Aging and Disability Services Division
CBC-MS200 Community Service Options Program for the Elderly

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I. INTRODUCTION

The Aging and Disability Services Division (ADSD) recognizes that many individuals at risk of being placed in a facility for long-term care can be cared for in their homes or communities, preserving independence and ties to family and friends with supportive services.

The Community Service Options Program for the Elderly (COPE) originated in 1987. This program provides community-based, non-medical services to enable frail, elderly persons to remain in their own homes and avoid placement in a long-term care facility. The provision of any home and community-based services are based on the identified needs of the participant and available funding. The ADSD will assist participants with accessing other available services, as needed. Every biennium, the service needs and the available funding for the program are reviewed by the ADSD and presented to the Nevada State Legislature for approval.

The State of Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization. The State of Nevada also understands that people who are elderly are able to lead satisfying and productive lives when appropriate services and supports are provided. The ADSD is committed to the goals of self-sufficiency and independence.

II. AUTHORITY

Pursuant to NRS 427A.250, the ADSD created the COPE program. The goal is to allow recipients to live in their own homes when appropriate.

The ADSD has the flexibility to design this program and select the mix of services that best meets the goals of the program. This flexibility is predicated on administrative and legislative support, as well as availability of funds. The ADSD also acts in accordance with recommendations made by the Nevada Commission on Aging (COA) as established in NRS 427A.038.

The COPE policies follow a course of procedures to assure that the requirements of NRS 427A.250 and regulations in NAC 427A are achieved. The COPE policy addresses:

- Recipient eligibility for the COPE program;
- Services which assist a COPE recipient in sustaining an independent community-based lifestyle;
- Data management and analysis.

Applicable Statutes and Regulations:

- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person); 232 (Department of Health and Human Services); 422A (Welfare and Supportive Services); 426 (Persons with Disabilities); 427A (Services to Aging Persons); 449 (Medical and Other Related Facilities)
- Nevada Administrative Code (NAC) Chapters 427 (Persons with Disabilities); 427A (Services to Aging Persons); 449 (Medical and Other Related Facilities)

III. POLICY

Nevada's COPE program complies with certain statutory requirements and offers services to eligible recipients to assist them to remain in their own homes or community.

A. GENERAL ELIGIBILITY CRITERIA

Applicants/recipients must meet and maintain all criteria to be eligible during the period of time the recipient receives COPE services.

The ADSD determines eligibility for COPE. The ADSD determines program eligibility by confirming the following criteria is met for each applicant:

1. Applicants/recipients must be 65 years of age or older;
2. Reside in the State of Nevada;
3. Meet financial eligibility according to the monthly income and asset guidelines established by NAC 427A;
4. Meet and maintain a Level of Care (LOC) for admission to a nursing facility within 30 days if not for the services provided by the COPE program;
5. Demonstrate a continued need for one or more COPE service to prevent placement in a Long-Term Care Facility;
6. Be at imminent risk of nursing home placement within 30 days as determined by the ADSD using established criteria;
7. Demonstrate an understanding and willingness to utilize available personal and financial resources to support service needs.

B. ELIGIBILITY, COVERAGE, AND LIMITATIONS

1. The ADSD management monitors the overall purchase of service costs statewide and notifies each office of the availability of funds for processing cases or service authorizations.
2. COPE is limited by legislative mandate and the available funding each fiscal year. Services may be suspended, reduced, or terminated, when the budget authority has been exhausted,
3. COPE services may not be provided while a recipient is a resident of any licensed residential facility for groups, homes for individual residential care, assisted living facility or an inpatient of any institution (e.g. hospital, nursing facility, Intermediate care Facility for Individuals with Intellectual Disabilities or a Related Condition (ICF/IID)).
4. COPE services may not be provided when a recipient is receiving services through another ADSD program. The recipient cannot receive services under two or more such programs at the same time.
5. Payment will not be made for services provided outside the State of Nevada.

6. Recipients who are enrolled or elect to enroll in a hospice program may be eligible to remain on the COPE program if they require COPE services to remain in the community. Close coordination between the hospice agency and the COPE case manager is required to prevent any duplication of services. COPE services will only be provided for recipients enrolled in hospice when the need for services is unrelated to the terminal condition and the need exceeds the services provided under the hospice benefit.

7. Any applicant/recipient who is eligible for Fee For Service Medicaid benefits will not be eligible for the COPE program.

   Any applicant/recipient who has been deemed ineligible for Medicaid benefits due to any divestiture of assets may not be eligible for the COPE program.

   An applicant who meets other COPE eligibility requirements, who is pending Medicaid eligibility may be placed temporarily on the COPE program, at the ADSD Social Service Manager's discretion.

8. The applicant/recipient must be a U.S. Citizen, or an alien legally admitted for permanent residency. The applicant/recipient must also reside in the State of Nevada and services will only be provided while residing at home.

   In addition, Social Security numbers must be provided by every applicant/recipient. Verification by the ADSD is required and can include:

   a. Copy of Social Security Card;

   b. Copy of Social Security check;

   c. Letter from the Social Security Administration (SSA); or

   d. Copy of the SSA benefit letter.

   Failure to comply with these requirements may result in denial, suspension or termination from the COPE program.

C. INTAKE AND ASSESSMENT

The ADSD has developed policies and procedures to ensure fair and adequate access to the COPE program.

1. Referral Process

   a. An inquiry or referral for the program may be made by contacting the local ADSD office. An intake form CBC-102 will be completed.

   b. Qualified ADSD staff in each local office will review referrals and contact applicants and/or the applicants' family to verify the information provided and the types of services needed. This initial contact will determine preliminary financial eligibility, needed tasks, and support system.

   c. If there is indication the applicant meets all the required eligibility criteria, a face-to-face interview with the applicant will be scheduled with a qualified ADSD staff member.

d. If it is determined the applicant does not meet the required eligibility criteria, a face-to-face interview will not be scheduled, and the applicant will be denied in writing, and referred to other agencies and programs as appropriate. The applicant will be advised to contact the ADSD if there is a change in condition or support system.

e. If the applicant is going onto the waiting list, a screening will be completed to determine appropriateness for the program. If the person is not going onto a waiting list, an assessment will be conducted to determine appropriateness of services.

2. LOC Screening and Eligibility Determination

The procedure used for screening an applicant will be as follows:

a. At the time of the face-to-face interview, a qualified ADSD staff member will complete the LOC screening and verify all eligibility criteria for the COPE program is met. A State Application for Assistance will also be completed to determine financial eligibility.

b. The initial assessment is conducted by the ADSD designated staff at the location where the services are offered whenever possible. Financial documentation is obtained and imminent risk(s) identified.

c. A signed Authorization for Release of Information form is required for all COPE recipients and provides written consent for the ADSD to release information about the recipient to others to access needed services.

d. The applicant and/or authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.

e. Qualified ADSD staff will inform the applicant and/or authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services may share confidential information without a signed Authorization for Release of Information.

f. The applicant/recipient will be given the right to choose COPE services in lieu of placement in a Long-Term Care Facility. The applicant will be provided information and education regarding facility placement if the applicant and/or the Legally Responsible Individual (LRI) prefers placement in a long-term care facility. The referral for COPE will then be closed and the recipient will be notified in writing of the closure.

g. If it is determined the applicant does not meet the required eligibility criteria, the applicant will be notified in writing and referred to other agencies and programs as appropriate. The applicant will be advised to contact the ADSD if there is a change in condition or support system.

3. Waiting List/No Funds Available

If funding is not available a Wait List will be utilized. The Wait List is prioritized as follows:

1. Applicants currently in a nursing facility or acute care and desiring discharge;
2. Applicants with the highest LOC score indicating greatest functional deficits.
3. Applicants requiring services due to a crisis or emergency such as a significant change in support system.
4. Applicants transitioning from another home and community-based program.
5. Applicants with a terminal illness.
6. Applicants requiring minimal essential personal assistance (eating, bathing, toileting, dressing, mobility, self-care) as defined by NRS 426.723.

When funding becomes available, the applicant will be processed for the COPE program based on priority and application date.

4. Assessment Process

   a. The applicant/recipient will be assessed for services, support system and available resources, and a written Plan of Care (POC) developed. The POC is based on the assessment of the applicant/recipient's functional and service needs;

   b. The applicant/recipient, his or her family, and/or LRI should participate in the development of the POC;

   c. The POC is subject to approval by the ADSD Unit Manager and dependent on the appropriateness of services and availability of funds;

   d. Recipients will be given freedom of choice of providers for each covered service included in the written POC. A copy of the POC will be given to all service providers; and

   e. All forms must be complete with signature and dates where required.

5. Effective Date for COPE Services

   Approval and an effective date of service will be given once all eligibility requirements are verified as meeting the criteria, and funding is available. If an applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

6. Administrative Case Management

   The ADSD staff is responsible for monitoring the provision of services included in the recipient's POC. In addition, the ADSD staff is responsible for completing and performing certain administrative activities, which include:

   a. Evaluation and/or reevaluation of the LOC annually or more often, as needed;

   b. Assessment and/or reassessment of eligibility and the need for COPE services annually or more often, as needed;

   c. Development and/or review, in conjunction with the recipient, of the POC annually or more often, as needed;

d. Coordination of multiple services and/or providers;

e. Ongoing contact will be determined by the recipient and/or the personal representative and documented on the POC. Contacts must be made to sufficiently verify that services are being provided appropriately or as outlined in the POC, and identify changes in condition or service needs. They may be conducted by telephone or e-mail. More contacts may be made if there has been a significant change in the recipient's health care or safety status;

f. There will be a documented face-to-face contact in the place of residence and/or where services are provided to each recipient at least once every 365 days, or more often as appropriate;

g. Service authorizations;

h. Monitoring the overall provision of services to ensure needs are being met;

i. Assuring that the recipient retains freedom of choice in the provision of services;

j. Notifying all affected providers of any unusual occurrence or change in status of a recipient;

k. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff; and

l. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

7. Reassessment for Services

Reassessments are conducted during a face-to-face visit annually. The recipient must also be reassessed when there is a significant change in their condition.

The recipient's reassessment will include financial eligibility, LOC, functional status, support system, and needs addressed by the POC.

D. FINANCIAL ELIGIBILITY

Income may not exceed the institutional guidelines established by the Division of Welfare and Supportive Services (DWSS) of the Department of Health and Human Services (DHHS).

During the initial assessment and reassessment processes the qualified ADSD staff will:

1. Complete the State Application for Assistance with the applicant/recipient and/or a LRI;

2. Obtain verification of gross income. All income is considered when determining eligibility, other than income excluded pursuant to NAC 427.408. Any money deposited in a bank account is considered income for the month it is deposited and thereafter is considered an asset. Income eligibility will be determined according to the guidelines approved by the Nevada Commission on Aging (COA);

3. Obtain verification of all assets and resources. Applicant/recipient and/or a LRI must disclose and provide all related documentation as part of the eligibility determination process; and
4. Submit the application and supporting financial documentation to the designated ADSD staff member for approval.

IV. PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

All service providers must obtain and maintain a provider agreement with the ADSD. This includes general compliance with all insurance, workers compensation, and other requirements in accordance with NAC 449.

All service providers must comply with any additional specifications described in the Scope of Work of the contract and/or as described under each specific service outlined in this chapter.

Additionally, all service providers must cooperate with the ADSD and/or state or federal reviews or inspections.

The ADSD maintains a provider agreement with provider agencies, not with individual persons. If an individual wishes to provide personal care services to a recipient, they must enroll with an Intermediate Service Organization (ISO) pursuant to NRS. 449.4304.

A. PROVIDER AGREEMENT AND LICENSING

All providers must provide the ADSD with verification of compliance with the following requirements at the time of the provider agreement application, its renewal, and upon request:

1. Enrollment with the Division of Health Care Financing and Policy (DHCFP) one of the following Provider Types:
    a. 30 – Attendant Care;
    b. 48 or 58 with a specialty code 039 – Homemaker;
    c. 48 with a specialty code 209 – Adult Day Care;
    d. 48 with a specialty code 208 – Companion;
    e. 48 or 58 with a specialty code 199 – Chore;
    f. 48 or 58 with a specialty code 191 – Respite; and/or
    g. 48 or 58 with a specialty code 202 – Personal Emergency Response System; (PERS)
2. Provider Agreement Application;
3. Signed Scope of Work for each service provided;
4. Master Services Provider Agreement;
5. Business Associate Addendum;
6. Reference Checklist for required insurance
    a. Insurance must list the ADSD as an additional insured; and
    b. Must include coverage for sexual molestation and physical abuse;
7. Signed acknowledgement of the Community Based Care Provider Billing Manal
8. Notification of utilization of current or former Nevada State employees;

9. Enrollment vendor number through the State Controller's Office; and
10. No exclusion from the National Exclusions Database through the Federal Office of the Inspector General United States Department of Health and Human Services.

Failure to provide all required documentation may cause the provider's agreement application/renewal to be denied, and/or result in termination of an ongoing contract.

B. CRIMINAL BACKGROUND CHECKS

1. All employees and volunteers of providers enrolled with the ADSD, including owners, officers, administrators, managers, and consultants must undergo state and federal criminal background checks a minimum of every five (5) years, and as indicated, to ensure no convictions of applicable offenses have been incurred. Documentation of the request, and applicable results, must be maintained in the personnel record and made available to the ADSD upon request. All personnel including volunteers, must have the criminal background check initiated by the hiring/employing agency through the Nevada Department of Public Safety prior to the provision of any reimbursable services to a program recipient. Providers are required to initiate diligent and effective follow-up to obtain results of background checks within 90 days of submission of fingerprints and continue until results are received. Documentation must be maintained by the employer and submitted to the ADSD upon request.
2. The ADSD will not enroll any person or entity convicted of a felony or misdemeanor for any offense which the state agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of the ADSD.
3. The ADSD will deny a provider service agreement to any applicant, or may suspend or revoke all associated provider contracts of any provider if:
    a. The applicant or service provider has been convicted of any offense enumerated in NRS 449.174; or
    b. The applicant, or service provider, upon receiving information resulting from the criminal background check, or from any other source, continues to employ a person who has been convicted of an offense as listed in NRS 449.174. The hiring/employing agency must take timely and appropriate action on the results of the background check as outline on the Division of Public and Behavioral Health (DPBH) website.
4. If an employee believes that the information provided as a result of the criminal background check is incorrect, he or she must immediately inform the employing agency or the ADSD (respectively) in writing. An employing agency, or the ADSD, that is so informed within five (5) days, may give the employee a reasonable amount of time, but not more than 60 days, to provide corrected information before terminating the employment or contract of the person pursuant to this section. The employee must be removed from providing services to any ADSD recipient until the issue has been resolved.

C. EMPLOYMENT STANDARDS

All employees, volunteers, and independent contractors providing direct services must:

1. Be at least 18 years of age;

2. Demonstrate the ability to read, write and communicate with the recipient;
3. Have the skills to perform services as described on the POC;
4. Be tolerant of varied life styles;
5. Be able to identify emergency situations and respond accordingly;
6. Be able to document services provided;
7. Be able to maintain confidentiality, and
8. Demonstrate a mature attitude toward work assignments and the needs of the recipient.

D. TRAINING

All employees, volunteers and independent contractors providing direct services to a COPE recipient are required to successfully complete an approved training program. The training program shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision. Each employee, volunteer or independent contractor must be trained, evaluated and be determined competent by the provider prior to delivering services to a COPE recipient.

In addition, all licensed personal care agencies and adult daycare facilities contracted with the ADSD must arrange training for all staff in accordance with regulations established by NAC 449.

Training must include the following subjects:

1. Policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;
2. Record keeping and reporting including billing and daily record documentation;
3. Information about the specific needs and goals of the recipients;
4. Confidentiality; and
5. Any other training as designated by the ADSD.

E. RECORD KEEPING AND BILLING PROCEDURES

Providers may only provide and bill for services that have been authorized by the ADSD that have been identified in the POC.

The provider must maintain medical and financial records, supporting documents, and all other records relating to the provision of services under this program. The provider must retain records for a period pursuant to the State record retention policy. These records must be maintained by the provider for at least six (6) years after the date the claim is paid. If any litigation, claim or audit is started before the expiration of the retention period provided by the ADSD, records must be retained until all litigation, claims, or audit findings have been finally determined. Overpayments are subject to recovery by the ADSD.

1. The provider must maintain all required records for each employee, volunteer or independent contractor of the agency, regardless of the length of employment.
2. The provider must maintain the required record for each recipient who has been provided services, regardless of length of service period.

The daily record is documentation by a provider, indicating the type of service provided and the time spent. This record is utilized to support the subsequent billing for those services. The documentation includes the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this will be clearly documented in the recipient file. The caregiver will initial after the daily services are delivered, with a full signature of the caregiver on each daily record.

Each provider must accurately complete and sign the daily record for each recipient served. Claims for services provided must be submitted in accordance to the guidelines established by the ADSD Provider Billing Manual, which will be made available upon approval of the provider agreement with the ADSD.

Providers may use electronic signatures on the daily record documentation. Using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation of services provided and the time spent providing those services.

If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file.

At a minimum, the provider must document the following on all daily records to validate the service given and the time spent providing the service:

1. Consistent service delivery within program requirements and services outlined on the POC;
2. Amount and types of services provided to recipients;
3. When services were delivered (actual date and time in/out);
4. Signature of recipient or authorized representative; and
5. The caregiver, employee or volunteer must sign the daily record form.

If the recipient is unable to sign due to a cognitive and/or physical limitation, this will be clearly documented in the recipient's file.

F. IMPROPER BILLING PRACTICES

Any provider or its agent(s) that is found to have engaged in improper billing practices may be subject to recoupment, denial, suspension or termination from participation in the COPE program.

The findings and conclusions of any investigation or audit shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Improper billing practices may include, but are not limited to:

1. Submitting claims for unauthorized visits;
2. Submitting claims for services not provided; for example, billing a visit when the recipient was not at home, but the provider was at the recipient's residence;
3. Submitting claims for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care

provider's signature, the month, day, year, and exact time in and out of the recipient's home. Providers shall submit or produce requested documentation upon request;

4. Submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;
5. Submitting claims for the full authorized number of units when the actual amount of service units provided was less;
6. Submitting claims for services provided by an unqualified individual; or
7. Submitting claims for services not authorized on the POC.

G. SERIOUS OCCURRENCE REPORTING

Providers must submit through the online Serious Occurrence portal, or via form NMO-3430A, all serious occurrences involving the recipient, the provider's staff, or anything affecting the provider's ability to deliver services within 24 hours of discovery. The documentation supporting the serious occurrence must be maintained in the recipient's file. A follow up SOR form will be completed by the ADSD social worker within five (5) working days and maintained in the agency's recipient record.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

1. Suspected physical, verbal or sexual abuse or harassment;
2. Elopement from an inpatient setting;
3. Medical or medication errors;
4. Unexplained hospital visit;
5. Theft or Exploitation;
6. Criminal activity;
7. Injuries requiring medical intervention;
8. Medical emergencies;
9. Suicide threats or attempts
10. Any event reported to Child or Elder Protection Services of law enforcement agencies;
11. Death of recipient; or
12. Loss of contact with the recipient.

H. WITHDRAWAL OF SERVICES

A Provider Agency may withdraw from providing services for the following reasons:

1. The recipient or other person in the household subjects the caregiver to physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;

2. The recipient is ineligible for COPE services;
3. The place of service is considered unsafe for the provision of services;
4. The recipient requests services to end;
5. The recipient or PCR refuses services offered in accordance with the approved POC;
6. The recipient is non-cooperative with the establishment of delivery of services, including providing accurate and timely submission of required forms;
7. The provider is no longer able to provide services as authorized (i.e., no qualified staff);
8. The recipient requires a higher level of services than those provided within the scope of the caregiver; or
9. The recipient refuses services of the caregiver based solely or partly based on race, color, national origin, gender, religion, age, disability (including AIDS and AIDS- related conditions), political beliefs or sexual orientation of the caregiver.

Provider Agency's notification responsibilities:

1. Immediate Termination - The Provider may terminate PCS immediately for reasons 1 through 4 above.
2. Advance Notice Termination - The Provider must provide at least five (5) calendar days advance written notice to recipients when COPE services are terminated for reasons 5 - 9 above.

In all cases, the Provider is responsible for making reasonable attempts to ensure continuity of care through referrals to other providers when appropriate.

The provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The ADSD case manager must be notified by telephone within one (1) working day. The Provider must submit written documentation within five (5) working days.

The Provider will send a written notice advising the ADSD case manager of the effective date of the action of the termination of service, the basis for the action, and intervention/resolution(s) attempted prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

A Provider's inability to provide services for a specific recipient does not constitute termination or denial from the COPE program. The recipient may choose another provider.

V. COPE SERVICES

The ADSD determines which services will be offered under the COPE program. Providers and recipients must agree to comply with all program requirements for service provision. Services must be directed to the individual recipient and related to their health and welfare.

A. COVERAGE AND LIMITATIONS

Under the COPE program, the following services can be covered if identified in the POC as necessary to avoid institutionalization.

- Personal Care Services;
- Homemaker Services;
- Personal Emergency Response System (PERS);
- Social Model Adult Daycare;
- Adult Companion Services;
- Respite Care Services;
- Chore Services.

The recipient cannot receive COPE services while in a long-term care facility including a hospital, nursing facility, ICF/IID, institution for the mentally ill, licensed residential facility for groups, homes for individual residential care or licensed assisted living facility.

COPE services may not be provided when a recipient is receiving services through another ADSD program. The recipient cannot receive services under two (2) or more such programs at the same time.

The following coverage and limitations will also apply:

1. Mileage Authorization Request

   Mileage for travel to and from a recipient's home or for shopping is not reimbursable.

2. Reimbursement to Family Members

   Payments will not be made for services provided by a recipient’s immediate family or LRI.

   The COPE program may reimburse family members for providing COPE services in hardship situations. Hardship includes residing in an area that lacks qualified providers for a specific service, or existing providers lack the capacity to staff the service. The Social Services Manager must give prior approval and will monitor provider capacity to make necessary changes as to provider assignments as staffing becomes available.

   In the case of a hardship approval, reimbursement will not be made directly to family members for any COPE services. Family members must become employees of a contracted Personal Care Agency and must meet all prescribed provider qualifications.

3. Reimbursement to Caregivers Residing with the Recipient

Payments will not be made for IADLs that are covered services within COPE, when a LRI or caregiver resides in the home. Services must be directed to the individual recipient and related to the recipient's health and welfare.

4. Self-Directed (SD) Model

   The self-directed model is a service delivery option which allows the recipient to direct personal care services. Entry into this model must be approved by the ADSD.

   The recipient must have the ability to express the desire to direct their personal care services and an understanding of the responsibilities involved with this model. Only a recipient or an LRI has the right to request this delivery model.

   A recipient has the option of selecting a Personal Care Representative (PCR) to direct services on the recipient's behalf. The PCR cannot be reimbursed for providing personal care or acting as the PCR.

   This option is utilized by accessing services through an Intermediary Service Organization (ISO), which provides oversight of provider qualifications and processes service claims for reimbursement. The ISO is the employer of record and the recipient is the managing employer. This allows the recipient or the PCR to recruit, hire, train, supervise and schedule the personal care attendant. All individuals seeking this type of self-directed program will be responsible to follow policies and procedures established by Medicaid Service Manual Chapter 3500.

5. Non-covered Services

   The COPE program offers intermittent services designed to delay or prevent institutionalization. Examples of non-covered services may include:

   a. Services determined could reasonably be performed by the recipient;
   b. Services normally provided by a LRI, PCR, or caregiver;
   c. Services not authorized on the recipient's POC;
   d. Services maintaining areas of the home not used directly by the recipient;
   e. Services provided to someone other than the intended recipient;
   f. Services requiring the technical or professional skill that state statute or regulation mandates must be performed by a health care professional licensed or certified by the state unless enrolled in the ISO model;
   g. Services providing for the care of pets except in cases where the animal is a certified service animal; or
   h. Transportation or escort services.

B. RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. Demonstrate an understanding and willingness to utilize available personal and financial resources to support service needs;

2. Apply, pursue and or accept other benefits including Medicaid, if eligible;
3. Disclose all assets and cooperate with all eligibility determinations;
4. Notify the provider(s) and the ADSD of any change in eligibility;
5. Notify the provider(s) and the ADSD staff of current insurance information, including the name of the insurance coverage, such as Medicare or private insurance;
6. Notify the provider(s) and the ADSD staff of changes in medical status, service needs, address or location changes, and/or any change in status of the LRI;
7. Treat all providers and their staff members respectfully;
8. Sign the daily record(s)/provider visit form(s) to verify that services were provided, and not falsify records when services were not received;
9. Notify the provider and/or the ADSD staff when scheduled visits cannot be kept or services are no longer required;
10. Notify the provider agency and/or the ADSD staff of any missed appointments by the provider agency staff;
11. Notify the provider agency and the ADSD staff of any unusual occurrences, complaints regarding delivery of services or specific staff, or to request a change in caregiver or provider agency;
12. Furnish the provider agency with a copy of an Advance Directive;
13. Not request any provider to perform services, or work more than the hours authorized in the POC;
14. Contact the ADSD staff to request a change of provider agency, if desired;
15. Not request a provider to work or clean for a non-recipient, family or household members, or pets that are not certified service animals; and
16. Complete, sign and submit all required forms.

C. ATTENDANT CARE SERVICES

Coverage and Limitations

1. Attendant services are provided by licensed personal care agencies or ISO agencies whom have a provider agreement with the ADSD.
2. Attendant care services must be performed in accordance with the written POC developed in conjunction with the recipient or their representative and authorized by the ADSD using a standardized assessment tool.
3. Attendant care services are provided in the home.
4. Attendant care services include:
    a. Assistance with bathing, showering, or a bed bath. Includes hair shampooing;
    b. Assistance with dressing and undressing;

c. Assistance with toileting needs, which includes: helping the recipient to and from the bathroom, assisting the recipient with a bedpan or other toileting procedures, and routine care of an incontinent recipient, including use of incontinent briefs and protective sheets. Also includes changing a colostomy bag and emptying and maintaining a urinary drainage system;

d. Assistance with transferring and positioning non-ambulatory recipients from one stationary position to another. This includes adjusting/changing recipient's position in a bed or chair and assisting a recipient out of bed, chair, or wheelchair;

e. Assistance with ambulation, which is the process of moving between locations. This includes walking or helping the recipient to walk with support of a wheelchair, walker, cane, or crutches or assisting a recipient out of bed, chair or wheelchair;

f. Assistance with grooming. This includes combing/brushing of the hair, shaving the face, legs, or underarms, oral hygiene including denture care, fingernail care, and the application of orthotics; and

g. Assistance with eating, which includes putting food into the recipient's mouth or substantial cueing due to cognitive deficits. Specialized feeding techniques will not be authorized.

D. HOMEMAKER SERVICES

Eligibility for this service requires that the recipient have functional deficits that would directly preclude them from performing their IADLs.

Service Coverage:

1. Homemaker services are provided by licensed personal care agencies or ISO agencies whom have a provider agreement with the ADSD.
2. Homemaker services are provided when the recipient is unable to manage the home, or the individual regularly responsible for these activities is absent and no other support system exists.
3. Services must be directed to the individual recipient and related to the recipient's functional and service needs.
4. The following IADLs are considered covered homemaking services through the COPE program:
    a. Meal preparation: menu planning, storing, preparing, serving of food, cutting up food, applying condiments and plating food;
    b. Laundry services: washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.) Excludes ironing;
    c. Light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas; and
    d. Essential shopping to obtain: medications, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient.

Service Limitations:

1. Activities the homemaker shall not perform and are not reimbursable include but are not limited to the following:
    a. Transporting the recipient in any vehicle;
    b. Repairing electrical equipment;
    c. Ironing;
    d. Giving permanents, dyeing or cutting hair;
    e. Escort services;
    f. Washing walls and windows;
    g. Moving heavy furniture, climbing on chairs or ladders;
    h. Purchasing alcoholic beverages that were not prescribed by the recipient's physician;
    i. Doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow-covered areas, and vehicle maintenance;
    j. Care of pets except in cases where the animal is a certified service animal.

The ADSD is not responsible for replacing goods which become damaged or lost in the provision of service.

E. PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Coverage and Limitations

1. PERS is an electronic medical alert device that allows an individual at risk to secure assistance in case of an emergency by pushing a button on the device which dials the phone remotely. This system alerts the individual's designee/responding agency that an emergency has occurred, and the individual requires emergency assistance.

2. PERS services are limited to those recipients who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time. The recipient must also be physically and cognitively capable of using the device in an appropriate and proper manner.
3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the POC.

Additional Provider Responsibilities

1. The provider is responsible for ensuring the response center is staffed by trained professionals at all times.
2. The provider is responsible for any replacement or repair needs that may occur.
3. Providers of this service must utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory standards or equivalent standards.
4. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

Additional Recipient Responsibilities

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider or the ADSD staff when the equipment is no longer working.
2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the COPE program, or when the recipient moves from the area.
3. The recipient may not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.
4. The recipient is required to test the PERS device once per month at a minimum to ensure it is working properly.

F. SOCIAL MODEL ADULT DAYCARE

Coverage and Limitations

1. Social adult day care is provided for four (4) or more hours a day on a regularly scheduled basis, for one (1) or more days per week.
2. Services are provided are non-medical, and are in a setting that is away from the recipient's home.
3. It encompasses social service needs to ensure the optimal functioning of the recipient.
4. Meals provided are furnished as part of a program of adult day care services but must not constitute a "full nutritional regime" (i.e., three meals per day).
5. Services are provided in accordance with the goals in the recipient's POC and not merely diversional in nature.
6. Transportation costs for transportation between the consumer's residence and the social adult day care center are not reimbursable by the ADSD.

G. ADULT COMPANION SERVICES

Coverage and Limitations

1. Provides non-medical care, supervision and socialization to the functionally impaired recipient in his or her home or place of residence, which would provide temporary relief for the primary caregiver.
2. Assists the recipient with such tasks as meal preparation and clean up, light housekeeping and shopping. These services are provided as an adjunct to the Adult Companion Services and must be incidental to the care and supervision of the recipient.
3. This service is provided in accordance with the goals in the recipient's POC and is not merely diversional in nature.

H. RESPITE CARE

Coverage and Limitations

1. Respite services are short-term, temporary services provided to eligible recipients to allow LRIs or unpaid primary caregivers a temporary break from the daily routine of providing care to the recipient.
2. Respite provides general assistance with ADLs and IADLs and provides supervision to functionally impaired recipients in their homes or place of residence. Evaluation of available support systems will be made to determine eligibility for this service.
3. In-home respite may be provided when all the following conditions apply, and in accordance with NAC 427A.442:
   a. The recipient has a primary, live-in caregiver;
   b. Respite care is provided for the temporary relief of the primary caregiver who is also responsible for the continuous care of the recipient;
   c. The recipient needs supervision and someone on the premises at all times;
   d. There are no other resources available to assist the recipient;

Respite services will not be authorized for the relief of the personal care attendant; supplemental staffing should be requested from a contracted agency.

In-home respite care is limited to 14-days, for a total of 336 hours, per fiscal year per recipient. All respite services will be tracked internally to ensure service limits are not exceeded, and authorizations will be reviewed by the ADSD supervisory staff.

Authorized scheduled COPE services will be suspended during the respite period and an amendment to the POC covering respite will be developed. The respite provider will assume in-home services.

The primary caregiver being relieved will, prior to leaving, arrange for all food for the recipient to be on the premises, except in emergency respite cases. The primary caregiver will also arrange for the care of pets and yard maintenance before leaving.

I. CHORE SERVICES

Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third-party payer is capable of, or responsible for, their provision. Without Chore services, the recipient would be at risk of institutionalization.

Chore services are those tasks that exceed light housekeeping and are nonskilled, professional services.

1. Coverage and Limitations
   a. This service includes heavy household chores such as:
      i. Cleaning windows and walls;
      ii. Shampooing carpets;

iii. Removing trash and debris from the yard;

iv. Packing household items and belongings to assist a recipient with moving; and

v. Snow removal to allow access to home and entryway.

b. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any COPE program covered services.

2. Provider Responsibilities

a. Providers performing heavy household chores and minor home repair services must maintain the home in a clean, sanitary and safe environment.

VI. ADMINISTRATIVE REVIEW

A. SUSPENSION OF SERVICES

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being suspended. The notice will include:

1. The reason for the suspension;
2. A statement of the rights of the recipient to an Administrative Review; and
3. The process for filing a request for an Administrative Review.

An applicant may have their service(s)/eligibility suspended for any of the following reasons:

1. If a recipient is admitted to a hospital or long-term care facility and it is likely the recipient will be eligible for COPE services within 60 days from the day of admission, a recipient's case may be suspended instead of closed.
2. Services will not be covered or reimbursed while the recipient's case is in suspension status.
3. If at the end of the 45 days from the date of admission the recipient has not been removed from suspended status, the case must be closed. The ADSD will send a letter to the recipient or the recipient's LRI on the 45th day of suspension identifying the 60th day of suspension as the effective date of termination, and the reason for the termination.

B. RELEASE FROM SUSPENSION STATUS

If a recipient has been released from a hospital or long-term care facility before 60 days have elapsed, within five (5) working days of the recipient's discharge, the ADSD case manager must:

1. Complete a new LOC and Social Health Assessment if there has been a significant change in the recipient's condition or if it appears the recipient may not meet the LOC required for long-term care placement.
2. Complete a new POC if there has been a change in needed services. If a change in functional need is expected to resolve in less than 30 days, a new POC is not necessary. Documentation of the temporary change and the date of resolution must be made in the case manager's notes.
3. Contact the service provider(s) to reestablish services and provide documentation of any change in service authorizations.

C. DENIAL OF APPLICATION

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being reduced. The notice will include:

1. The reason for the denial;

2. A statement of the rights of the recipient to an Administrative Review; and
3. The process for filing a request for an Administrative Review.

An applicant may be denied for the COPE program for any of the following reasons:

1. The applicant is under the age of 65 years.
2. The applicant does not meet the LOC criteria for nursing facility placement.
3. The applicant is not at risk of imminent placement in a nursing facility within 30 days if COPE services were not available.
4. The applicant has failed to demonstrate a need for at least one COPE service.
5. The applicant and/or their representative has failed to cooperate with the ADSD in verifying eligibility for services or establishing and/or implementing the POC, and/or implementing services.
6. The ADSD has lost contact with the applicant.
7. The applicant has moved out of state.
8. Another agency or program will provide the services.
9. The applicant is in a long-term care facility (e.g. hospital, nursing facility, ICF/IID) and discharge within 30 days is not anticipated.
10. The applicant and/or their representative has withdrawn the request for home and community-based services.
11. The applicant and/or their representative have participated in activities designed to defraud the COPE program or other programs administered by the ADSD.
12. The applicant and/or their representative failed to provide all required documentation.
13. The applicant does not meet the financial eligibility criteria.
14. ADSD has filled the number of positions allocated to the COPE program based on available funding. The applicant has been approved for the Waiting List and will be contacted when funding is available.

D. REDUCTION OF SERVICE

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being reduced. The notice will be given at least 15 days before the services are to be reduced, and will include:

1. The effective date the case is reduced;
2. The reason for the reduction;
3. A statement of the rights of the recipient to an Administrative Review; and
4. The process for filing a request for an Administrative Review.

A recipient's services may be reduced for the following reasons:

1. The recipient or his/her representative have requested a reduction in services.
2. The recipient no longer needs the service.
3. The recipient no longer requires the number of service hours previously provided.
4. Another agency, program or the recipient's support system will provide the service.
5. Change or clarification of policy.
6. Funding is no longer available.

E. TERMINATION OF SERVICES

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being terminated. The notice will be given at least 15 days before the services are to be terminated, and will include:

1. The effective date the case is terminated;
2. The reason for the termination;
3. A statement of the rights of the recipient to an Administrative Review; and
4. The process for filing a request for an Administrative Review.

A recipient's case may be terminated for the following reasons:

1. The recipient is deceased.
2. The recipient no longer meets the LOC criteria for nursing facility placement.
3. The recipient and/or their LRI have requested termination of COPE services.
4. The recipient fails to apply for, pursue or accept a claim for other benefits, or fails to provide information essential to establish such a claim.
5. The recipient's residence has become unsafe for the recipient or his/her service provider.
6. The recipient and/or their LRI have participated in activities designed to defraud COPE or other programs administered by the ADSD.
7. The cost of services provided to the recipient exceed the average cost of care for a patient who receives care in a nursing facility.
8. The recipient is no longer at risk of imminent placement in a nursing facility within 30 days if COPE services were not available.
9. The recipient has failed to demonstrate a continued need for at least one COPE service.
10. The recipient and/or their LRI has failed to cooperate with the ADSD in verifying eligibility for services, establishing and/or implementing the POC, or implementing services.
11. The ADSD has lost contact with the recipient.

12. The recipient has resided out-of-state for 30 days or longer.
13. Another agency, program, or the recipient's support system will provide the service.
14. The recipient is in a long-term care facility (e.g. hospital, nursing facility, ICF/IID) and discharge within 60 days is not anticipated.
15. Change or clarification of policy.
16. Funding is no longer available.
17. The recipient and/or their authorized representative have failed to notify the ADSD of changes in income or assets that would affect the recipient's eligibility.
18. The ADSD has filled the number of positions allocated to the COPE Program through funding available. The applicant has been placed on the Waiting List and will be contacted with a position is available.

F. ADMINISTRATIVE REVIEW REQUEST

1. An Administrative Review is a process that provides an applicant/recipient the opportunity to appeal an adverse action taken by the ADSD. An applicant/recipient may file an appeal according to the procedures and regulations established by NAC 427A.460-427a.488. An Administrative Review may be requested when:
    a. Services are denied, terminated, or reduced without concurrence, except when the action occurs due to a lack of available funding for the PAS program.
    b. There is a grievance regarding the delivery, quality, duration or scope of service(s) being provided.
    c. An applicant/recipient has not been given a choice between home and community-based services and institutional care, or a choice between service providers.

2. The applicant will receive a copy of the Statement of Understanding and a copy of the Administrative Review Process during the initial assessment visit. If an applicant is denied, terminated, suspended or services have been reduced for the PAS program, a letter will be sent which includes information on the Administrative Review process.

Refer to CBC-MS500 for more information on the Administrative Review Process.

VII. QUALITY ASSURANCE

Quality assurance is a method that allows for review of services provided to recipients, quality of services provided to recipients, and identifying areas for improvement.

The ADSD established Quality Assurance Programs will be utilized to assist in assuring recipients are receiving required services.