Preparing for and Beginning Services Facilitation

A Four-Part Online Training Series Leading to Certification

Module 2 of 4

Slide 1

Welcome to Module 2 in the series of four training modules for Services Facilitators in Virginia. Completion of all 4 Modules and successful completion of the learning exercises along the way will satisfy DMAS training requirements to provide Consumer-Directed Services Facilitation in Virginia.

Slide 2

In Module 2, we will look at:

- What happens before a referral is made to a services facilitator, and how does a referral get to you?
- What is involved in accepting a referral -- and how do you initiate the services? In this section we will cover the conditions needed for Services Facilitation to begin, setting up a record, and contacting the individual.
- What happens when you meet with the person at the initial comprehensive visit? Here, we will review plan development and documentation requirements.
- Lastly, what do you do to follow-up from the initial comprehensive visit, including services authorization and enrollment of attendants?

Slide 3

Module 2, Preparing for and Beginning Services Facilitation, covers the first three steps in this flow chart--the “front end” of Services Facilitation, so to speak.

Slide 4

First, let’s review what has already happened before a referral gets to you.

Slide 5

Before a Services Facilitator receives a referral:
The individual has already been pre-screened and found eligible for the DD, EDCD, or ID Waiver, or EPSDT;

The individual has selected the consumer-directed model -- and you to provide Services Facilitation; and

In most cases, an overall service plan has already been developed, and CD services are being added to the plan.

Slide 6

As we mentioned in Module 1, each of the three Waivers has a different screening process.

In the DD Waiver, screening teams at the Health Department Child Development Centers across the Commonwealth use the Level of Functioning (LOF) Instrument to screen for categories on the Level of Functioning (LOF) Survey. In addition to the LOF, the following forms are completed at the time of screening: Medicaid-Funded Long-Term Care Authorization (DMAS-96); Documentation of Individual Choice between Institutional Care and Home and Community-based Services (DMAS-459); Provider Consent form (DMAS-219); and the DD Medicaid Waiver Level of Functioning Survey Summary Sheet (DMAS-458).

Please note that these forms, and the forms that are mentioned as we proceed, are available in the Module 2 Training Materials but should be accessed for use directly from the DMAS website by going to the Virginia Medicaid Web Portal, clicking Provider Services, clicking Provider Forms Search, and entering the number of the form. (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch).

In the EDCD Waiver, a Preadmission Screening Team of the local Department of Social Services and the local Department of Health uses the Uniform Assessment Instrument (UAI) to screen for eligibility for admission to a nursing facility. In addition to the 12-page UAI, the following forms are completed by the Screening Team: the DMAS-96; DMAS-97; and DMAS-95 Addendum for CDPAS (if applicable). In addition to a Preadmission Screening Team of local social services and health department representative, screening can also be provided by some hospitals and nursing facilities.

Slide 7

And in the ID Waiver, CSBs or BHAs use the LOF to screen for LOF categories. Forms completed in addition to the LOF are: Virginia Home and Community-Based Waiver Choice of Provider (DMAS-460); and Documentation of Individual Choice between Institutional Care and Home and Community-based Services (DMAS-459C).

Waiver services are offered to an individual as an alternative to avoid admission to an institution. “Imminent risk of institutional placement” is defined as “needs to enter a facility within one month if he or she does not receive waiver services.” For the DD and ID Waivers, the facility is an ICF/ID, and for the EDCD Waiver, the facility is a nursing facility. Waiver services should
always be considered by screeners when an individual meets the institutional criteria specified in the waiver and is at risk of institutional placement without waiver services. In the EPSDT program, a Medicaid-eligible individual under the age of 21 is prescreened for EPSDT by the primary care provider completing the Functional Status Assessment (DMAS 7). Preadmission screening is not contingent upon a person applying to determine financial eligibility for Medicaid coverage. Often the financial eligibility for Medicaid occurs at the same time an individual seeks to qualify for assistance. Even though they may be eligible, the individual may just be placed on the DD or ID Waiver waiting list until funding for waiver services is available.

It is important that you receive a copy of the screening instrument and related documents prior to initiating Services Facilitation. For example in the ID Waiver, the Support Coordinator will have a copy of the Supports Intensity Scale (“SIS”) which measures the frequency and intensity of supports an individual with an intellectual disability needs to meet quality of life goals. You should receive a copy of the SIS.

To learn more about the screening process, please refer to the following Module 2 Training Materials: The Uniform Assessment Instrument; Medicaid EDCD Waiver Process Flow for Enrollment; Level of Functioning Survey; A Guide for Long-Term Care Services in Virginia (DMAS Division of Long Term Care, July 2013); and copies of the screening forms mentioned.

Slide 8

Once an individual has been prescreened and determined eligible, choice of waiver instead of facility and choice of provider must be documented when services are initiated:

- In the DD Waiver, the DMAS-459 documents choice of waiver instead of facility, and the DMAS-459A documents choice of providers.
- In the EDCD Waiver and the EPSDT Program, the DMAS-97 documents choice of providers.
- In the ID Waiver, individuals use the DMAS-459C to document choice of waiver instead of facility, and the DMAS-460 to document choice of providers.

In all three Waivers, the individual reviews and signs the Individual Selection of Consumer-Directed Services, the DMAS-489. In the DD waiver, this form must be signed and maintained by either the Services Facilitator or case manager. In the EDCD Waiver, the form must be maintained by the Services Facilitator. In the ID waiver, the form is maintained by the Support Coordinator.

It is important that you receive a copy of all of the relevant forms prior to initiating Services Facilitation.

Examples of these forms are included in the Module 2 Training Materials however all referenced forms should be obtained for use directly through the Virginia Medicaid Web
At the time individuals are referred to a Services Facilitator, most will have an overall service plan in place. The CD service plan will not be included in the overall service plan unless the individual is transferring from another Services Facilitator. It is important to know what is included in the overall plan and how CD services complement other services. A common feature of all service plans is that the planning process should incorporate person-centered practices.

- In the DD Waiver, the individual will already have a Plan of Care coordinated by the Case Manager.
- In the EDCD Waiver and the EPSDT Program, there may be multiple Plans of Care prepared by different providers.
- And in the ID Waiver, each individual will have a Person-Centered Individual Supports Plan prepared by the CSB and participating providers. Part 3 includes a list of outcomes shared by those supporting the individual. If the existing Part 3 does not contain outcomes that would relate to supports provided by a particular CD service, the CSB can work with you and the individual and family to arrive at outcomes that are meaningful and measurable for the CD plan for supports.

Be sure to get a copy of any existing plan prior to initiating Services Facilitation.

Now you are ready to accept a referral for Services Facilitation. You receive a referral because the individual has chosen you from a list of available Services Facilitators.

- For the DD Waiver, the list comes from the individual’s Case Manager.

For the EDCD Waiver, the list comes from the Department of Social Services Pre-Admission Screening Team. It can be maintained by either the local Department of Social Services or the local Department of Health.

For the ID Waiver, this list comes from the CSB Support Coordinator. If and when you are contacted by the CSB Support Coordinator regarding a selection of you as Services Facilitator, it is recommended that you confirm with the Support Coordinator that the individual is currently enrolled in the ID Waiver.
Slide 14

- For EPSDT, the list comes from the primary care provider.

Slide 15

- And, referrals can also come from other providers.

Slide 16

First, accept a referral only when you are available to initiate and provide Services Facilitation on an ongoing basis. You have the right to refuse a referral if the individual is not appropriate for CD services.

Slide 17

Second, make sure you have received the screening instrument and related forms discussed in the previous section.

Slide 18

In the EDCD Waiver, you will then need to complete DMAS-225 (the “Medicaid Long Term Care Communication Form”). Form 225 allows the local Social Services Department and providers to exchange information related to:

- The Medicaid eligibility status of an individual;
- A change in an individual’s level of care;
- Admission to or discharge from an institution or community-based services, or the death of an individual;
- Service Authorization Number for Medicaid Services; and
- Other information known to you or other providers that might cause a change in the eligibility status or patient pay amounts of an individual.

After completing DMAS-225, you will return it to the local Department of Social Services to let them know the individual is receiving Services Facilitation from you as of a certain date. Also distribute it to all relevant parties as directed on the form.

In the DD Waiver, the Case Manager completes the form. In the ID Waiver, the DMAS-225 is completed by the Support Coordinator.

Slide 19

You also need to obtain a signed Consent to Exchange Information Form from the individual. The DMAS-219 can be used, as can the Uniform Authorization to Exchange Information form. **You can find examples of both of these forms in the materials included on the website with**
this Module. In the ID Waiver, you can also obtain a copy of a Consent to Exchange Information Form from the CSB Support Coordinator.

Additionally, you should give the individual a HIPAA privacy notice and a form to sign acknowledging receipt.

Slide 20

Lastly, individuals may have a patient pay that will need to be collected, and you should determine the status of that patient pay. If the individual is newly enrolled or currently receiving services under the ID Waiver and has a patient pay that must be collected, ask the Support Coordinator to designate this in writing and provide a copy to you. In the ID Waiver, the Support Coordinator identifies the collector of patient pay based on the highest number of billable hours and then sends a written communication to that provider. The provider then is responsible for doing the checking electronically as to the amount, then deducts that per billing.

Slide 21

As we discussed in Module 1, not everyone is eligible to consumer-direct services. Therefore, when accepting a referral, it is important to check on the following.

Services may be furnished only to individuals who:

- Are enrolled in the DD, EDCD, or ID Waiver; EPSDT; or Medicaid Works; and
- They must have an appropriate service plan.

Residents of Nursing Facilities, Institutions for Mental Disease, Intermediate Care Facilities for Individuals with Intellectual Disabilities, or Psychiatric Residential Treatment Facilities cannot consumer direct; and if an individual is in a hospital, consumer-directed services cannot be reimbursed during the hospital stay.

Additionally, consumer direction is not permitted if the individual’s health, safety, and welfare in the home environment is jeopardized.

Slide 22

Now you are ready to verify Medicaid eligibility and contact the individual! Before you make contact, you can verify Medicaid eligibility by checking the Medicaid portal.

Slide 23

If the individual is Medicaid eligible, within 10 days of the referral you must contact the individual.
When you make contact, you will want to:

- Introduce yourself and explain your role as a Services Facilitator. If possible, you may also engage in a brief discussion about the purpose of Services Facilitation, what an EOR is and the EOR’s role, the role of the Fiscal/Employer Agent, information about who can be attendants, and timeframes for meetings, visits, training, and beginning services. The amount of information you share will differ with each individual.
- Although it is not always possible, you should also try to determine who the EOR will be. If you can, it allows you to complete and fax the “Fiscal Agent Services Request Form” (FARF) to the Fiscal/Employer Agent (F/EA), prior to the initial comprehensive visit, so that a Welcome Package and be mailed to the EOR, which will save time getting attendants enrolled. The following slide contains information about obtaining and sending the FARF form.
- Finally, schedule a day and time for the Initial Comprehensive Visit – and ensure that there is adequate time for the visit. The time required will, of course, depend on whether the initial comprehensive visit will include EOR Training.

Following the phone conversation, if you identified the EOR, you can complete and fax the Fiscal Agent Services Request Form (FARF) to the F/EA. The F/EA’s role is discussed in great detail later. At the front end of Services Facilitation, the role, upon receipt of a completed FARF, is to send a Welcome Packet to the EOR. If you did not identify an EOR, you will need to do so at the initial visit and complete and send the FARF form.

You can download the FARF form from this address: https://www.publicpartnerships.com/programs/virginia/fiscal/adminlogin.asp --and use the login “vaprovder” and the password “vacdmfp5.” You can also request it by phone by calling toll-free 1-866-259-3009. Once the FARF is completed, it can be faxed toll-free to 866-709-3319. The Welcome Packet that will be sent by PPL (the current F/EA) to the EOR includes an Employer Information Packet to be completed by the EOR and returned by mail to:

Public Partnerships, LLC, Fiscal Agent Services
P.O. Box 662,
Richmond, VA 23218-0662

If you have questions, PPL has also set up a special phone line just for Services Facilitators: 1-877-522-1058.

It is important to know that delay in determination of the EOR and completion of the FARF will lead to a delay in PPL’s ability to request the required tax ID number from the IRS, which will delay processing of attendant timesheets.
You can use the time between the referral and the initial visit to set up a record. DMAS prescribes the documentation that must be maintained by Services Facilitators. This slide shows the information DMAS requires you to keep:

- All assessments (in other words, the UAI or LOF);
- All referral documents;
- Any service plans;
- Each Individual Service Authorization Request;
- Service Authorizations received;
- For the EDCD Waiver, the current DMAS-225 from the local Department of Social Services;
- Consent and authorization forms;
- Guardianship and Power of Attorney documentation;
- Letter to physician (if applicable);
- For the EDCD Waiver, the DMAS-95;
- Documentation of all contacts with the individual;
- Documentation of quarterly reviews (face-to-face);
- For the DD and EDCD Waivers, the DMAS 99LOC (Level of Care review); and
- Any Adult or Child Protective Services complaints filed.

If you work for an agency, it is also important to include any other forms or information your agency might require. Be sure to check with your supervisor.

For additional record-keeping and documentation requirements, always refer to the current DMAS Provider Manual for the applicable Waiver. You can find all current Manuals at the website referenced on this slide.

For the DD Waiver, select Individual and Family Developmental Disabilities Waiver Services; For the EDCD Waiver, select Elderly or Disabled with Consumer Directed Services; For the ID Waiver, select Intellectual Disability Community Services; and For EPSDT, select EPSDT Manuals.

Now that you have accepted and processed the referral and set up a record, it’s time to conduct the initial (also called comprehensive) visit!

The initial comprehensive visit must occur on or before the delivery of services, depending on the waiver. It encompasses many requirements that we will review in a minute.
The initial comprehensive visit is done only once upon the individual’s entry into CD services. If an individual changes Services Facilitators or the individual subsequently adds another CD service, the new Services Facilitator performs a reassessment visit, but not a comprehensive visit.

EOR Training may be a part of the initial comprehensive visit.

If possible, it is advisable to send copies of the EOR Manual and other pertinent information to the EOR prior to the initial comprehensive visit so that the EOR has time to review the materials.

**Slide 30**

There are many things you will need to do at the time of the initial visit.

First, use this visit as an opportunity to meet and get to know the individual (and the EOR if it is not the individual).

Assure that the individual is appropriate for CD services.

Discuss EOR duties and responsibilities, and provide a copy of the EOR Manual if one was not provided previously.

Ensure that the individual understands his or her rights and responsibilities in the program.

Review and sign the Service Agreement between the Individual and the CD Services Facilitation Provider form.

Conduct the initial assessment and develop the plan or plans for CD services. It is very important that the assessment occurs after the individual is determined to be eligible, but before the attendant begins services.

Lastly, make sure the person or EOR signs all of the forms found in the Employer Packet.

We’ll look at each of these in more detail now.

**Slide 31**

You may already know the individual before you meet with him or her during the initial visit. If not, introduce yourself and be sure to explain your role.

Take a moment to review what will happen during the visit and how long it should take.

You can also use the introduction to briefly explain the role of the EOR as the employer of CD attendants and mention other responsibilities such as who can and cannot be hired; meetings, visits, and trainings; when supports can be initiated, and when they can start to hire attendants. You can let them know that you will go over these in greater detail later in the visit and during the EOR Training.
Encourage (and answer) any questions that the individual, EOR, or anyone else present during the visit may have.

Assure the EOR that you are available for any questions that arise after the visit, and be sure to leave your contact information!

**Slide 32**

During the initial visit, you will also need to determine that the individual is eligible to engage in CD services and that the conditions are understood by the EOR. The following conditions must be met:

- The individual must be present for services;
- Services must be provided according to the CD services plan;
- Services must be authorized by the appropriate authorization contractor--there is no payment for services that are not authorized;
- Services must be provided by qualified providers; and
- A viable back-up plan must be in place. Prior to enrollment in the waiver, the individual should have had a back-up plan already established. However, it is a good idea to check with the individual and make sure that the back-up plan on file is still viable.

Additionally, if the individual has medication or skilled nursing needs that cannot be met through CD services—for example, needs that cannot be addressed through nurse delegation or supervision—consumer direction is not appropriate for the individual.

**Slide 33**

You will also want to take time to review the qualifications for the EOR, explaining that this is either the individual using the services or someone who acts on behalf of the individual.

For example, a parent of a child under 18 years of age or a family member or a caregiver of an adult with a cognitive disability who is unable to act as an EOR, can serve as the EOR on behalf of the individual in using CD services. The EOR is the person who will sign tax paperwork, oversee attendants, and sign timesheets. The EOR can never be the paid attendant or the Services Facilitator.

The EOR is the person who will be receiving the EOR training that you will provide and sign all the required forms.

If the individual cannot act as the EOR and has no one else able to assume the CD employer responsibilities, CD services are not appropriate for the individual.
It is important that EORs understand both their responsibilities and rights as an employer. As the employer, they are the point of contact for CD attendants. You, as the Services Facilitator, assist the EOR to resolve issues. EOR responsibilities include:

- Writing attendant job descriptions;
- Recruiting, hiring, training, supervising, managing, and if necessary, dismissing attendants as needed;
- Establishing performance evaluation criteria for each attendant;
- Establishing schedules and tasks to be completed by each attendant;
- Keeping track of the services provided by the attendant; and
- Establishing a system for signing and submitting timesheets.

Each person has rights that you should carefully explain to them. First, there is a **right to appeal** any action related to initial or continued eligibility for Medicaid, including:

- Delayed processing of an application;
- Actions to deny a request for services; and
- Actions to reduce or terminate coverage after eligibility has been determined.


There is also a **right to confidentiality** or privacy. All providers must protect the confidentiality of individuals who apply for and receive Medicaid services. Personal identifying information about an individual cannot be disclosed without the individual’s or his or her legally authorized representative’s written consent.

Individuals also have a **right to consent to services.** Written consent must be given before waiver services can begin and before services are changed.

Each individual has a **right to receive services that are individually planned** and tailored to the individual. Individualized planning is required for all waivers. Services can be planned in a variety of ways. Some people see this as a very personal process in which they do not want or need others to be involved, so meeting with their case manager/support coordinator and providers separately may be what they want and need. Others want to have all of their providers to come together in one meeting to discuss services. Some people want intensive, personal meetings to discuss all aspects of their life and to plan in depth for services. There are different kinds of planning processes that can be used to develop waiver and other services. Planning and services should always focus on the individual’s needs and choices. Everyone has unique personalities, needs, perspectives, and supports, so waiver services must be individualized and
personal. For more information on individualized, person-centered plans and practices, see http://www.personcenteredpractices.org.

Individuals have a **right to choice**. This includes the right to choose to receive services in the community, the right to choose waiver service providers (including Services Facilitators), and the right to change providers.

**Individuals may have other rights as well.** For example, the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by DBHDS*, often referred to as the “*Human Rights*” *Regulations*, address a large range of rights of people receiving services from certain providers, including ID Waiver providers and certain DD Waiver providers. You can find more information about the *Human Rights Regulations* at www.dbhds.virginia.gov/OHR-default.htm.

**Slide 36**

After the roles and responsibilities are discussed, a *Service Agreement between the Individual and the CD Services Facilitation Provider* is signed and dated. A copy must be kept in both the EOR’s and your records. Be sure to explain the contents of the agreement and answer any questions the individual may have before signing the agreement. The agreement provides that either party can terminate the agreement upon 10 day’s notice to the other party. *A copy of this Agreement is provided in the Module 2 Training Materials.*

**Slide 37**

The initial comprehensive home visit is designed for the Services Facilitator to collaborate with the individual and the individual’s family or caregiver, as appropriate, to identify the individual’s needs and assist in the development of the CD services plan. As such, you will be gathering information from the individual, family and caregiver that enables the development of that plan. The assessment and CD services planning have some common elements across the three waivers, and some areas that vary from waiver to waiver. Common elements include the need to:

- Review existing documents that have been provided;
- Use person-centered planning;
- Identify the individual’s needs as they relate to CD services; and
- Develop a plan for each CD service that is coordinated with other service plans.

*A sample chart of attendant tasks is included in the Module 2 Training Materials.*

**Slide 38**

The use of Person-Centered Practices is a way of assuring that individuals have the same rights and responsibilities as other people, including:

- Expressing what they want in their everyday lives;
- Taking and/or maintaining control of their lives;
• Making their own choices;
• Connecting and contributing to the community;
• Having opportunities to improve their lives and have joy, happiness, and purpose;
• Seeing family and friends as often as they like; and
• Managing their own money and other resources.

You are respecting people and their rights if you:

• Listen carefully to them;
• Work together with them and whomever else they choose (family, friends, neighbors) to support them in living the life they want;
• Offer choices about when, where, and how they get their supports—and honor those choices; and
• Help them plan better for the present and the future; work and/or contribute in other ways to their community; be involved in groups, organizations, and social activities that interest them; and learn new things; and stay healthy and safe.

Any plan for CD services should always include:

• A positive description of the individual -- what people like and admire about the individual and what his or her talents and gifts are;
• Who is important to the individual, including family, friends, and paid professionals;
• What is important to the individual - likes, preferences and routines;
• What is important for the individual is needed for health and safety;
• What others need to know or do to support them;
• How the individual prefers to communicate;
• Characteristics of the people who best support the individual;
• An action plan that says who will do what by when; and
• Evidence that the plan is updated as the individual’s needs and preferences change.

Slide 39

The processes and forms that are specific to each Waiver and to EPSDT are presented in the next few slides. Let’s first talk about the DD Waiver.

In the DD Waiver, the Services Facilitator will review the LOF and the existing Plan of Care developed by the individual’s case manager.

During the initial visit, the Services Facilitator elicits from the individual and family member and/or caregiver all of the individual needs to be addressed. This of course must occur prior to the start of services for any individual choosing to receive CD services. The information gathered during the visit should result in the development of the supporting documentation for the appropriate CD service(s) for the individual. The Plan of Care is recorded on DMAS-97AB, which we will cover in a minute.
A copy of this supporting documentation must be forwarded to the individual’s Case Manager to initiate the authorization process. This can be done up to 60 days prior to the current plan’s end date.

**Slide 40**

In the EDCD Waiver, prior to the initial visit, the Services Facilitator reviews the UAI and any existing Plans of Care. During the visit, the Services Facilitator will identify, with the individual and/or family member or caregiver, all individual needs to be addressed in the Plan of Care. During the visit, the Services Facilitator—with the individual—will develop a safe, appropriate Plan of Care that will meet the identified needs of the individual and complete any other assessments that may be needed.

A copy of this Plan of Care must be shared with other providers of services to the individual. Services authorization requests can be submitted 30 days prior to the current plan end date.

**Slide 41**

In the ID Waiver, be sure you obtain the individual’s existing person-centered Individual Supports Plan, Parts I, II, III (and, if the CD plan starts at the same time as the other Waiver services, Part IV) from the Support Coordinator. Part III includes a list of outcomes shared by those supporting the individual currently. If the existing Part III does not contain outcomes that would relate to supports provided by a particular CD service, the Support Coordinator will be able to work with you and the individual or family to arrive at outcomes that are meaningful and measurable for the CD plan for supports.

Using the results of the initial visit and the existing Person-Centered Individual Supports Plan, complete a CD Plan for Supports (one per service). The recommended format for the CD plan(s) is the Part V Plan for Supports available at: http://www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm.

If the DMAS-97AB is used instead of the recommended Part V Plan for Supports, the Personal Preferences Tool should be used to meet person-centered waiver requirements. This is available online at http://www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm. Include the date of the initial Services Facilitator visit on the CD Plan for Supports.

A copy of the Plan(s) for Supports, along with a summary of the information gathered from the comprehensive visit, must be sent to the individual’s Support Coordinator. An ISAR should be submitted to DBHDS as soon as possible.

**Slide 42**

The DMAS-97AB is a very important document. It assesses the Level of Care an individual needs, which governs the attendant hours that are permitted for a particular service.
Instructions appear on the form, which again is included for reference purposes in the Module 2 training materials but should be accessed for use directly from the Virginia Medicaid Web Portal.

Please note that, while the DMAS-97AB can be used for the ID Waiver, without the Preference Tool, the plan is not considered to be individualized and person centered.

Slide 43

Module 3 will cover EOR Training that is required of Services Facilitators. Again, this training can be provided at the initial visit, or within 7 calendar days following the initial visit in the EDCD Waiver or within 7 calendar days following service authorization in the DD and ID Waivers.

At the training, the Services Facilitator is required to review the DMAS EOR Manual. If you are planning to provide EOR Training at the initial (comprehensive) visit, you should have mailed a copy ahead of your visit. If you are not providing EOR training at the time of the initial visit, you can bring a copy and leave it for the EOR to review between the visit and the training.

It is also recommended that you also provide the individual with a copy of “Your Guide to Directing Your Own Supports in Virginia,” a user-friendly guide compiled by individuals who use CD services.

You can find a copy of both manuals in the Module 2 training materials. For the most up-to-date version of the EOR Manual, be sure to access copies of it directly from the Virginia Medicaid Web Portal.

Slide 44

After PPL receives a “Fiscal Agent Services Request Form” (FARF) that you have sent to them, PPL forwards the EOR an EOR Information Packet that contains various information and forms to be signed. This packet of materials and the forms should now be reviewed and completed (if they were not previously completed).

- The EOR Confirmation of Information Form is completed by PPL, and the EOR needs to review it for accuracy.
- There are 3 tax forms that must be completed:

-Form SS-4 is an application for an Employer Identification Number (EIN) and it must be signed by the EOR. It allows PPL to obtain the EOR’s EIN.

-Form 2678 is the Employer/Payer Appointment of Agent. PPL completes this form, and the EOR must sign it.

-Form 8821 must also be signed by the EOR. This form permits PPL to discuss the employer withholding account with the IRS.
• The Signature Authority and Release of Information form must be completed and signed. This form tells PPL who it can discuss the individual’s services with and who can sign timesheets.

• The Attendant Employment Application Request form, which is completed by the EOR using information from the attendant, does not require a signature.

• Other forms, which are used only if and when applicable, include: Address Change forms for the individual and the EOR; Notice of Discontinued Employment Form, to be used only when an attendant leaves employment; Acceptance of Responsibility for Employment Form, which is used only when the attendant has been convicted of a non-barrier crime; and forms the individual can use to develop an attendant job description, conduct attendant evaluations, document, and communicate likes and dislikes.

Other information included in the packet includes a pay schedule and timesheet information; and Frequently Asked Questions (FAQs).

All required forms in the packet must be completed correctly, and many must be signed and dated before the EOR can begin employing an attendant. Additionally, services must be authorized before an attendant can be paid for working. We will cover service authorizations in a moment.

Slide 45

Following the initial visit, the Services Facilitator has several things to do in follow up. We will go over each one of the responsibilities in the next few slides.

Slide 46

The EOR is responsible for sending PPL the originals of the following forms from the Employment Packet:

• SS4 Application for Employer Identification Number;
• Form 2678: Employer/Payer Appointment of Agent;
• Form 8821: Tax Information Authorization;
• Signature Authority/Release of Information;
• Acceptance of Responsibility for Employment Form (if applicable); and
• Attendant Application Request form, if attendant has been chosen. (This form may be completed on-line or in hard copy.)

As with other forms, the EOR should keep copies prior to sending signed originals to PPL. Also, remember to keep a copy for the individual’s file.
Slide 47

The Services Facilitator must be sure to maintain copies of all forms and other documentation of the Initial Comprehensive Home Visit (including date, time, and location) in the individual’s record.

Slide 48

In all waivers, the Services Facilitator must inform the individual’s primary health care provider that services are being provided.

- In the DD Waiver, the Services Facilitator must request skilled nursing and other consultation as needed. The Services Facilitator must also have RN consulting services available, either by a staffing arrangement or through an agreement. The RN consultant is to be available as needed to consult with individuals and Services Facilitators on issues related to the health needs of the individual. This requirement does not involve an actual visit to the individual, unless needed, and is not meant to replace appropriate physician's office visits.

Slide 49

In the EDCD Waiver and the EPSDT Program, the Services Facilitator must request consultation as needed.

Slide 50

- In the ID Waiver, the Services Facilitator must request skilled nursing an other consultation as needed regarding the health needs of the individual. ID Waiver skilled nursing consultation is also available as needed for this purpose. This requirement does not involve an actual visit to the health care provider and is not meant to replace appropriate physician’s office visits.

Slide 51

In order for CD services to begin, the Services Facilitator must assure that CD service authorizations are submitted correctly and immediately. You may recall from Module 1 that:

- KePRO performs authorization for services under the EDCD Waiver. Service authorization is requested by completing and submitting DMAS-98 to KePRO in the EDCD Waiver and the EPSDT Program and to the case manager in the DD Waiver. An example of this form is included with the training materials with Module 2 on this website, however forms for use should be accessed through the Medicaid portal.

- The Division of Developmental Services (formerly the Office of Developmental Services (ODS)) at DBHDS authorizes services under the ID Waiver. Service authorization is requested through completing and submitting an ISAR electronically for each CD service
being requested to the individual’s Support Coordinator, along with a summary of the initial visit and the CD Plan for supports. Be sure to include a start date of Services Facilitation (in other words, the date of the initial visit), along with start date for CD Services. As we discussed in Module 1, this requires registration with Delta. ISARs may not be forwarded by paper.

The Services Facilitator cannot be paid until the CD ISAR is authorized by DBHDS through IDOLS and entered into the DMAS computer system. Services Facilitators will receive a notice of this computer entry. Upon receipt, you should review the computerized DMAS Preauthorization Notice for accuracy of all information and forward any needed corrections to the Support Coordinator.

If the individual has a patient pay obligation, also obtain from the Support Coordinator the written notification that identifies the collector of the patient pay (as explained in the ID Community Services Manual, Chapter IV) at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Slide 52

Billing procedures are covered in more detail in Module 4. As for now, just remember that you can bill for the initial visit at this point. It is extremely important to confirm DMAS Waiver rates, prior to billing, on the DMAS website: http://www.dmas.virginia.gov/Content_pgs/ltc-wvr.aspx.

The Initial Comprehensive Visit is Code # H2000, using CMS-1500 form.

Please note that DMAS has informed providers that paper 1500s will not be accepted after April 1, 2014.

It is important to understand that the Initial Comprehensive Home Visit can be billed only once per individual receiving CD services. If the Services Facilitator changes and a new assessment is required, the new Services Facilitator will submit a revised CD ISAR and bill for a Reassessment Visit – not an initial visit.

Slide 53

You have now completed Module 2 of the four-part online series for meeting the requirements for training as a Services Facilitator.

Please note that all of the web links provided in this Module are contained in the accompanying training materials.

Please complete the learning assessment for Module 2 before proceeding to Module 3.

Thank you for your participation!