is disagreement, the case will be referred to the local professional director for review and final determination by a physician.

#### Section 15 - (SSW and RN)

##### DMS-1 Predictor Score

The predictor score must be completed. To be eligible for the LTHHCP, the patient's level of care needs must be determined and must be at the Skilled Nursing Facility (SNF) or Health Related Facility (HRF) level. The predictor score must be completed for home health aide and personal care services to assure adequate information for placement of personnel.

If the patient is institutionalized the predictor score should be obtained from the most recent DMS-1 completed by the discharge planner of that facility. If the patient is at home, it may be necessary for the nurse from the LTHHCP or certified home health agency to complete a DMS-1 form during the home assessment to ascertain the predictor score. Refer to the instructions for completing the DMS-1, if necessary.

##### Override necessary

An override is necessary when a patient's predictor score does not reflect the patient's true level of care. For example, a patient with a low predictor score may require institutional care due to emotional instability or safety factors. Either the institution's Utilization Review physician or physician representing the local professional director must give the override.

##### Can needs be met through home care?

Indicate if the patient can remain at home if appropriate services are provided. If the patient should not remain at home for health or safety reasons, be specific in your reply.

##### Institutional Care

Give specific reason why institutionalization is required. Check the level of institutional care the patient requires. Indicate if the patient can be considered for home care in the future.

#### Section 16 - Summary of Service Requirements - (SSW)

This information is to be used in correlation with services required for the patient to remain at home (Section 14). This section is to determine the cost of each individual service, source of payment, date services are effective and total monthly budget.

The SSW should complete this section including unit cost and source of payment. Subtotal and total costs will be determined by the local social services department.

Section 17 - Person who will relieve in an emergency - (SSW and RN)

This should be an individual who would be available to stay with the patient, if required, in a situation where the usual, planned services are not available. An example would be, when an aide did not appear on schedule, and the patient could not be left alone.

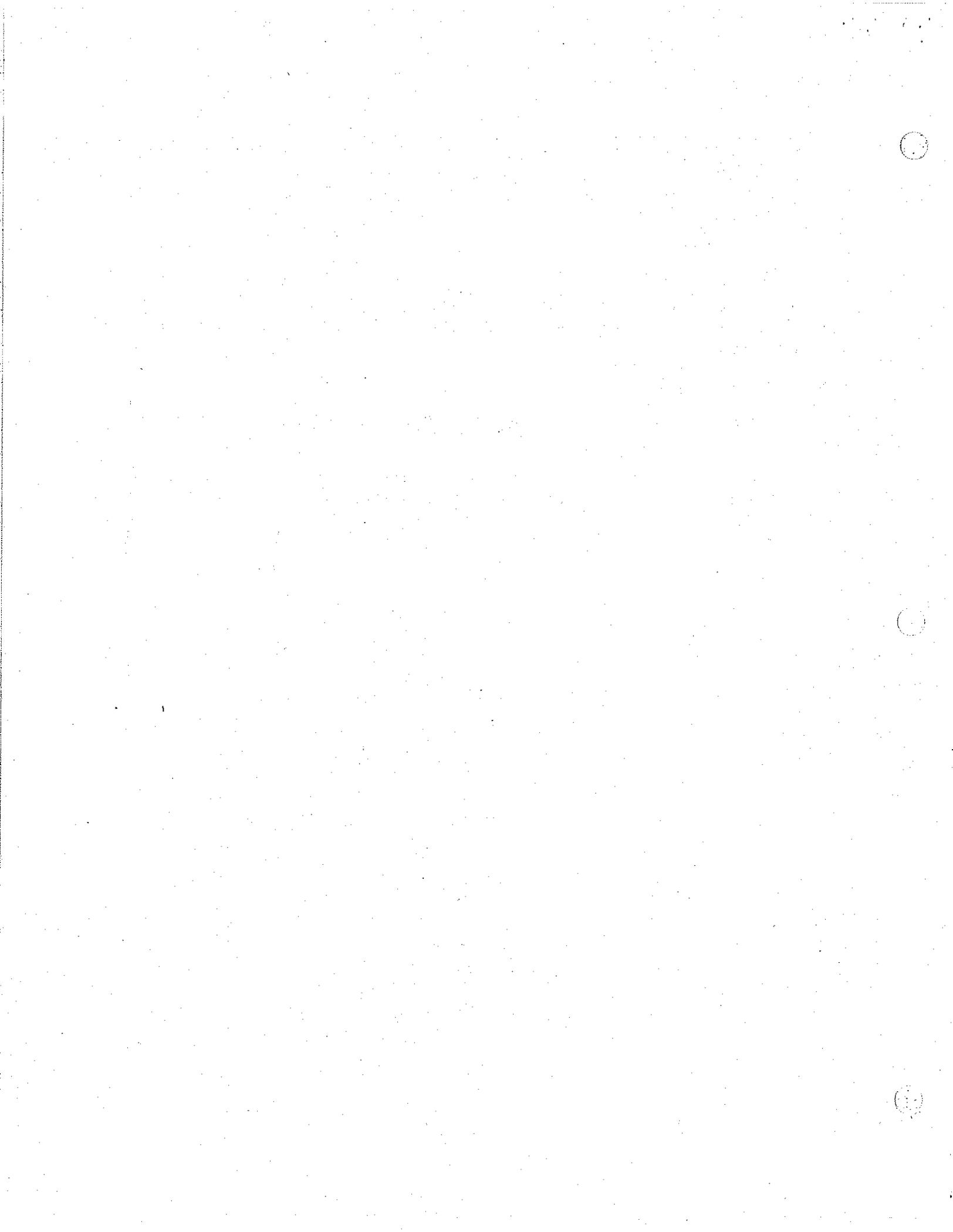
Narrative - (SSW and RN)

The narrative should be used to describe details of the patients condition, not covered in previous sections, that will influence the decision regarding placement of the patient.

Assessment completed by

Each professional should sign and date this form. Include agency and telephone number.

Authorization to provide services for the LTHHCP, Home Health Aide or Personal Care Services will be provided by the Local District Social Services Commissioner or his designee.





**7. To be completed by S S W**

**OTHERS IN HOME/HOUSEHOLD:** Indicate days/hours that these persons will provide care to patient.  
If none will assist explain in narrative.

Name	Age	Relationship	Days/hours at home	Days/hours will assist
1.				
2.				
3.				
4.				

**8. To be completed by S S W**

**SIGNIFICANT OTHERS OUTSIDE OF HOME:** Indicate days/hours when persons below will provide care to patient.

Name	Address	Age	Relationship	Days/Hours Assisting
1.				
2.				
3.				
4.				
5.				

**9. To be completed by S S W**

**COMMUNITY SUPPORT:** Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.				
2.				
3.				
4.				

**10. To be completed by S S W and R.N.**

**PATIENT TRAITS:**

	Yes	No	? N/A	If you check No, ? N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts Diagnosis				
Motivated to remain at home				

**11. To be completed by S S W and R.N. as appropriate.**

**FAMILY TRAITS:**

	Yes	No	?	
a. Is motivated to keep patient home				If no, because
b. Is capable of providing care (physically & emotionally)				If no, because
c. Will keep patient home if not involved with care				Because
d. Will give care if support services given				How much
e. Requires instruction to provide care				In what—who will give

**12. To be completed by R.N.**

**HOME/Place where care will be provided:**

HOME/Place where care will be provided:	Yes	No.	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, others (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

**ADDITIONAL ASSESSMENT FACTORS:**

\_\_\_\_\_

\_\_\_\_\_

**13. To be completed by R.N.**

**RECOVERY POTENTIAL ANTICIPATED**

**COMMENTS**

Full recovery _____	<input type="checkbox"/>	_____
Recovery with patient managed residual _____	<input type="checkbox"/>	_____
Limited recovery managed by others _____	<input type="checkbox"/>	_____
Deterioration _____	<input type="checkbox"/>	_____

14. To be completed by RN - SSW to complete "D" as appropriate

FOR THE PATIENT TO REMAIN AT HOME - SERVICES REQUIRED

SERVICES REQUIRED	WHO WILL PROVIDE			AGENCY/FAMILY	AGENCY FREQUENCY
	YES	NO	TYPE/FREQ/DUR		
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O2, medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

15. To be completed by SSW and RN.

DMS Predictor Score \_\_\_\_\_ Override necessary  Yes  No

Can patients health/safety needs be met through home care now?  Yes  No

If no, give specific reason why not \_\_\_\_\_

Institutional care required now?  Yes  No If yes, give specific reason why.

Level of institutional care determined by your professional judgment: SNF  HRF  DCF

Can the patient be considered at a later time for home care? Yes  No  N/A



17. To be completed by SSW and RN

Person who will relieve in case of emergency

Name	Address	Telephone	Relationship
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Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:

R.N. \_\_\_\_\_

Date Completed \_\_\_\_\_

Local DSS Staff \_\_\_\_\_

Date Completed \_\_\_\_\_

Supervisor DSS \_\_\_\_\_

Date \_\_\_\_\_

Agency \_\_\_\_\_

Telephone No. \_\_\_\_\_

District \_\_\_\_\_

Telephone No. \_\_\_\_\_

District \_\_\_\_\_

Telephone No. \_\_\_\_\_

Authorization to provide services:

Local DSS Commissioner or Designee \_\_\_\_\_

Date \_\_\_\_\_

## APPENDIX E

### JOB GUIDELINES FOR NURSE SUPERVISOR OF PERSONAL CARE SERVICES

#### General Statement of Duties

The nurse supervisor is responsible for the nursing supervision of personal care services in accordance with the policies and procedures listed in the New York State Department of Social Services Regulations 505.14.

#### Primary Duties

As explained in the Administrative Directive on Scope and Procedures for Personal Care Services, the nurse supervisor is responsible for the orientation of personal care service providers for each new assignment, the evaluation of these provider's abilities, the provision of on-the-job instruction for these providers, the evaluation of the health care needs of the patient and the maintenance of records and forwarding reports. In addition, this nurse may assist in the development and implementation of the required basic and in-service training of personal care service providers.

#### Required Knowledge, Skills and Abilities

Knowledge of what constitutes good nursing care for the elderly, chronically ill or disabled in the home setting; the ability to identify symptoms and signs of current and potential health problems; the ability to assess a patient's functional capacity to manage safely in the home setting and to assess the home environment for potential hazards; the ability to work with other professionals in assessing the psychosocial factors which affect the patient's ability to manage safely in the home setting; the knowledge and ability to develop an appropriate plan of care based on nursing assessment and physician's orders; the ability to assess the quality of the aide's performance and provide on-the-job instruction; the ability to assess the training needs of persons providing personal care services, and personal characteristics to work with other disciplines in providing coordinated services to patients and their families.

#### Qualifications

##### Minimum Qualifications

1. A limited permit to practice or a license and current registration to practice as a registered professional nurse in New York State.

A nurse employed as a nurse supervisor shall be licensed and currently registered in this state or hold a limited permit to practice as a registered nurse in this state pending the issuance of a license. Both the local district and the nurse may be subject to prosecution in accordance with the provision of Title VIII of the Education Law if a nurse during any period of his/her employment does not have a current New York State license or limited permit.

Qualifications (Cont'd)

2. At least two years satisfactory recent experience as a registered nurse.

A nurse shall have been employed for at least two years as a registered professional nurse. Employment in other capacities is not acceptable. In addition, the nurse shall have references from all relevant previous employers indicating satisfactory performance.

3. A combination of education and experience which is equivalent to the experience requirements described in 2. above, with at least one year of experience in nursing care.

The applicant may substitute a Bacclaureate Degree in nursing from a school registered by the New York State Education Department for one year of experience required above. However, the applicant must have at least one year satisfactory experience as a registered professional nurse.

Recommendations

All nurse supervisors are required to meet the minimum qualifications listed above. Whenever feasible, program administrators should select a nurse with nursing experience in a certified home health agency, an Article 36 facility. (Certified home health agencies include home care services units or county nursing services, hospital-based home care units, visiting nurse services and long-term home health care programs). There are three advantages to a nurse with this type of experience: First, this nurse usually will have had direct experience in the provision of home care services and the supervision of personal care service providers. Second, a Public Health Nurse supervisor will have monitored this nurse's on-the-job performance. Finally, working with other public health nurses, the nurse will have gained additional skill and knowledge.

If such nurse is not available, the program administrator should consider a nurse who has had experience in the provision of nursing care for the elderly, chronically ill or disabled and the supervision of paraprofessionals (e.g., nurse's aides) in the care of these individuals. This would mean experience as a staff nurse on a medical/surgical unit of a hospital, rehabilitative facility, or nursing home. A nurse with experience as a discharge planner might also be an appropriate candidate. If a significant percentage of the cases include child care cases, the administrator may want to substitute nursing care experience in pediatrics or maternal child health. Whatever the type of experience, the administrator should check that the nurses' past responsibilities included the provision of nursing care and the supervision of paraprofessionals.

APPENDIX F

PLAN FOR DELIVERY OF  
PERSONAL CARE SERVICES

NAME OF LOCAL DISTRICT: \_\_\_\_\_

NAME OF PERSON COMPLETING THE PLAN: \_\_\_\_\_

TITLE OF PERSON COMPLETING PLAN: \_\_\_\_\_

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When the answer to a question requires attachments or additional space, please label the answer with the number of the question, including the letter designation for the section and numbers and letters for all sub-sections.

A. GENERAL INFORMATION:

1. Does your agency provide personal care services as an item of Medical Assistance?

YES

NO

If NO, please explain on an attached sheet of paper why you do not. Do not complete the balance of the plan. (Label Sheet A.1.)

2. Where is the administrative responsibility for this program placed in your agency?

SERVICES

MEDICAL ASSISTANCE

OTHER (Explain)

3. Attach an organizational chart to show the local of program administration including the relationship of this program to Medical Assistance and to Services. (Label Chart A.3.)

4. Project the average monthly caseload and the annual total caseload, which will receive the following services:

MONTHLY: PERSONAL CARE  
SERVICES \_\_\_\_\_

HOME HEALTH AIDE  
SERVICES \_\_\_\_\_

ANNUAL: PERSONAL CARE  
SERVICES \_\_\_\_\_

HOME HEALTH AIDE  
SERVICES \_\_\_\_\_

5. What are your projected costs for the current calendar year for the following?

PERSONAL CARE SERVICES \_\_\_\_\_

HOME HEALTH AIDE SERVICES \_\_\_\_\_

ASSESSMENTS --

CERTIFIED HOME HEALTH AGENCY \_\_\_\_\_

SUPERVISION \_\_\_\_\_

6. Diagram or outline on a flowchart on a separate sheet of paper the process by which a client requests personal care services from your agency, including delivery of service and reauthorization. Indicate sections and positions of staff involved. (Label Page A.6.)

B. PROVISION OF SERVICE:

1. How will Personal Care Services be provided (check all which apply)?

Indicate next to each, the percentage of your personal care program which will be provided by each provider:

- a.  Direct, D.S.S. staff  
(Answer Questions in B 3a) \_\_\_\_\_%
- b. Contract with:  
(Answer Questions B 3b, 1, 2, 3) \_\_\_\_\_%
  - (1) Voluntary Homemaker Agency \_\_\_\_\_%
  - (2) Public Agencies \_\_\_\_\_%
  - (3) Proprietary Agencies \_\_\_\_\_%
- c.  Agreement with Individual Providers  
(Answer Questions in B 3c) \_\_\_\_\_%

2. Describe the rationale for the allocation of cases among the types of providers listed above.

3. Answer all questions applicable to those checked above.

a. Direct - By D.S.S. Staff:

1) How many personal care aides/homemakers do you have on staff? \_\_\_\_\_

2) In which unit or division are they located within the agency?  
\_\_\_\_\_

- 3) Attach a copy of job specifications for personal care aide/homemaker. (Label Specifications, B 3.a3)
- 4) Do these personal care aides/homemakers fulfill any other functions? (check all which apply)

- Care of child - caretaker relative is absent
- Care of child - caretaker relative is ill
- Help caretaker relative learn to care for child and home
- Protect child
- Prevent foster care placement
- Care of adult, Adult Protective Services
- Other (Please list)

5) What percentage of personal care aide's/homemaker's time is spent on Personal Care Services? \_\_\_\_\_%

6) Who is responsible (indicate position and unit) for the administrative supervision of the personal care aide/homemaker for each of the following:

Time Records: \_\_\_\_\_

Discipline Action: \_\_\_\_\_

Performance Evaluation: \_\_\_\_\_

Identification of Training Needs: \_\_\_\_\_

**b. Contract Arrangements with Other Agencies:**

- 1) For each of the agencies with whom you contract, complete a provider information sheet. (Label B 3.bl) Copies may be found at the end of this plan. If additional copies are needed, they may be reproduced from those attached.

- 2) If you are using a local contract with local variations, which has not been approved by the State Department of Social Services, please submit a copy of that contract for approval. (Label Contract, B 3.b2).
- 3) Describe the process used to select agencies with whom your local social service district contracts. Include copies of any written materials used. (Label materials B 3.b3)
- 4) Is your agency requesting an exception to use a proprietary agency?

YES                       NO

If YES, explain the reason why this exception is requested.

- 5) What services will be purchased from proprietary agencies?

Personal Care functions, including bathing, grooming, toileting, transfer activities, assistance in eating.

Environmental and nutrition support, including preparation of meals, care of home, laundry, shopping.

Other (explain)

c. Arrangements with Individuals:

- 1) Does your agency plan to use individual providers of personal care services?

YES                       NO

If YES, indicate which functions will be delivered by an individual provider:

- Personal Care functions, including bathing, grooming, toileting, transfer activity, assistance in eating, only.
- Environmental and nutrition support, including preparation of meals, care of home, laundry, shopping, only.
- Other (explain).

2) Is your district requesting permission to utilize individuals to provide personal care functions?

YES                       NO

If Yes, explain why such exception is necessary.

3) How many individual providers will be used? \_\_\_\_\_

4) How many cases will be served? \_\_\_\_\_

5) Describe on a separate sheet of paper the minimum qualifications for individual providers and methods used to determine that such individuals are qualified to deliver personal care services. (Label Sheets B 3.c5).

6) Describe how the local social service district will handle the following:

a) Training of individual (If plan has been submitted to department for approval, indicate the name under which plan was submitted).

- b) Supervision by a registered professional nurse of individual.
  
  
  
  
  
  
  
  
  
  
- c) Administrative supervision of individual provider's performance in delivering services and compliance with authorization.
  
  
  
  
  
  
  
  
  
  
- d) Payment to individuals.
  
  
  
  
  
  
  
  
  
  
- e) Supervision of and/or Payment of taxes.
  
  
  
  
  
  
  
  
  
  
- f) Supervision of and/or Payment of insurance.
  
  
  
  
  
  
  
  
  
  
- g) Supervision of and/or Payment of other benefits or deductions.

- 7) If local version of an agreement with individual providers is used, please submit a copy of that agreement for approval. (Label Agreement, B 3.c.7).

C. PHYSICIAN'S ORDERS:

1. Do you intend to obtain physician's orders on forms developed by State?

YES

NO

If NO, please submit a copy of the form which you propose to use for approval. (Label Form C 1.).

D. ASSESSMENT:

1. With which certified home health agencies does your district contract for nursing assessments? (Indicate if agency has a specific geographical area which it serves). Do you reimburse the certified home health agencies at the maximum reimbursable rate established by the State Department of Health for this agency?

YES

NO

If NO, how is the rate negotiated?

2. Indicate which staff is responsible for social assessments.

SERVICES

MEDICAL ASSISTANCE

OTHER

3. Are assessments done jointly by the certified agency and the local social service district when possible?

YES

NO

If NO, indicate reasons why not.

4. If your district has added amendments to the State Model Contract (Administrative Directive - Contracting for Personal Care Services, Appendix B) or uses a local contract, attach such amendments or contracts for review and approval. (Label D 4.).

5. Does your district intend to use the nursing and social assessment form in Appendix D?

YES

NO

If NO, attached a copy of the nursing and social assessment forms which your district intends to use. (Label D 5.).

E. NURSING SUPERVISION:

1. Who is responsible for the supervision of the personal care program?

Public Health Nurse through contract with a certified home health agency or public health nursing service. List those agencies with whom local district contracts (Answer Question in E 2.a.).

R.N. on D.S.S. staff (Answer Questions in E 2.b.).

Local district is requesting an exception for provision of nursing supervision by provider agencies (Answer Questions in E 2.c. and on the Provider Information Sheet).

2. Answer the appropriate questions below depending on above questions.

a. Supervision Provided by Contract with Certified Home Health Agency

1) Who is the designated contact person in the local social service district who serves as the liaison with the certified home health agency?

NAME: \_\_\_\_\_

POSITION/TITLE: \_\_\_\_\_

2) What procedures exist for the transfer of information from the nurse supervisor to the D.S.S. or from D.S.S. to the nurse supervisor?

3) Is the nurse supervisor involved in training programs for personal care aides/homemakers?

YES

NO

If YES, describe role.

- 4) Is the nurse supervisor involved in the evaluation of the performance of individual personal care aides/homemakers?

YES  NO

If YES, describe role.

- 5) Does the nurse supervisor have any additional responsibilities?

YES  NO

If YES, indicate other responsibilities and percentage of time spent on such activities.

b. Supervision Provided by D.S.S. Staff

- 1) How many nurses are employed by D.S.S.? \_\_\_\_\_
- 2) Provide a functional duty description for the nurses including the titles, duties, and qualifications for each position. (If the description is used directly from Department Regulations Section 680, this question may be answered by citing the reference used). (Label E b.2.).
- 3) What is the ratio of nursing supervisors to personal care aides/homemakers? \_\_\_\_\_
- 4) What is the ratio of nursing supervisors to persons providing environmental and nutrition support services? \_\_\_\_\_
- 5) Indicate the location of the nurse on the organizational chart required in question A.3.

- 6) Does the nurse have direct supervisory responsibility for the personal care aides/homemakers?

YES

NO

If No, what procedures exist for the feedback of information from the nurse supervisor to the person responsible for the supervision of personal care aides/homemakers?

- 7) What procedures exist for the feedback of information from the nurse supervisor to the case manager?

- 8) Is the nurse supervisor involved in training programs for personal care aides/homemakers?

YES

NO

If YES, describe role.

- 9) Is the nurse supervisor involved in the evaluation of the performance of the individual personal care aides/homemakers?

YES

NO

If YES, describe role.

- 10) Does the nurse supervisor have any additional responsibilities?

YES

NO

If YES, indicate other responsibilities and percentage of time spent on such activities.

c. Supervision Provided by Provider Agencies

1) Explain why the local social services district is requesting an exception to provide nursing supervision through a provider agency.

2) Do the nurses within the provider agency serve as a contact person between D.S.S. and the provider agency?

YES

NO

If NO, indicate who serves as the contact person.

3) What procedures exist for the transfer of information from the nurse supervisor to the D.S.S. or from D.S.S. to the nurse supervisor?

Questions about the nurse supervisor in the provider agency are included on the Provider Information Sheet.

F. CASE MANAGEMENT:

1. Where is responsibility for the overall case management of personal care cases placed in your agency?

SERVICES

MEDICAL ASSISTANCE

OTHER \_\_\_\_\_

2. How are referrals for personal care services received and handled?

3. Is information on the services provided to referred person provided back to referring agency?

YES

NO

If NO, explain why not.

4. Who has responsibility for preparation of and signing of authorizations for services?

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

5. Indicate staff responsible for maintenance of case records.

SERVICES

MEDICAL ASSISTANCE

If State form is used for the case narrative, indicate the number. \_\_\_\_\_  
If a local form is used, include a copy. (Label Form F.5.)

6. If clients have complaints regarding the service, whom do they contact?

D.S.S.

CERTIFIED HOME HEALTH AGENCY

PROVIDER AGENCY

OTHER (explain)

7. Explain procedures for reviewing and evaluating client complaints, including emergency replacement of providers.

G. MONITORING OF SERVICE:

1. Where is the responsibility for development and implementation of a plan for monitoring and evaluating personal care programs placed in your agency?

SERVICES

MEDICAL ASSISTANCE

OTHER

2. Describe the district's plan for monitoring personal care services, including any of the following techniques used, sampling techniques and the titles of persons responsible for monitoring the providers used.

On-site Reviews:

Client Case Record Reviews:

Personal Care Worker Files:

Visits to Client's Home:

Assessment of Training Program:

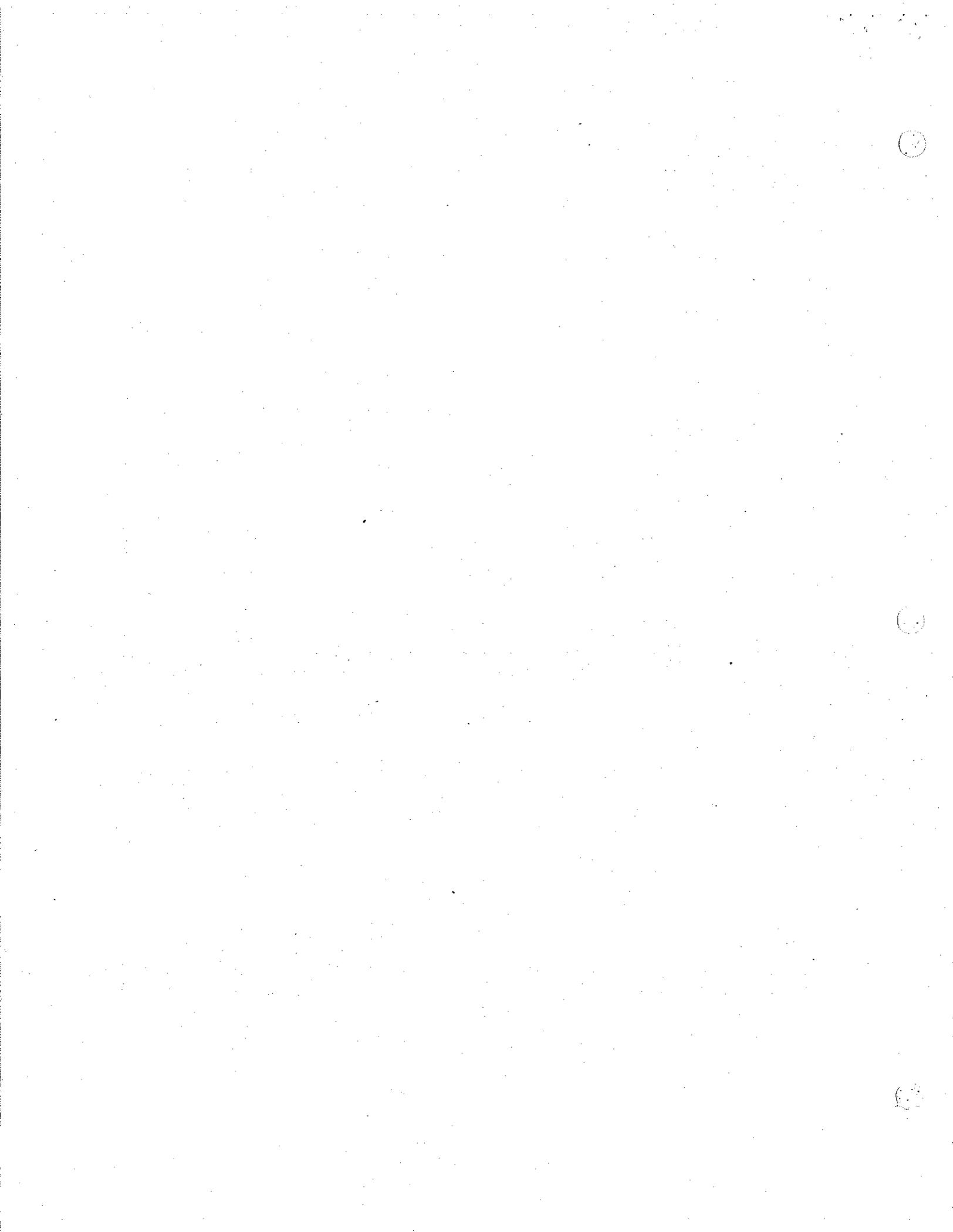
Fiscal Monitoring:

Telephone Survey:

3. Describe procedures used in following up monitoring activities to assure that corrective action is taken by the provider agency.

H. OTHER

Indicate any other characteristics or problems of the personal care program in your district.



PROVIDER INFORMATION SHEET  
CONTRACT ARRANGEMENTS WITH PROVIDER AGENCIES  
B. 3. b 1

Name of Provider Agency  
Any local identifying code number used for agency  
Address of Agency

Addresses of Satellite Agencies doing business under the same name

-----

1. What percentage of your district's personal care cases are handled by this agency? \_\_\_\_\_%

2. Check all of the following which describe this agency:

- NON-PROFIT  HOMEMAKER AGENCY  
 PROPRIETARY  OTHER (explain)  
 CERTIFIED HOME HEALTH AGENCY

3a. The following information must be disclosed by the provider agency:

- (i) The name and address of each person with an ownership or control interest in this agency or in any subcontractor in which this agency has direct or indirect ownership of 5% or more;
- (ii) Whether any of the persons named, in compliance with paragraph (i) of this section, is related to another as spouse, parent, child or sibling;

- (iii) The name of any other provider agency in which a person with an ownership or control interest in this agency also has an ownership or control interest;
- (iv) The ownership of any subcontract with whom the provider has had business transactions totaling more than \$25,000 during the immediately preceding 12 month period;
- (v) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any wholly owned supplier or between the provider and any subcontractor, during the immediately preceding five year period.

3b. Has any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider been convicted of a criminal offense?

YES

NO

If YES, list the name(s) and address(es) of such person(s); the nature and underlying facts of such conviction(s); and the sentence imposed upon such conviction(s).

3c. Does this agency have formal arrangements or contracts with any other agency?

YES

NO

If YES, list the name(s) and address(es) of the related agency(ies) and describe the relationship and any functions provided by one agency for another. For subsidiaries and franchises, indicate the name of the parent firm. For non-profit agencies, indicate the type of agreement or contracts.

4. What personal care services functions are provided under a contract arrangement by this agency?

- Personal care functions only.
- Environmental and nutrition support only.
- Personal care and environmental and nutrition support functions.
- Other

5. Does this agency provide nursing supervision as part of its contract responsibilities?

- YES  NO

If YES, answer the following questions:

- a. How many nurses are employed by the provider agency for supervision of personal care aides/homemakers? \_\_\_\_\_
- b. What is the ratio of nursing supervisors to personal care aides/homemakers? \_\_\_\_\_
- c. What is the ratio of nursing supervisors to persons providing environmental and nutrition support services? \_\_\_\_\_
- d. Provide a functional duty description, including titles, duties, and qualifications of each nursing position.

e. Indicate the location of this nurse within this agency, including the relationship with the nurse to the personal care aides/homemakers.

f. What training is provided by the provider agency and the local social services district for this nurse?

g. Is the nurse supervisor involved in the training program for personal care aides/homemakers?

YES

NO

If YES, explain role.

h. Does the nurse supervisor have any additional responsibilities?

YES

NO

If YES, indicate other responsibilities and percentage of time spent on such activities.

6. What other services are provided by this agency under Medical Assistance or under Title XX. (List service and funding sources).

7. What is the rate of reimbursement for personal care services provided by this agency? Attach schedule of all rates charged by agency, including rates charged for non-Medicaid services.

8. How was this rate of reimbursement established?  
(Check all those that apply)

- A cost based rate established individually for each provider.
- A rate negotiated with this agency individually.
- A rate established by D.S.S. for all agencies from whom services are purchased.
- Other (explain)

9. Indicate what items of expense are included in the rate for this provider. (Check all which apply)

Rate of salary of personal care aides (excluding benefits). State amount. \$ \_\_\_\_\_

Rate of fringe benefits for personal care aides. List benefits provided and the rate for each. \$ \_\_\_\_\_

Indicate total salary and benefits. \$ \_\_\_\_\_

Salary of Administrative staff. (List the positions and duties of those contributing to the support of this service, including supervisors and consultants. If the position is involved in other programs, indicate the percentage of time involved in personal care services).

- Fringe benefits for administrative staff.
- Cost of maintaining administrative offices.
- Cost of telephone and postage.
- Cost of office supplies and equipment depreciation.
- Training of staff (See Administrative Directive 78 ADM-19).  
(Check those items which are included in the rate).
  - Salary for Trainers
  - Space for Training
  - Equipment used in Training
  - Materials for Trainees
  - Assessment of Skills and Understanding
  - Other (list)

What is cost of preparing or training (exclude health exam) an individual aide? \$ \_\_\_\_\_

If the total cost of training an aide is not included in the rate, indicate who is responsible for the expense of training? Indicate whether any part of the training cost is borne by the aide.

Are public funds used for training?

- YES                       NO

If YES, indicate the source.

Physical examinations. (See Administrative Directive 78 ADM-86)

Immunizations and Health Screening. (See Administrative Directive 78 ADM-86)

Uniforms

Indicate what is included:

Provide total uniform

Provide agency patch or emblem

Provide maintenance and laundry

Other (list)

Insurance

Liability

Fire Insurance

Other (explain)

Transportation

If transportation is not included in the rate, but is paid, indicate the basis of payment.

Private car - mileage

Indicate rate \_\_\_\_\_

Public transportation - bus

Public transportation - taxi

Other (explain)



If transportation is not included in the rate, what proof of transportation cost is required for reimbursement?

Other items included in rate (list)

Does this agency receive any unrestricted donated funds?

YES

NO

If YES, indicate source.

10/10/10

10

10

10