New Client

TO WAIVER SERVICES

Resolute Care Services

GRACEFUL SERVICE. COMPASSIONATE HEART

Thank You!

I just wanted to take this time to thank you for choosing to trust me with the care of your loved one.

The process to move forward looking for the right care is never easy. With my help I hope the journey won't be as difficult.

The first step is always the hardest. Trying to get all the right pieces together is part of the journey.

Together, I hope we can make the coordination of your care just a bit less frustrating.

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WHAT YOU CAN EXPECT

I pride myself on providing my clients with the very best I have to offer: trust, guidance, respect, and persistence.

I try my best to set realistic timelines to follow and to answer questions and provide information as soon as I can.

With care coordination there are always times when waiting is what we must do and can seem like it will take forever. Just know that I am working for you and will do my best to move things along as quickly as I can.

TIMELINE

New Client to Waiver Services

WAIVER *timeline*

01. *Person Centered Intake*

This is one of the first steps that must be taken. Person Centered Intakes are done with the Aging and Disability Resource Center Intake Coordinator within the Independent Living Center in Kenai, 907-262-6333.

DEADLINE

_____

02. *Care Coordinator Selection*

The intake coordinator has a list of available care coordinators in your area. Choose one who will work for you. If you're not happy with the one you have chosen you have the right to find a new one.

DEADLINE

_____

03. *Waiver Paperwork*

Your selected care coordinator will request a few documents be signed by you, the client, or your legal representative. These will include releases of information (ROI's) , appointment of care coordination, recipient rights and responsibilities, and the waiver application.

DEADLINE

_____

04. *Preparing for the Assessment*

Once the waiver application has been submitted the next step is to have a Client Assessment Tool (CAT) done. Your care coordinator will go over this with you. A list of what to expect is listed on pg. 12.

DEADLINE

_____

IMPORTANT *Dates*

Keep track here.....

Date: _____

01: _____

Notes: _____

_____

_____

- [ ] _____
- [ ] _____
- [ ] _____

Date: _____

02: _____

Notes: _____

_____

_____

- [ ] _____
- [ ] _____
- [ ] _____

Date: _____

03: _____

Notes: _____

_____

_____

- [ ] _____
- [ ] _____
- [ ] _____

Date: _____

04: _____

Notes: _____

_____

_____

- [ ] _____
- [ ] _____
- [ ] Write Objective Three Here

The PROCESS

A deeper dive into the Timeline to know of what to expect.

01

PERSON CENTERED INTAKE

TIME FRAME: Before services can start

INTRODUCTION: A Person Centered Intake is done by an Aging and Disabilities Resource Center Intake Coordinator with the Independent Living Center. For someone living in Seward that would be done with the Kenai office. To call and schedule an appointment please call 907-224-6333. A PCI can usually be done over the phone but if you prefer one can be done in person. You would just need to see when that can be scheduled.

OVERVIEW

- [ ] Participant, Decision Support, and Representative Information
- [ ] Children with Complex Medical Conditions Status
- [ ] Developmental Disability Status
- [ ] Exploring Options and Level of Care (LOC) Screen
- [ ] Eligibility
- [ ] Outcomes and Referrals

WHAT WILL BE COVER

- ✓ Collecting Information- Demographics and Functional Screen
- ✓ Analyzing the Results- Knowing the Resources
- ✓ Identified Resources and Follow-up

02

CARE COORDINATOR

TIME FRAME: Once PCI has been completed

INTRODUCTION: Care coordinators can facilitate supported decision-making by helping people make a plan for the support that they want. Supported Decision-Making, or "SDM," is a way to get help making choices. Supported Decision-Making means that you make your own choices. You can choose family, friends, or staff who you want to help you make your choices. Think about who you want to support you. Supported Decision-Making has both supporters and a decider. You are the decider. You can choose who will be your supporters. Your supporters are your primary providers, care coordinator, and personal care assistant (PCA's). You can have many supporters. You might want some supporters to help you with some things but not others. For some things, you might want two or three people to support you. For other things, you might just want one supporter. You can always change your mind and change your supporters.

Care coordinators will assist with the application, annual plan of care, and ongoing monthly case management.

Every supporter should be:

Someone you trust

This goes for all the people involved in the waiver process.

Someone who...

Agrees to be a supporter If there is any hesitation maybe they are not the right person to assist you.

03

WAIVER PAPERWORK

TIME FRAME: First

INTRODUCTION: Below is a list of the forms that your care coordinator will go over with you and your legal representative, if you have one, and you may be required to complete.

Forms

- Uni - 05 Appointment For Care Coordination Services
- Uni -16 Release of Information
- ADRC Person Centered Intake Summary (initials)
- Application for ALI/APDD/CFC/CCMC/IDD
- Uni - 07 Recipient Rights and Responsibilities
- Uni - 09 Verification of Diagnosis
- For APDD only Proof of DD eligibility (DD registry letter)
- Medical and Functional Documentation
- Proof of Medicaid Eligibility (usually just Medicaid #)
- Legal Representative documents, if applicable

04

PREPARING FOR THE ASSESSMENT

TIME FRAME: Once forms and application have been submitted

INTRODUCTION: The assessment involves a detailed functional assessment and observation of the person, an interview with the person, and consideration of supporting documentation. The Assessor wants to know what the person can do for him/herself and what kinds of hands on help has been needed within the last 7 days. There is a separate CAT for children, which is used for the CCMC waiver. The Assessor uses the Consumer Assessment Tool (CAT) to determine LOC based on the numerical values. Every CAT is reviewed by an SDS assessment supervisor prior to LOC determination. A Care Coordinator (CC) can attend the assessment appointment at the request of the applicant and/or legal representative. CC's are not required but are helpful when present.

What will the assessment go over

- You will need to demonstrate their abilities or inabilities when asked. Such as your ADL's and IADL's.
- Family is encouraged to limit attendance and not interrupt the assessment
- Let the assessor know if you expect to have comments after the interview is concluded
- Make notes during the assessment to discuss with the assessor after they are done DON'T INTERRUPT
- Hold your comments during the assessment, unless a question is directed to you

If you are found to meet Nursing Facility Level of Care (NFLOC), you and your Care Coordinator will receive a notice (letter) of Level of Care Determination and a copy of the Consumer Assessment Tool (CAT) from SDS.

GUIDELINES

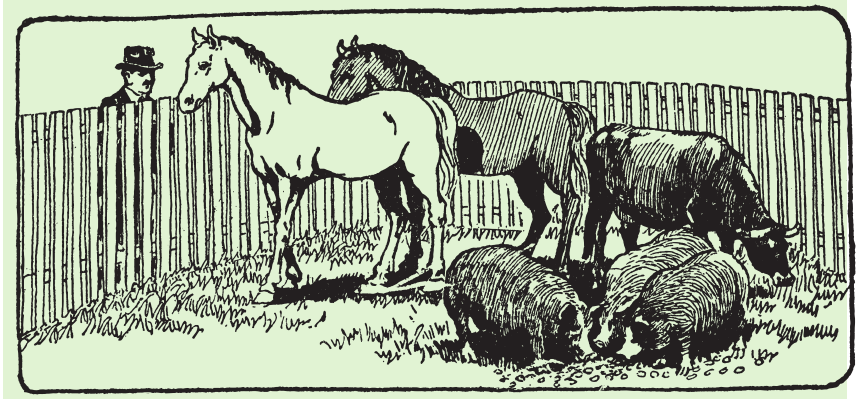
Alaska State DHSS

PROGRAM *Guidelines*

Conditions of Participation (COPs)

- Care coordinators assist individuals to gain access to home and community-based waiver services under 7 AAC 130; Community First Choice services under 7 AAC 127; and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid.
- Care coordinators do this through a person-centered process led by the recipient and the planning team of the recipient's choosing. Care coordinators also perform targeted case management services, which include helping recipients to complete an application and then submitting the application for home and community-based waiver services, Community First Choice services, or both.
- Once an applicant is determined eligible, care coordinators assist applicants with identifying goals, planning for services and selecting service providers. Care coordinators then assist the recipient-directed team to develop an initial support plan. Finally, care coordinators assist recipients to direct the team in reviewing goals and renewing the support plan annually.
- On-going care coordination is a home and community-based waiver service that includes monthly monitoring of the effectiveness of the support plan. Care coordinators remain in contact with the recipient throughout the support plan year, in manner and with a frequency appropriate to the needs of the recipient.
- For a recipient receiving only Community First Choice services, a care coordinator provides case management services during the recipient's support plan year.
- To offer care coordination services, a provider must be certified as a provider of care coordination services under 7 AAC 130.220(a)(2); meet the requirements of 7 AAC 130.238 and 7 AAC 130.240; and operate in compliance with the Home and Community-based Waiver Services Provider Conditions of Participation.
- To offer long term services and supports targeted case management, the provider must be certified under 7 AAC 128.010(b), and comply with the set standards.

HTTPS://HEALTH.ALASKA.GOV/DSDS/PAGES/REGULATIONS



Fee Schedule

Paid by Medicaid

Fee

SCHEDULE

Monthly *Care Coordination*

- Two monthly contacts. One face-to-face
- Available for questions and issues that may arise
- Coordination of care that is needed

$286.94

Annual *Plan of Care*

- Review plan of care
- Review last 12 months medical records
- Review level of care
- Review qualifying diagnosis from provider
- Answer any questions or concerns

$458.60

Initial *Application*

- Appointed as Care Coordinator
- Complete waiver application
- Assist with assessment
- Help select HCBW Agency

$107.66

F.A.Q'S

Frequently Asked Questions

Frequently Asked *Questions*

Q1. Why the Goat and Chicken

Aside from being two of my favorite animals to have raised, goats are known for their curiosity, balance, and intuition. And chickens are known for their courage and bringing forth new life

Q2. What if I don't have Medicaid

We have a wonderful Medicaid Fee Agent here in Seward at the Seward Community Health Center. Just call 907-224-2273, ask for Outreach and Enrollment.

Q3. What do I do if I don't qualify for Waiver Services

We have a great community here in Seward. If you do not qualify for waiver services there are other options we can look into.

Q4. Who can be my PCA (Personal Care Assistant)

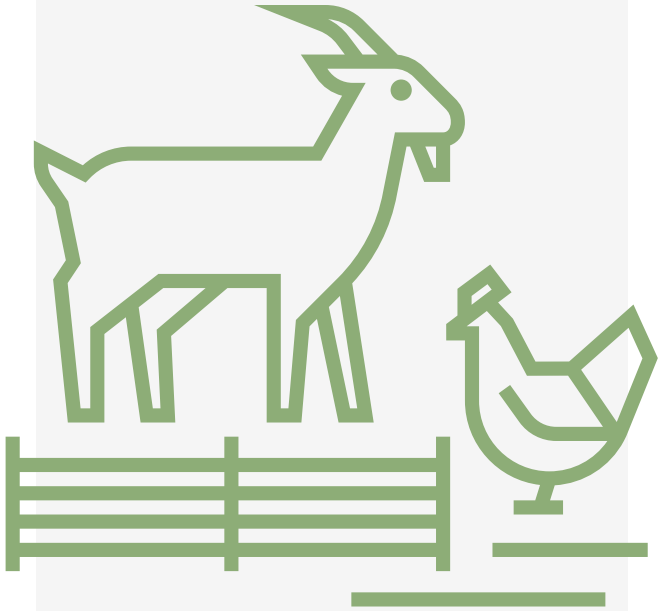
You have options for PCA's. We can find a company who has one available or if you know someone we can get them certified with an agency to work for you.

Q5. My question is not listed here

Ask away! If I do not know the answer I will find it for you. Please do not hesitate to ask.

LET'S CONNECT

Want to know about me and other services I offer?
Please check out my website...



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FACEBOOK

RESOLUTE
CARE
SERVICES, LLC