



Signature Sheet
for
Approval of the
Wyoming Home Services
Policies & Procedures



To Be Removed

To Be Inserted

NO.	Section	Pages	NO.	Section	Pages
1.	Required Reporting	15	1.	Required Reporting	15
2.	Financials	16-17	2.	Financials	16-17
3.	Services	20-23	3.	Services	20-23
4.	Forms	27-29	4.	Forms	27-29
5.	Attachments	38	5.	Attachments	38
6.	Dispute Process	31	6.	Dispute Process	31
7.			7.	Waiting List Care Coordination Instructions and Spreadsheet	N/A

Following are the significant changes made to the Policy and Procedures

Section	Change Clarification
Services	Added 'Waiting List Care Coordination' and direction on how to perform this service.



Heather Babbitt, Senior Administrator

1-8-2016

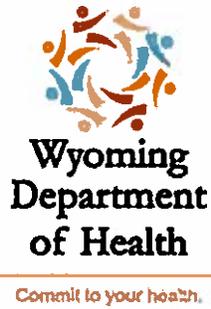
Date



Lindsay Healy
Program Manager

1/8/2016

Date



Wyoming Home Services

Policies & Procedures
Manual

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Introduction to Wyoming Home Services

The Wyoming Home Services (WyHS) program is mandated by the State Of Wyoming through W.S. § 9-2-1208. WyHS is fully funded by the State of Wyoming General Fund. Initially, termed the Community Based In-Home Services Program, WyHS was created to serve Wyoming's senior citizens and disabled adults eighteen (18) years of age and older. Priority is given to individuals at risk of premature or inappropriate institutionalization. WyHS is a social program, which can provide up to ten (10) services for eligible individuals. These services include: care coordination, personal care, homemaking, chore, respite, personal emergency response systems, adult daycare, hospice, home modification, and medication setup.

WyHS is granted out to one (1) provider in each county in Wyoming, totaling 23 providers throughout the State. Every four (4) years the program is put out for a competitive application. Year's two (2) through four (4) are continuation grant years, in which the organization who is awarded the grant in the competitive year, houses and maintains the program.

In order to apply to be a provider for Wyoming Home Services in Wyoming, an organization must apply during the competitive grant year. At this time, public notices are published in statewide newspapers. Organizations then request an application, based upon the instructions of the public notice, in order to apply. If there is more than one applicant in a county, a team of individuals will be gathered to score the applications submitted and the grant funds will be awarded to the highest scoring applicant.

When an organization applies to become a provider of WyHS in their county, they select which services they are going to provide. The one (1) mandatory service to be provided is care coordination. The organization shall employ an individual who is trained by the division to serve as an Access Care Coordinator (ACC) to provide the care coordination service. Access care coordinator training is provided by the Division at least one time per year, with individualized trainings available as needed throughout the year.

In order to be eligible for the WyHS program, potential clients must be at least eighteen (18) years of age, determined through an ongoing assessment (AGNES) to be at-risk of premature institutionalization, and be in need of program services. No person will be denied services based upon their inability to pay for services, payment for services is based upon a sliding fee scale and a mutual agreement between the client of services and the provider of services. Any payment collected will be considered program income.

Definitions

Access Care Coordinator. A person certified by the Wyoming Department of Health, Aging Division, Community Living Section to provide care coordination services for the Wyoming Home Services program.

Adult Day Care. Adult day care is a community based group program designed to meet the needs of adults with physical or mental disabilities through an individual activity care plan. It is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective setting during any part of a day, but less than 24-hour care.

At-risk. An individual unable to perform normal daily tasks independently due to multiple problems which can include, but are not limited to physical, emotional, or cognitive functioning, environment, abuse or neglect.

Capitation. A cost containment measure which places spending limits on community based in-home services funding for each client.

Care Coordination. A set of logical steps and processes of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient, and cost effective manner.

Central Registry. Means the registry maintained by the Wyoming Department of Family Services pursuant to W.S. §14-3-213, which indexes perpetrators of child abuse or neglect and abuse, exploitation or abandonment of disabled adults.

Certified Nursing Assistant. A person who is currently certified by the Wyoming State Board of Nursing.

Chore. Chore services may include snow removal, yard maintenance, deep cleaning of household appliances or other services per the discretion of the provider.

Client. An at-risk adult, age 18 or older, who is the client of Wyoming Home Services.

Client Evaluation. Interviewing and observing the client, usually in the client's home, in order to obtain information on the client's functional capacity, available personal and social support resources, perceived problems, and services currently received from formal or informal sources.

Continuing Education Booklet (CEU Booklet). The form in which ACC's will document and track education related to their work as an ACC.

Days. Calendar days.

Department. The Wyoming Department of Health.

Disability. Per the ADA Amendments Act of 2008, a physical or mental impairment that substantially limits one or more major life activities.

Division. Aging Division.

Evaluation. Determining the status of the client for service (s) that can be addressed by the program. This will be completed as specified by the Division.

Financial Year. An accounting period of twelve months starting July 1 through June 30.

Grantee. An organization that provides services outlined in an approved grant funded by the Division.

Health Evaluation. An evaluation of a client's medically related needs by a physician, physician extender or licensed nurse.

Heavy Housework. Examples include but are not limited to moving heavy furniture, washing windows, cleaning baseboards, cleaning the floor on hands and knees, shampooing carpets, deep cleaning of kitchen appliances, cleaning overhead light fixtures & fans, cleaning & organizing cupboards & closets.

Homemaker. A person who assists with environmental services such as, but not limited to, light housekeeping, basic meal preparation, shopping, and laundry. Homemakers do not provide personal care.

Home Modifications. Minor modifications that are necessary to facilitate the ability of at-risk adults to remain in their homes and that are not available under other programs. A maximum of three hundred dollars (\$300) per client per year may be expended under this program for such modifications.

Hospice. A program for the terminally ill and their families given in a home or health facility which provides medical, palliative, psychological, spiritual, and supportive care and treatment.

Immediate Family. A person such as a spouse, parent, stepparent, parent-in-law, child, stepchild, child-in-law, sibling, half-sibling, stepsibling, sibling-in-law, grandparent, step-grandparent, grandparent-in-law, and grandchild.

Level of Care. Level of services a client may need such as in home, intermediate, or institutional.

Light Housekeeping. Services such as sweeping, vacuuming and mopping floors, dusting, cleaning in the areas used by the client which are essential to the client's maintaining a sanitary home.

Local Match. Local funds raised by the provider to be used to match state funds within the provider's budget.

Medication reminder. Per Chapter 7 of the WY State Board of Nursing, a CNA may perform the following, reminding the client to take medication, assisting with the removal of a cap or blister pack, assisting with the removal of a medication from a container for a client with a disability which prevents independent performance of this act, observing the client take the medication, applying topical ointments to intact skin, inserting Dulcolax & glycerin suppositories rectally.

Medication setup. A licensed pharmacist or licensed nurse can administer medications into a client's medication box.

Outreach. Identifying and establishing contact with persons who need the services provided by the program.

Personal Care. Activities include, but are not limited to, bathing, grooming, feeding, ambulating, exercising, oral hygiene, and skin care.

Personal Emergency Response System (PERS). An electronic device worn by the client to summon emergency help.

Physician Extender. Physician Assistant (PA) and/or Advanced Practitioner of Nursing.

Respite Care. Temporary, substitute supports to provide a brief period of relief for caregivers.

Senior Citizen. Any person 60 years of age or older.

Service Plan. Documentation of the services that will be provided to meet the needs and goals of the client.

Service Unit. One hour of direct service provided to the client with the exception of PERS. One service unit for PERS is defined as an initial hook-up, the monthly service, or the termination of service.

Significant Change of Status. A significant change of status includes, but is not limited to, if a client goes into the hospital for more than 24 hours, if a client moves, if a client's home has an infestation, the WyHS provider is informed that a client 'isn't doing well', a client's ADL or IADL number changes, etc.

Sliding Fee Schedule. Payment for services rendered to eligible clients based on the ability to pay.

Unable. Lacking the necessary ability to pay client fees for WYHS services.

Unsafe. Threatening, dangerous or posing physical or emotional harm.

Unwilling. Opposed to paying the client fees for WYHS services.

Community Living Section

The Community Living Section (CLS) is a section within the Wyoming Department of Health's Aging Division. The CLS houses multiple programs, primarily under the direction of the Older Americans Act of 1965, as amended in 2006.

Provider Organizations

Once a provider organization is awarded the Wyoming Home Services grant funds, they will begin to serve Wyoming's eligible citizens.

Employees

The provider organization will need to hire and train the appropriate staff to provide services. All care coordinators, homemakers, CNA's, and nurses must be covered by liability insurance and bonding.

- ***New Employee Orientation:*** All staff shall have a general orientation completed during the first week of employment and prior to direct client contact, documentation of this orientation shall be kept in each employee's personnel file. This orientation shall include, but is not limited to, the following areas as related to job responsibilities:
 - Confidentiality;
 - Emergency procedures;
 - Cardio-Pulmonary Resuscitation (CPR)
 - First Aid
 - Universal precautions
 - Client rights and responsibilities;
 - Elder and disabled abuse and reporting procedures;
 - Communication;
 - Understanding and working with various client populations; and
 - Understanding basic human needs.
- ***Access Care Coordinator Manager:*** Each provider organization shall employ an ACC manager. The ACC manager provides oversight and supervision of all other ACC's. The ACC manager has prior management experience and has experience working in the home services arena. The ACC manager will be as a certified State of Wyoming, Aging Division ACC. The ACC manager shall be knowledgeable about the current WyHS grant application and contract, with the corresponding goals and financial requirements. If a provider organization has only one (1) ACC, this ACC will be considered the ACC Manager.
- ***Access Care Coordinator (ACC):*** The provider organization must employ a full time equivalent ACC, duties are detailed in the 'Services' section under 'Care Coordination'. In order to become an ACC, a person must attend an ACC training put on by CLS and meet the following qualifications:
 - Be at least 21 years of age;
 - Have a high school diploma or GED;

- Meet at least one (1) of the following criteria:
 - Have completed at least forty-eight (48) semester hours or seventy-two (72) quarter hours of post-secondary education in a related field;
 - Be a certified nursing assistant (CNA);
 - Have at least two (2) years of experience in social services working with the elderly or people with disabilities.

Following initial certification, an ACC shall maintain certification by completing twelve (12) contact hours of job related continuing education each financial year. Each year, the WyHS program manager will provide ACC's with a continuing education booklet (CEU booklet). This booklet will have a place for the ACC to track all continuing education completed in the previous year. Each educational event must be verified by certificate of attendance, signature from presenter, or signature from the provider organization director. The CEU booklet due every June at the end of the fiscal year, the original CEU booklet must be provided to the WyHS program manager. Specific due dates will be stated on each year's booklet.

- **SAMS Personnel:** The provider organization must employ a person to input all Wyoming Home Services data into the Social Assistance Management Software (SAMS) program. SAMS personnel must have a license to access the program and must be trained by CLS staff. The CLS will purchase one (1) SAMS license per provider organization, if the provider organization wishes to obtain more than one (1) license, they have the opportunity to purchase licenses.
- **Certified Nursing Assistant (CNA):** If the provider organization intends to provide personal care to eligible clients, then a CNA must be the person providing that service. CNA's shall follow the rules and regulations promulgated by the Wyoming State board of Nursing pursuant to its authority under W.S. § 33-21-119 thru W.S. § 33-21-156 and the federal requirements (Public Law 100-203). A CNA hired to provide personal care must have a current license, in good standing, through the Wyoming State Board of Nursing. This CNA must also have the home health aide training component of their licensure. Licensure and home health aide training can be verified on <https://nursing-online.state.wy.us/Verifications.aspx>. In following the Wyoming State Board of Nursing regulations, a CNA must be supervised by a licensed nurse. Additional information on the Wyoming State Board of Nursing rules and regulations can be located at <https://nursing-online.state.wy.us>. Any questions regarding nursing rules, regulations, or licensure shall be directed to the Board of Nursing.
- **Homemaker:** If the provider organization intends to provide homemaking services to eligible clients, then a homemaker must be employed. Minimum requirements for a homemaker are the following:
 - Eighteen (18) years of age and older;
 - High school diploma, General Educational Development (GED) Test;
 - Valid driver's license and access to reliable transportation;
 - Physical ability to perform required tasks;
 - Absence of any felony or misdemeanor convictions related to abuse, neglect, exploitation, intimidation, or abandonment.

A homemaker must have a minimum of eight (8) hours of the following training, in the following areas, before any client assignment:

- General staff orientation as specified in Section 9 of WyHS rules;
- Documentation responsibilities;
- Practical knowledge and skill in homemaking;
- Maintaining a clean, safe, and healthy environment.

Homemakers shall be supervised by the ACC at least every one-hundred eighty (180) days, at which time the competency form is completed. For additional information on the competency form, please see the 'Forms' section of this manual.

- **Chore Personnel:** If the provider organization intends to provide chore services to eligible clients, then a chore personnel must be employed or the services may be secured via a subcontractor.

Hiring

When hiring individuals to provide Wyoming Home Services to eligible clients, the provider organization must first do the following:

- **All WyHS Employees:** Prior to working independently in a client's home, the provider organization must obtain written documentation of at least two (2) character references from a previous employer, if any, or other knowledgeable and objective sources.
- **Wyoming State Board of Nursing Licensure Verification:** For all personnel that are licensed by the Wyoming State Board of Nursing (BON), the provider organization must verify that the individual is in good standing with the BON.
- **Department of Family Services (DFS) Central Registry Screen:** The provider organization must fill out the DFS form and submit according to the stated instructions. Prior to the employee working unsupervised, a clear Central Registry Screen must come back to the provider organization. The Central Registry Screen will cost the provider organization \$10 per screening submitted. This fee is the responsibility of the provider organization. Detailed information regarding this process is provided in the 'Forms' section of this manual. The process of completing a central registry screen is detailed on the attached form titled '*Checklist for Completing the Central Registry Form for New Employees*'.
- **Background Check:** It is required, beginning July 1, 2015, by the Community Living Section that all employees working directly with clients of Wyoming Home Services have a completed background check. As stated in CLS rule for the WyHS program, "No Licensed Nurse, CNA, or Homemaker/Chore personnel shall have been convicted of a felony or a misdemeanor related to abuse, neglect, exploitation, or abandonment of adults or children." The provider organization is responsible for the cost of the completion of a fingerprint card, CLS will pay for the cost of the background check. Background checks must be handled and processed by the director of the provider organization, unless the director of that organization has completed the '*Executive Director Designation for Background Check Results*' in order to designate an employee to handle and process background checks. The process of completing a background check is detailed on the

attached form titled '*Checklist for Completing the Background Check Card for New Employees*'. All forms referenced in this section are located in the 'Attachments' section of this manual.

Required Reporting

Data Tracking

There are multiple ways in which the services provided through Wyoming Home Services is tracked and subsequently reported to CLS. The initial copy of the financial and program reports shall be mailed to the program manager by the due date. If revisions are submitted, then providers may scan and email a copy, provided that the scanned copy is in color.

- ***SAMS Data Entry:*** All services provided through Wyoming Home Services are expected to be entered into the SAMS program by the 8th working day of the month following. Much of the information requested on the quarterly financial reports and the quarterly program reports is pulled from the SAMS program. Please refer to the SAMS section of this manual for additional information.
- ***Quarterly Financial Reports:*** Based upon the state financial year, from July 1 to June 30, financial reports will be submitted to the CLS, WyHS program manager quarterly. The quarterly financial reports are created by the CLS Program Manager and given to the provider prior to the report due date. The due dates are approximately as follows:
 - October 15
 - January 15
 - April 15
 - July 15
- ***Quarterly Program Reports:*** Also, based upon the state financial year, from July 1 to June 30, program reports will be submitted to the CLS, WyHS program manager quarterly. The quarterly program reports are created by the CLS Program Manager and given to the provider prior to the report due date. The due dates are approximately as follows:
 - October 15
 - January 15
 - April 15
 - July 15
- ***Year End Close Out Report:*** This report is only used when a yearend payment and/or adjustment is required. The CLS Program Manager will create and provide this form to the provider organizations included in the quarterly financial report file. Upon the submission of the fourth quarter financial report, the program manager will make a close out payment if matching funds have exceeded the 5% and state funds are remaining. Following the receipt of this payment, the provider organization shall submit the completed close out report.

Financials

When a provider organization submits an application for WyHS grant funds, it is required that the organization turn in a full, detailed proposed budget for all funds that will be used for the program. This includes the requested state funds, local funds, projected program income, in-kind, and any other sources of funds that will be used for WyHS.

- ***WyHS State Funds Amount:*** Each provider will be notified of the allotted amount of WyHS state funds they can request. This will be done when the grant application is sent out to all providers, in the spring of each year.
- ***Program Income:*** Funds that are paid by WyHS program participants for the services they are receiving. These funds must be used first, before any other funds, to supplement the WyHS program.
- ***Matching Funds:*** Each provider organization must provide at least five (5) percent of the contracted amount, based on actual expenses, to be applied as a local match for its budget. For example, a provider must match \$5000 for a WyHS grant amount of \$100,000, totaling at \$105,000 to be spent on the WyHS program. Matching funds may include non-federal public or private funds, cash, WSSB funds, or in-kind. Funds used for match in the WyHS program may not be duplicated as match in any other programs. Matching funds shall be accrued and reported, via the quarterly financial report, on a quarterly basis.
- ***In-Kind Funds:*** In-kind funds are the value of personnel, goods, and services which the provider organization does not actually pay for. Provider organizations must document the contributed resource of value.
- ***Cost Capitation:*** A cost containment measure which places spending limits on WyHS funding for each client. Each provider organization must have a cost capitation policy for the Wyoming Home Services program.
- ***Sliding Fee Scale:*** WyHS providers shall utilize the Division's sliding fee scale to determine an agreed upon amount that the client is able to pay for services, this is updated and provided yearly at the ACC training. The agreed upon amount shall be stated on the service plan and signed by the client and the ACC. Such fees will be considered program income.
- ***Client Fees:*** Clients paying a fee for services will be provided with monthly statements regarding the number of service units and the agreed upon fee for services. After 60 days, if a client has not paid the amount on the statement, that statement shall be zeroed out. Provider organizations shall not use legal means or collections to recover funds on unpaid statements. Clients will not be denied services based upon an inability to pay. If the client is unable to pay the agreed upon amount, the client shall notify their ACC of their inability to pay, at which time the ACC and client shall determine a new agreed upon amount. At this time a new service plan will be filled out, reflecting the new agreed upon amount.
- ***Direct Services:*** Direct services must account for at least 70% of WyHS grant funds. Direct services are directly related to delivering goods, services or work effort to clients or customers of the WyHS program. Direct costs generally include: salaries or wages

including vacations, holidays, sick leave and other excused absences of employees working, other employee fringe benefits allocable on direct labor employees, consultant services contracted to accomplish specific WyHS grant/contract objectives, travel of direct labor employees, materials, supplies and equipment purchased directly for use on the WyHS grant, and communication costs such as long distance telephone calls or telegrams identifiable with the WyHS grant.

- ***Indirect Costs:*** Indirect costs must not exceed 30% of the WyHS funding amount. Represent the expenses of doing business that are not readily identified with the WyHS grant. Indirect or administrative costs generally include: general administration and expenses, such as the salaries and expenses of executive officers, personnel, administration and accounting, depreciation or use allowances of buildings and equipment, costs of operating and maintaining facilities, audit expenses, computing services, utilities, or custodial services.

Client Eligibility

W.S. § 9-2-1208 states that ‘The department of health shall administer a state program to provide community based in-home services for Wyoming senior citizens and disabled adults eighteen (18) years of age and older. Priority shall be given to persons at risk of placement in nursing homes, assisted living or other institutional care settings and the program may serve persons who are not senior citizens if the program’s services are needed to avoid institutional placement.’

- ***Eligibility for WyHS:*** In order to be eligible for the Wyoming Home Services program, a potential client must be at least 18 years of age, determined through an ongoing assessment to be at-risk of premature institutionalization, and be in need of program services.
- ***Aging Needs Evaluation Summary (AGNES):*** The AGNES is the division’s initial evaluation and level of care tool used to determine eligibility for the WyHS program. Within the AGNES are the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) scales. Potential clients are eligible for WyHS if they have 2 areas of need on either of these scales or between the two scales.
- ***Exceptions:*** Potential clients may still be eligible, even if they do not meet two (2) area of need requirement, if they have a need for services to prevent inappropriate or premature institutionalization. This is determined on a case by case basis, at the discretion of the ACC. ACC’s may also contact the WyHS program manager for additional direction and guidance.
- ***Needs versus Wants:*** Services provided by the WyHS program are to serve the **needs** of Wyoming’s eligible populations, not necessarily the **wants**.

Local Policies

Local policies are policies that provider organizations have put into place to govern day to day business. Each provider organization may have multiple local policies that they follow. The CLS does have some topics that require a provider to maintain a policy.

Required Local Policies

- ***Adult Protective Services (APS) Policy:*** Each provider organization must have an APS policy in place. This policy must define what abuse, neglect, and exploitation are and provide a process in which employees can follow if they suspect abuse neglect, or exploitation of a Wyoming Home Services client.
- ***Tips, Gratuities, and Gifts Policy:*** Staff members who are employed with the Wyoming Home Services program are prohibited from accepting any and all individual gratuities, gifts, property, tips, or other incentives from the consumer or the consumer's family. Under no circumstances will it be acceptable for any staff to accept cash or cash equivalent as an individual gift, gratuity or additional payment for services. Each funded contractor shall develop a written policy and procedure to enforce this policy.
- ***Waiting List Policy and Procedure:*** It is the responsibility of each provider to establish a written policy on waiting list procedures. This policy should include how a client is put on the waiting list, how a client comes off the waiting list, and if a client is not ready to come off the list, where does that client go on the list.
- ***Emergency Preparedness Plan:*** Each provider shall have an emergency preparedness procedure, both for the place of business and when in the WyHS client home, in which all CNA's, Homemakers, and ACC's will be trained in. A disaster or emergency may be a local, community, regional, or statewide event. Disasters or emergencies may include, but are not limited to:
 - Tornadoes;
 - Fires;
 - Floods;
 - Blizzards;
 - Power outages;
 - Vehicle wrecks;
 - Declared health crises.

Services

Each provider organization has the opportunity to provide up to ten (10) services under the Wyoming Home Services program. These Services are care coordination, personal care, homemaking, chore, respite, personal emergency response system, adult day care, hospice, home modification, and medication setup. The provider organization will choose the services to be provided upon grant application completion. If a provider chooses to add another service to their grant during the provision of the grant year, the provider organization must submit the following: (1) a request to do so in writing, signed by the director and board chair, (2) the appropriate updated service pages from the grant application, and (3) the updated budget pages, if necessary.

WyHS services shall not be performed in nursing homes, intermediate care facilities, assisted living facilities, or group homes. There shall not be any duplication of services. Clients may receive services from other programs, but WyHS services should never be performed at the same time, on the same date as similar services from other programs. **Clients must be present during the provision of all WyHS services.**

- ***Care Coordination:*** A set of logical steps and processes of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient, and cost effective manner. Care coordination is a mandatory service, every client receiving Wyoming Home Services shall receive care coordination services. Care coordination must be provided by a certified access care coordinator.
 - ***Waiting List Care Coordination:*** The time that an Access Care Coordinator spends with potential WyHS clients prior to being on the WyHS program. This can include discussing services, evaluating, the sliding fee scale, completing paperwork, etc. The time that an ACC spends conducting waiting list care coordination can be tracked in SAMS, under Case Management, once that client begins receiving WyHS services.
 - ***Initial Evaluation:*** The ACC will determine initial eligibility using the AGNES. The ACC will work with the new client to complete an entire AGNES form. At this time, pages one (1) through five (5) will be completed. The new client must show at least two (2) areas of need in the ADL and/or IADL area. If a client does not meet this requirement, he or she must have a need for services to prevent inappropriate or premature institutionalization. This initial evaluation is valid for one (1) calendar year, at which time a new, full AGNES must be completed. A service plan shall be developed based upon the needs identified in the AGNES.
 - ***Service Plan:*** Based upon the completed AGNES, needs are identified. At this point the ACC will complete a service plan based upon the identified needs. The service plan will include the following information:
 - Start/End Dates of the authorized services
 - Name, address, phone number
 - Emergency contact information
 - ADL & IADL numbers and scores initially and for each quarter
 - Income information
 - Agreed upon fee for services
 - Services to be provided

- Functions of services to be provided
- Frequency of services to be provided
- Signature from client, ACC, and licensed nurse (if personal care, skilled nursing, or med setup services are needed)
- *Individual Comprehensive Ability of Needs (ICAN):* The ICAN shall be completed by the ACC at the initial evaluation and yearly following. The ICAN is not used to determine eligibility. The ICAN establishes a baseline of the client's needs and abilities and indicates trends thereafter. The ACC will utilize their professional skills, observations, and discussion with the client to complete the form. The client should not fill out the ICAN. The ICAN is to be retained in the client's file in chronological order. The ACC will then enter the client name, ICAN score and number of points per category in the ICAN spreadsheet, provided by CLS staff.
- *Quarterly Evaluation:* An evaluation of a client must be made by the ACC, in the client's home, to evaluate the quality and need for services at least every ninety (90) days. During this evaluation, the ACC must complete an ADL/IADL page, pages six (6), seven (7), or eight (8) of the AGNES. Adjustments in the service plan may be made at this time, as necessary. Clients receiving only care coordination and PERS services may have two (2) quarterly visits via telephone and two (2) quarterly visits must be completed in the client's home.
- *Significant Change of Status:* If a significant change of status occurs, the ACC shall complete a new AGNES, service plan, and ICAN. A significant change of status can include the following:
 - The client is hospitalized for more than twenty-four (24) hours
 - The client moves
 - The client's home has an infestation (bed bugs, mice, etc.)
 - The WyHS provider is informed that the client 'isn't doing well'
 - The client does not receive services for 30 continuous calendar days
 - The client's ADL or IADL number changes
- *Personal Care:* Activities include, but are not limited to, bathing, transferring, grooming, feeding, ambulating, exercising, oral hygiene, and skin care. Personal care is a hands on service and must be performed by a Certified Nursing Assistant (CNA) or a licensed nurse. WyHS is a social model program, medical interventions such as colostomy care and catheter care shall not be provided by WyHS. Per the Wyoming State Board of Nursing, a CNA must be supervised by a licensed nurse. If there is any question regarding services to be provided by a CNA or licensed nurse, please refer to the Wyoming State Board of Nursing rules or contact them directly.
- *Homemaking:* Homemaking can be broken down into two different types, light housekeeping and shopping. Homemaking is a 'hands-off' service.
 - *Light Housekeeping:* This includes services such as sweeping, vacuuming and mopping floors, and dusting. Homemaking services shall only be completed for the WyHS client, not others living in the home. Homemaking services shall not pose any health risk to staff. Homemaking does not include the following:

- Cleaning baseboards;
 - Cleaning floors on hands and knees;
 - Moving heavy furniture or objects;
 - Climbing ladders;
 - Washing windows;
 - Washing walls or ceilings;
 - More than one day accumulation of dishes;
 - Shampooing carpets.
- *Shopping*: Shopping should be preapproved through the ACC and must be authorized on the client's service plan. The provider organization shall maintain a local policy on how money is handled for shopping. The provider should maintain a written record, according to local policy, of any forms of currency given to the homemaker for shopping purposes. This record should include the date, amount given, items to be purchased, and the client and homemaker signatures. After the shopping is completed, change shall be returned to the client. The written record shall then include the amount of change returned and the client and homemaker signature.
- *Respite Care*: A temporary substitute support provided to the WyHS client, in order to relieve the client's caregiver for a brief period of time.
 - *Chore*: If chore services are needed in order to prevent premature institutionalization, WyHS funds can be used to provide the services or hire a sub-contractor to provide the chore services. Examples of chore include, but are not limited to, moving heavy furniture, washing windows, cleaning baseboards, cleaning the floor on hands and knees, shampooing carpets, deep cleaning of kitchen appliances, cleaning overhead light fixtures & fans, snow removal, yard maintenance, or other services per the discretion of the provider organization.
 - *Personal Emergency Response System (PERS)*: This electronic device, worn by the client to summon emergency help, may be provided to WyHS clients in need of the service. The ACC shall verify that the PERS unit for each WyHS client, receiving the service, has been tested monthly. Documentation that the PERS unit was tested should be kept in the client file. There are multiple ways in which an ACC can verify that the test was completed:
 - The ACC can go out to the client's home and test the PERS unit monthly
 - The ACC can monitor the activity report, provided by the PERS company, in order to verify that tests were completed within the month. If a test is shown as not completed within the month, then the ACC shall follow up and verify that the PERS unit is functioning properly
 - CNA's or homemakers may test the PERS unit as a part of their homemaking or personal care duties while they are visiting a client. The CNA or homemaker shall be adequately trained on how to test the PERS unit, this shall be documented on the CNA/homemaker competency form. The task of testing the PERS unit shall be listed as a task on the client's task sheet.

- **Adult Day Care:** Adult day care is a community based group program designed to meet the needs of adults with physical or mental disabilities. If a provider chooses to offer this service, it must be done through a certified Adult Day Care facility. Please refer to the Wyoming Department of Health, Aging Division, Office of Healthcare Licensure and Survey for more information <http://www.health.wyo.gov/ohls/index.html>.
- **Hospice:** A program for the terminally ill and their families given in a home or health facility. If a provider chooses to offer this service, it must be conducted through a certified Hospice agency. Please refer to the Wyoming Department of Health, Aging Division, Office of Healthcare Licensure and Survey for more information <http://www.health.wyo.gov/ohls/index.html>.
- **Home Modification:** Minor modifications that are necessary to facilitate the ability of at-risk clients to remain in their homes and that are not available under any other programs. A maximum of three hundred dollars (\$300) per client, per year may be expended for such modifications. A visual inspection of the home shall be completed by the ACC to determine the client's need. If it is found that the requested home modification will not be of direct benefit to the client, the provider shall deny the request. If the home is in poor condition and not structurally sound, the home modification will not be approved. The approved home modification must be documented on the client's service plan. When the modification is complete, the service plan shall be updated. In order to receive a home modification, a client must meet the following criteria:
 - Must be currently enrolled in the WyHS program
 - Must own the home or receive prior written approval from landlord
 - Must demonstrate a need for a safer and/or adapted environment
 - The modification must directly assist the client's ability to complete his or her ADL's or IADL's.
- **Medication Setup:** A licensed pharmacist or licensed nurse may place medications into a client's medication box or container, for easier administration at a later time. This service does not include medication administration, no exceptions.

Legal Matters

Access Care Coordinators shall not have guardianship or power of attorney of WyHS clients. If guardianship or power of attorney is previously established due to the client being immediate family, the ACC shall not provide care coordination or direct services to that client. An alternate ACC will need to provide services to that client. If there is no alternate ACC, the project director or designee shall assume the care coordination for that client.

- ***Legal Representatives:*** Legal representatives can be guardians, power of attorneys, etc. Legal representatives can sign on behalf of the client in the event the client is unable to sign WyHS documents. Legal representatives must provide documentation, to the provider organization, such as power of attorney or guardianship documents before signing on behalf of the client. Any forms of documentation must be notarized. A copy of the documentation must be kept in the client file, with the document dated when received. Any updated documentation shall be kept in the client file in chronological order.
- ***Advanced Health Care Directives:*** If a WyHS client has documentation on his/her wishes regarding performing cardiopulmonary resuscitation (CPR), this documentation can be in the client file. It is the client and/or family's responsibility to make sure there is a document stating the client's wishes posted in the client's home in clear sight of any provider staff or EMS staff. If no document is posted in the home, provider staff should perform CPR. Providers shall have a policy regarding advanced directives, CPR, and comfort one as to provide guidance to their staff.

Client Files & Documentation

All client files and documentations shall be kept for 6 years following client termination, according to HIPAA laws.

- ***Client Files:*** The provider must maintain a file for each client receiving Wyoming Home Services. All CLS issued WyHS forms shall be kept in the client files, please see the 'Forms' section of this manual for additional information on each form. Each WyHS file should be kept separate from any other program file a client may be receiving. Case files shall be confidentially maintained in a locked container or a locked room. A log should be maintained stating each authorized staff member that has access, this room or container should be locked when authorized staff are not present. All major activities related to the WyHS client are to be documented and recorded in the case file. This includes but is not limited to:
 - Initial referral documentation;
 - Signed copy of the Division's client rights and responsibilities (located on the back side of the service plan);
 - HIPAA documents;
 - Evaluation information;
 - Services provided;
 - Follow-up visits;
 - Changes in client status;
 - Service plan;
 - Service providers' notes;
 - Any related client information (i.e. – DNR, POA, etc.);
 - Information that is related to the coordination of care, communication, and client safety.
- ***Service Documentation:*** Staff providing direct services to clients will document the services rendered and other information in order to aid in communication and coordination of services for the client, monitor service quality, and take credit for what is done. This includes services rendered for the following:
 - Care coordination;
 - Personal care;
 - Homemaking;
 - Chore services;
 - Respite care;
 - Personal emergency response system;
 - Adult daycare;
 - Hospice;
 - Home modification, and;
 - Medication setup.

All documentation must include date and time. Time shall be either in AM/PM or military time, the entire organization must use the same method. Each time a staff member documents, the entry should be authenticated with the appropriate signature(s). All documentation should be completed with blue ink, white out should never be used.

Entries shall be specific and objective, opinions, complaints, and/or emotions are not to be included in client files. All staff should be trained on proper documentation, training for this is provided yearly at the Access Care Coordinator training and upon special request. All services billed for in SAMS shall have backup documentation.

- ***Accident & Incident Documentation & Reporting:*** All witnessed accidents and incidents (falls, etc.) must be documented in an official report in the client's file. All incidents or accidents that occur but are unwitnessed shall be documented in the client's file with time, date, occurrence, witnesses and any other pertinent information. If a client falls when staff is present or if a staff member finds a client who has fallen:
 - Emergency medical services (EMS) must be contacted to assess the client's potential injuries;
 - If a client refused EMS services when they arrive, this should be documented;
 - The client's emergency contact must be notified.
- ***Signature:*** If a client is unable to sign a document, the client can use initials, an 'X', or utilize a stamp, if they choose. These types of signatures must be witnessed initially by the ACC or licensed nurse. A legal representative can sign for the client, provided that the WyHS provider has, in possession, documentation of the legal relationship. If a client is unable to write initials, an 'X', and does not use a stamp or have legal representation, the ACC can document 'client unable to sign, verbal consent provided'. This must be witnessed by the ACC and another staff member at the initial instance. No staff can ever sign for a client.

Forms

The Community Living Section has distributed various forms that are required to be used for the Wyoming Home Services program. These forms shall not be used for any other program, unless specifically instructed to do so by CLS staff. All forms are attached to this manual, along with instructions, if applicable.

- ***AGNES (Required):*** Each WyHS client must have an AGNES completed upon starting the program, with a significant change of status, and yearly thereafter. For the WyHS program, the ACC must complete the full 8 page AGNES (dated 07/01/2012) with the client. When a person is started on the WyHS program and yearly, the ACC shall complete pages 1-5 of the AGNES and each quarter thereafter complete a new ADL/IADL page, from pages 6-8 of the AGNES. These records shall be kept in the WyHS client's chart, in chronological order.
- ***Service Plan (Required):*** A service plan must be completed on each WyHS client upon starting the program, with a significant change of status (if a change is required), and yearly thereafter. A WyHS service plan is developed based upon the AGNES evaluation, in conjunction with the client based upon their unique needs. The service plan shall state the specific services to be provided and the frequency in which those services are to be provided. The service plan must be signed by the client or their legal representative (if applicable) and the Access Care Coordinator. A service plan is active for one (1) year, at which time the ACC shall complete a new one. Each time a new service plan is completed, the ACC shall place the white original in the client file, provide the yellow copy of the service plan to the SAMS person, and the pink copy to the WyHS client. Written service plan instructions must be provided to staff before services are rendered. The ACC shall checkmark or write every service that the client will be receiving in the service plan time frame.
- ***ICAN (Required):*** An Individual Comprehensive Ability of Needs (ICAN) is to be completed for each WyHS client annually and with a significant change of status. The ICAN does not determine eligibility, but establishes a baseline of the client's abilities and needs and indicates trends thereafter. The ICAN should be completed by the ACC by utilizing their professional skills, observations (see, hear, smell) and discussion with the client. The client should not fill out the ICAN form. The ICAN should be completed in its entirety and reflect information for that point in time. The ACC will calculate the score. The ICAN then shall be retained in the client file, in chronological order. The ACC should then enter the client name, ICAN score, and number of points per category in the ICAN spreadsheet, which is provided by the WyHS program manager.
- ***Task Sheet (Required):*** The task sheet is used for any services that are provided in a client's home. The task sheet should be filled out by the ACC or the RN (for personal care) in order to specify to the employee what tasks shall be completed at the client's home. The employee should not add items to the task sheet, any additions or client requests should be approved through the ACC or RN. Once the sheet is filled out by the ACC or RN, it is given to the employee that is providing the direct care services. The task sheet can be used for one (1) up to ten (10) visits. The top portion and bottom portion of the task sheet may not be modified by the provider organization, the middle

portion of the form may be modified as needed by the provider organization. During the visit to the client's home, the employee will check off or initial each task that is completed. If the sheet is being used for one (1) visit, the employee can simply check each item and sign the sheet at the bottom, then the client shall review the sheet and sign at the bottom verifying the completion of the tasks that day. If the sheet is being used for more than one (1) visit, the employee shall initial each task that was completed. At the end of the visit, the sheet should be given to the client so they can initial next to each task that was completed, in order to verify completion of the tasks that day. When the employee is done using the sheet, then the employee and the client will sign at the bottom of the sheet, as a final verification of the entire task sheet.

- ***Adult Nursing Assessment (Required):*** The adult nursing assessment should be completed for clients receiving personal care. Personal care must be provided by a CNA, who is supervised by a licensed nurse. The adult nursing assessment must be filled out and completed by a licensed nurse. The adult nursing assessment should be updated annually and/or as needed. If a WyHS client is being discharged from the hospital, the hospital licensed nurse may complete the adult nursing assessment. The discharge paperwork is not sufficient to replace the adult nursing assessment.
- ***Nursing Delegation (Required):*** A licensed nurse shall complete a nursing delegation form for each WyHS client receiving personal care services. The intention of this form is to meet the Wy Board of Nursing requirement to delegate the unique personal care tasks, for a specific client, to a CNA. This form shall be completed annually and/or with a significant change of status, as specified on page twenty (20) of this manual. The nursing delegation will then be used to guide the completion of the task sheet for personal care. The nursing delegation form shall be updated every 180 days and as needed for changes in client's needs.
- ***Competency Form (Required):*** The competency form is to be completed for all CNA's, homemakers, and chore personnel. This form is completed every 180 days and verifies that the employee is competent in the stated skill areas. If the employee is a CNA, the competency form must be completed by a licensed nurse. If the employee is a homemaker or chore personnel, then the ACC may complete the competency form. The skills areas may verified through observation, verbal, or written demonstration. The completed competency form shall be placed in the employee file.
- ***Notice of Privacy Practices (Required):*** All WyHS clients must be provided with the Notice of Privacy Practices initially and every three (3) years thereafter. This document can be found at <http://www.health.wyo.gov>.
- ***Acknowledgement of Receipt of Notice of Privacy Practices (Required):*** The acknowledgement of receipt must be completed when the notice of privacy practices is given to the client at the start of care and every three (3) years thereafter. If a client refuses to sign the acknowledgement of receipt, please write 'client refused to sign' in the signature line of the form. The completed form shall be kept in the client file, in chronological order.
- ***Waiting List Form (Required):*** The ACC must fill out the waiting list form and submit it to the Aging Division, Community Living Section by the fifth (5th) working day each

month, for the previous month. It is the duty of the ACC to ensure that all areas of the form are completely filled out.

Client Resources

- ***Adult Protective Services (APS) Packets:*** APS packets must be given, reviewed and documented with each new WyHS client. They are then reviewed annually with each client. To order APS packets from the Community Living Section, please call or email the WyHS program manager or call the CLS toll free number at 1-800-442-2766.
- ***Unable to Self Evacuate (UTSE) Bags:*** ACC's can obtain these bags from the Aging Division, Community Living Section in order to provide them to WyHS clients that are unable to evacuate from their homes without assistance. The UTSE bag will signal to first responders that a person cannot evacuate independently. This bag can contain an emergency information card, medications, adaptive devices, and anything else that may be needed in an emergency.

Suspension and Termination of Services

Suspension or termination of WyHS services may be conducted in various situations with clients. Please follow the listed protocol for situations that may involve a suspension of services or termination of services.

- ***Suspension of Wyoming Home Services:*** Suspension of WyHS services means putting one or all services on temporary hold until an issue is resolved. WyHS services may be suspended for the following reasons:
 - Pest infestation;
 - Illegal drug usage while WyHS services are being provided;
 - Hospitalization.

Reasons for suspension are not limited to the previous stated reasons. Upon the identification that a service needs to be suspended, the ACC shall discuss the issue with the client and send a suspension letter. The suspension letter shall include the following:

- The effective date of the suspension;
- Under what circumstances suspension may be lifted;
- A contact name for WyHS;
- A contact number for WyHS.

An ACC may suspend one service, while continuing other services, if it is appropriate. For example, Mary has bed bugs, Mary's ACC suspends homemaking services, while continuing care coordination in order to assist Mary in securing services to get rid of the bed bugs.

- ***Termination of Wyoming Home Services:*** Termination of WyHS services means permanently ending all services with a client. A WyHS client may be terminated for the following reasons:
 - Level of care requirements are no longer being met;
 - Exceeding the cost containment level, as set by the provider;
 - Client is unwilling to pay the fee for service agreed upon by the client and the ACC;
 - Client chooses nursing home placement or other alternatives;
 - The client or client's family impedes the provision of services;
 - The provider has a reduction of funding or services;
 - The provider ceases to operate with no transferring of services;
 - The client does not receive services for thirty (30) continuous calendar days.

For the above reasons, providers must provide at least fourteen (14) business days written, advance notice of the intent to terminate services. The letter of notice of termination must include:

- The reason for termination;
- The end date of services;
- An explanation of the client's right to personal and/or third party representation at all stages of the termination process;
- Contact information for the Long Term Care Ombudsman Program;
- Contact information for the Aging and Disability Resource Center;

- The client's right to dispute the termination from services to the provider's director and board chair.

The letter must be on the provider organization's letterhead, and it shall be sent certified mail. The provider may provide services during the dispute process. If the client does not meet the deadline for dispute submittal, the dispute process ceases.

A client may be terminated immediately from the program and services may not be provided during the dispute process if:

- The client or client's family creates a hostile, dangerous or unsafe work environment for employees;
- The client becomes a danger to self or others.

For the above reasons, providers must provide notice of immediate termination of services. The letter of notice of immediate termination must include the same items listed above for the notice of termination of services.

- *Thirty (30) Days No Services:* Examples of thirty (30) continuous days of no WyHS services being provided would be: a client leaving Wyoming for the winter months, a client moves to another county and doesn't return, a client moves out of Wyoming, a client is in the hospital or nursing home for at least thirty-one (31) days. The thirty (30) day period begins on the first day of the missed service(s).
- *Dispute Process:* Upon receipt of the notice of termination, a client may appeal the decision with the provider organization's board of directors. If a client wishes to appeal, he or she must write the organization's board of directors within ten (10) calendar days of the date of the notice of termination. Upon receipt of the board of director's letter of decision regarding the appeal, if the client disagrees with the decision then the client shall follow Chapter 2, Section 4 of the Aging Division's Operational Rules.

Program Transfer

If the program is to be transferred from one provider to another, it is the responsibility of the transferring provider to inform clients of the impending change in writing, within fourteen (14) days prior to contract termination. The letter to the client must include:

- The name of the new provider;
- The name and phone number of the contact person with the new provider;
- Assurance that the client will not be arbitrarily dropped from the program due to the transfer;
- A statement informing the client that a new evaluation will be required and will occur within ninety (90) days of the transfer;
- The date of the transfer.

Confidentiality

All program and client information is subject to the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Program staff shall be trained on HIPAA and HITECH. All client files must be secured according to HIPAA and HITECH standards. Please use the Business Associate Agreement (Attachment B), attached to your contract, to implement the specific standards of these Acts.

SAMS' Services and Sub-services for Wyoming Home Services

The Wyoming Home Services Program provides services to qualified disabled and aging adults, aged 18 and over, who are at risk of premature institutionalization. These services are designed to keep individuals in the least restrictive, safe environment for as long as possible.

Eligibility: Clients must be 18 years of age or older, residing in Wyoming, and determined, through an ongoing evaluation, to be at risk of premature institutionalization.

SERVICES:

Service Category - Case Management - Service ~ Case Management (Care Coordination) –

REQUIRED SERVICE - Assistance in the form of access care coordination in circumstances where the person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers. Activities of care coordination include evaluating needs, developing care plans, authorizing services, arranging services, coordinating the provision of services among providers, follow-up and reassessment as required. **Tracking Care Coordination by hours provided to each unduplicated client is required.**

Unit Type: 1 Hour

There are five sub-services under Case Management:

- **Sub-Service - Evaluation Initial** - includes, but is not limited to, the time spent developing the service plan, doing the AGNES, completing the ICAN, HIPAA Privacy Practices and assessment for other community resources.
- **Sub-Service - Follow-up of Evaluation –CM** - phone call(s) or any contact with the Client.
- **Sub-Service - Quarterly evaluation** – every 90 days after the initial start date a personal visit (unless otherwise specified in the WyHS Policy and Procedure) with the client shall take place to evaluate if any change in services is needed;
- **Sub-Service - Re-evaluation renewal** – every year the ACC shall conduct an annual visit to the client which consists of completing a new service plan, AGNES, ICAN, and assessment for other community resources.

Service Category - Personal care - Service ~ Personal care - Providing personal assistance, stand-by assistance, supervision or cues for persons with the inability to perform one or more of the following activities of daily living; eating, dressing, bathing, toileting, transferring in and out of bed/chair, or walking. All personal care must be completed by a Wyoming licensed CNA who is supervised by a Wyoming licensed nurse.

Unit Type: 1 Hour

There are five sub-services under Personal Care:

- **Sub-Service - Dressing**
- **Sub-Service - Skin Care**
- **Sub-Service - Bathing/Showering**
- **Sub-Service - Transferring**
- **Sub-Service - Personal Care - other**

Service Category - Homemaker - Service ~ Homemaker - Providing assistance to persons with an inability to perform one or more of the following instrumental activities of daily living: preparing meals, shopping for personal items, managing money, using the telephone, or doing light housework.

Unit Type: 1 Hour

There are five sub-services under Homemaker:

- **Sub-Service - Housekeeping**
- **Sub-Service - Meal Preparation**
- **Sub-Service - Laundry/Linen Change**
- **Sub-Service - Shopping**
- **Sub-Service - Homemaker - Other**

Service Category - Chore - Service ~ Chore - Providing assistance to persons with the inability to perform one or more of the following instrumental activities of daily living: heavy housework, yard work, or sidewalk maintenance.

Unit Type: 1 Hour

There are three sub-services for Chore:

- **Sub-Service - Snow Removal**
- **Sub-Service - Handyman**
- **Sub-Service - Yard Maintenance**

Service Category - Respite care - Service ~ Respite - Respite care services offer temporary, substitute supports, or living arrangements for eligible clients in order to provide a brief period of relief or rest for family members or other caregivers.

Unit Type: Hours

There are four sub-services for Respite:

- **Sub-Service - In Home**
- **Sub-Service - Assisted Living**
- **Sub-Service - Adult-Day Care**
- **Sub-Service - Institutional**

Service Category - Adult Day Care (ADC) - Service Adult Day Care/Health - Provision of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day. **Licensed facilities only.** There are no sub-services.

Unit Type: 1 Hour

Service Category - NAPIS Other - Service ~ Hospice - Services provided to the terminally ill, allowing person to remain at home with their family. Licensed Hospice providers only.

Unit Type:

There are two sub-services for Hospice:

- **IN-Home Hospice**
- **Licensed Facility-Hospice**

Service Category - NAPIS Other - Service ~ Home Repair – Minor home modifications, such as hand rails or ramp, that are necessary to facilitate the ability of at-risk adults to remain in their homes and that are not available under other programs. A maximum of \$300.00 per client may be expended for such modification, and must be approved by WyHS Program Manager prior to any work starting the modification or grant is charged for modifications. There are no sub-services for Home Repair.

Unit Type: Hours

Service Category - NAPIS Other - Service ~ Nursing - Services that are within the scope of practice of a Wyoming licensed nurse, as defined by the Wyoming Nurse Practice Act. Services under Nursing include medication setups, delegating tasks, assessing and reassessing client's personal care and nursing needs.

Unit Type: 1 Hour

There are four sub-services for Nursing.

- **Medication Management** – Medication setups are the placing of medications into another container, such as a medication planner, for easier administering at a later time, e.g. service of oral medication and/or insulin set up. Medication setups do not include the preparing and immediate administering of the medication by the person who prepared it. As dictated by the Wyoming Statute, only a Wyoming licensed skilled nurse, working under the direction of a physician, may give injections or administer medications. [Policy Information Notice (PIN) [HOME-2009-01](#), Medication Setups for WyHS/Caregiver Programs]
- **Delegation** – Time spent completing the delegation form, this form specifies the delegated tasks and expected outcomes to CNA's.
- **Re-assessment** – Time spent re-assessing a WyHS client's needs.
- **Assessment** – Time spent completing the Adult Nursing Assessment.

Service Category - NAPIS Other - Service ~ Personal Emergency Response Systems (PERS) - Electronic warning device informing emergency personnel of an accident or safety hazard to a client in their home.

Unit Type: Monthly

There are two sub-services for PERS:

- **Sub-Service - Monthly**
- **Sub-Service - Installation**

<i>Attachments</i>
<i>Order of Attachments</i>
<i>Checklist for Completing the Central Registry Form for New Employees</i>
<i>Checklist for Completing the Background Check Card for New Employees</i>
<i>Executive Director Designation for Background Check Results</i>
<i>Central Registry Screen Form</i>
<i>SAMPLE WyHS Quarterly Financial Reporting Form</i>
<i>SAMPLE WyHS Quarterly Program Reporting Form</i>
<i>2015/2016 Slide Fee Scale</i>
<i>Aging Needs Evaluation Summary (AGNES)</i>
<i>WyHS Service Plan</i>
<i>Individual Comprehensive Ability of Needs (ICAN)</i>
<i>WyHS Task Sheet and Instructions</i>
<i>Adult Nursing Assessment</i>
<i>Nursing Delegation Form and Instructions</i>
<i>CNA/Homemaker Competency Form and Instructions</i>
<i>Monthly Report of Waiting Lists</i>
<i>Waiting List Care Coordination Instructions and Spreadsheet</i>
<i>Sample Discontinuation Letters</i>
<i>SAMS' Reports for 2015 Title III and WyHS Program Reports</i>
<i>Rules for Wyoming Home Services</i>
<i>Wyoming Statute § 9-2-1208</i>



Checklist for Completing the Central Registry Form for New Employees



- An 'Application for Child Abuse/Neglect and Adult Central Registry Screens' (SS-26, 11/5/2014) form will be completed. Please use the most up to date form by accessing <http://dfsweb.wyo.gov/central-registry>
- The organization hiring will complete the section titled 'To be Completed by Organization/Facility'.
- Leave the 'For DFS Office Use only' section blank.
- The new employee will complete the section titled 'To Be Completed by Person Being Screened'.
- Once all sections, referenced above, are completed by their respective parties, the application will be mailed, along with the appropriate payment and a self-addressed envelope, to the following address:
 - o Department of Family Services
Central Registry
2300 Capitol Ave, 3rd Floor
Cheyenne, WY 82002
- Do NOT send the completed Central Registry Form to the Aging Division, Community Living Section.
- The Department of Family Services (DFS) will return the results of the Central Registry Screen directly to the organization that requested the screen.
- The Central Registry Screen can take up to ten (10) business days before it is returned.
- The new employee may work with supervision, not independently, prior to Central Registry Screen completion and may work independently upon the receipt of a clear Central Registry Screen.



Checklist for Completing the Background **Check Card for New Employees**



***Note – You may complete and pay for new employee background checks independently or through CLS. If you choose to go through CLS, please follow the instructions detailed below.**

- A standard FBI 8x8 blue applicant finger print card shall be completed.
- The new employee must fill out their name, signature, residence, date, reason for fingerprinting, aliases, citizenship, social security number, sex, race, height, eyes, hair, date of birth, and place of birth.
- The organization must adhere the label, provided by the CLS, to the 'Employer and Address' section of the blue fingerprint card.
- New employees will go to the local Sheriff's Office, Police Department, or the Department of Criminal Investigation (DCI) to have their fingerprints completed on the standard FBI 8x8 Blue applicant fingerprint card.
- *Note – Employees may be charged up to \$5.00 to have their fingerprints completed, but no more, per Wyoming Statute 7-19-108.
- New employees will return the completed fingerprint card to the organization. The organization will then mail the completed blue fingerprint card to the following address:
 - o Wyoming Department of Health
Aging Division, Community Living Section
6101 Yellowstone Road, Suite 186A
Cheyenne, Wy 82002
- The Community Living Section will then log the new employee's name and mail the fingerprint card to DCI for completion of the WIN background check.
- The Community Living Section will pay for the cost of the WIN background check.
- The results of the WIN background check will be sent by DCI to the Community Living Section
- The results of the WIN background check will be opened by the Community Living Section for the purpose of routing the results to the correct provider.
- The Community Living Section will then seal the results, with tamper evident tape, and mail them to the organization director or designee.
- The mailed results will include an enclosure stating that the results have been opened and will be signed/dated by the CLS employee who opened them.
- The organization director or designee and the new employee must open the results together.

- The organization director or designee and new employee will sign the enclosure and put it in the employee's personnel file.
- The WIN background check can take 10-25 business days before it is returned to CLS, please allow 2-4 business days for CLS to route the results to the provider.
- Please note that the results must be opened by the new employee and the organization director or designee. If the director chooses a designee, the designation form must be completed and submitted to CLS.



Commit to your health.
visit www.health.wyo.gov



Thomas O. Forslund, Director

Governor Matthew H. Mead

Executive Director Designation for Background Check Results

I, _____, Executive Director of _____, designate the following employee (printed below), in the following county(ies), to open and review the results of background checks for the Wyoming Home Services Program and the National Family Caregiver Support Program, in my place. The background check results must be opened in the presence of the pertinent employee.

*Please remember that all results read are confidential.

Name of Designee: _____

County/Site Designated: _____

Date: _____

Executive Director Signature: _____

Date: _____

Aging Division, Community Living Section
6101 Yellowstone Road, Suite 186A • Cheyenne WY 82002
E-Mail: wyaging@wyo.gov • WEB Page: www.wyomingaging.org
FAX (307) 777-5340 • (307) 777-7986

APPLICATION FOR CHILD ABUSE/NEGLECT AND ADULT CENTRAL REGISTRY SCREENS

Background checks on volunteers, prospective employees, or an employee who has or may have unsupervised access to minors or vulnerable adults may be screened. Note: According to W.S. 14-3-214, "the applicant shall use the information received only for screening prospective employees and volunteers."

Instructions:

- 1) Complete page one and page two of this form ensuring the Authorization of Release of Information is signed and dated by the person being screened.
- 2) Authorization is only valid for thirty (30) days from the date signed.
- 3) A ten dollar (\$10) fee is required for each individual screened. Include a check or money order.
- 4) Submit a self-addressed envelope with the request. Postage is not required but is appreciated.
- 5) For accuracy purposes, please attach a typed list of the names, dates of birth and social security numbers, for all individuals being screened.
- 6) Incomplete forms and requests not accompanied by a check or money order and self-addressed envelope will be returned unprocessed.
- 7) Only applications with original signatures will be accepted.
- 8) The SS-26 Form will be returned to the agency requesting the screen within ten (10) business days of receipt.

Mail application to:

Department of Family Services
Central Registry
2300 Capitol Ave, 3rd Floor
Cheyenne, WY 82002

Note: Central Registry screens are specific to the State of Wyoming. For adult protection screens, you may also consider checking the Board of Nursing and Office of Health Licensing and Survey registries

*****The Department of Family Services no longer conducts Wyoming Criminal Record Prescreens.*****

To be Completed by Organization/Facility (Print clearly)

Name of person being screened _____

Organization/agency requesting check _____

Contact person for requesting organization/agency _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (____) _____

Please verify SSN and DOB with a driver's license or other means of identification and obtain a copy **for your records**.
 Please do not send the copies with this form.

For DFS Office Use only

Date Completed _____ Reference Number _____

Check Number _____ Money Order Number _____

Person being screened listed on the DFS Abuse/Neglect Central Registry? YES NO

Central Registry Specialist initials _____ DB _____

AUTHORIZATION OF RELEASE OF CHILD OR VULNERABLE ADULT WYOMING CENTRAL REGISTRY INFORMATION

To Be Completed by Person Being Screened (Please type or print legibly in ink.)

I hereby authorize the Wyoming Department of Family Services to conduct a Wyoming Central Registry Record Search to check for abuse, neglect and exploitation of children or vulnerable adults. I agree to provide the following information and any other information needed to initiate the background check. I understand that any falsification of information or substantiated abuse or neglect activities may be the grounds for termination of employment.

Full Legal Name _____

Maiden Name _____ Aliases _____

Social Security Number _____ Date of Birth _____

Ethnicity

- Caucasian
- Hispanic
- Black

- Native American
- Asian
- Other _____

Gender: Male Female

Current Address _____

City _____ State _____ Zip _____ Phone _____

List All Addresses for the past ten (10) years

"Voluntarily" List Names of Your Children (This information assures accuracy of the screen)

In the course of my duties, I will have unsupervised access to

Children _____ Adults _____ Both Children and Adults _____

I hereby authorize the results of this check be provided to the Organization/Agency identified on Page 1 of this form. If this application is being made as a requirement of a child placing agency, therapeutic foster care, and/or an adoption agency, I hereby authorize the requesting agency to provide the results of this check to the Department of Family Services.

AUTHORIZATION IS VALID 30 DAYS FROM THE DATE SIGNED

Signature of Person Being Screened

Date

*Pursuant to W.S. 14-3-214(f) and W.S. 35-20-116(a), any applicant receiving a report that a prospective employee/volunteer is "under investigation", shall be notified of the final determination of that investigation. A second screen result will be sent to the Organization/Agency on Page 1 when a final determination is made in these cases.



STATE FISCAL YEAR 2016

WYOMING DEPARTMENT OF HEALTH, AGING DIVISION QUARTERLY FINANCIAL REPORT OF GRANT EXPENDITURES

Grantee: *See Instructions for this column		STATE portion of Payments TOTAL Payments received DURING this quarter	
Address: Jul, Aug, Sept 2015		\$	
City: Oct, Nov, Dec 2015		\$	
County: Jan, Feb, Mar 2016		\$	
Quarterly Report Period Please mark the appropriate block		\$	
Jul, Aug, Sep 2015	<input checked="" type="checkbox"/>	-	
Oct, Nov, Dec 2015	<input type="checkbox"/>	-	
Jan, Feb, Mar 2016	<input type="checkbox"/>	-	
Apr, May, Jun 2016	<input type="checkbox"/>	-	
GRANT COVERED BY THIS REPORT (Please mark one box) State: Wyoming		CUMULATIVE TOTALS: Year To Date	
WyHS 1st Qtr		\$	
EXPENDITURES Total Expenditures reported from the previous quarters in this grant year (See Instructions)		CUMULATIVE EXPENDITURES Cumulative for FY 16	
(1) PROGRAM INCOME EXPENDED:		\$	
(2) STATE FUNDS EXPENDED: (Not WSSB funds)		\$	
(3) LOCAL CASH EXPENDED:		\$	
(4) WSSB FUNDS EXPENDED:		\$	
(5) IN-KIND UTILIZED:		\$	
(6) CSBG FUNDS EXPENDED:		\$	
TOTAL EXPENDITURES for this grant: \$		\$	
I certify this report is true and correct, that all expenditures reported herein have been made in accordance with the terms and conditions of this grant and are properly reflected in the grantee's accounting records.		Enter your total budget amount: You have expended #DIV/0! of your total budget this year. Enter your WyHS state allotted funds: You have used #DIV/0! of your state funds. Enter the unduplicated number of WyHS clients served during this Quarter.	
Name of Authorized Certifying Official:		Your quarterly cost per client is: #DIV/0!	
Printed NAME of Authorized Official:		Date:	
Signature of Authorized Official:		Date:	
Date:		Date:	
Program Manager:		Date:	
Deputy Administrator:		Date:	
Fiscal Manager:		Date:	
Payment or Adjustment		Federal State	

**Wyoming Department of Health, Aging Division,
Community Living Section
Fiscal Year 2015 Grants Quarterly Program Report Form
Wyoming Home Services (WyHS)**

Name of Organization:	
Address:	
City, State, Zip:	
Phone:	
Email:	

Quarter covered by this report:	1st Qtr - July, August, September 2015
--	---

Per contractual agreement, grantees must submit quarterly program reports to the Aging Division to provide information on the progress of the funded program. The questions refer directly to the FY2016 grant application Mission and Goals that was submitted to the Division.

*This form must be computer generated. No typewritten or hand-written documents will be accepted.

*A response must be provided to each question; do not leave any question blank. If there is no answer to a question, write "none".

Signature of Authorized Representative (Sign in Blue Ink)

Date

Print Name and Title of Authorized Representative

IMPORTANT: Quarterly program reports for first quarter of fiscal year 2015 must be received by the Aging Division, Community Living Section by _____. Failure to submit the required reports in a timely manner will delay future payments. Send the original quarterly program report to: WDH Aging Division, Community Living Section, 6101 Yellowstone Rd., Suite 186A, Cheyenne, WY 82002. **NO FAXES OR EMAILS WILL BE ACCEPTED.**

For the goals listed, answer the following questions to indicate the progress that you have made toward achieving the mission and goals during the previous three months (July 1, 2014 - September 30, 2014).

Goal One

Maintain or increase up to five percent (5%) the number of qualified aging individuals and disabled adults in Wyoming living in the least restrictive safe environment. Baseline for 2014 was 2,329 unduplicated WyHS clients statewide. A five percent increase is approximately 5-6 WyHS clients per county. See quarterly program report instructions to answer the questions.

1. Provide the number of AGNES completed this quarter for new WyHS clients. _____
2. Provide the average ADL number for all WyHS clients for this quarter. _____
3. Provide the average IADL number for all WyHS clients for this quarter. _____

Goal Two

Reduce the number of potential WyHS clients on waiting lists to zero. See quarterly program report instructions to answer the questions.

1. Provide the quarterly average number of clients on your waiting list. _____
2. Provide the staffing issues or problems listed on the Monthly Report of Waiting Lists for this quarter such as: funding for services, worker shortage, distance to home, client choice.

Goal Three

Reduce the number of WyHS clients **without adequate ADL or IADL** by five percent (5%) and ensure that all WyHS clients are in the least restrictive and safest environment. All clients are required to have an **ADL of at least 2 and/or and IADL of at least 2** prior to arranging or promising any services under the WyHS grant program. *Individuals may qualify without this requirement due to special circumstances.

1. Provide the number of WyHS clients taken off the WyHS program for this quarter due to the client falling under the 2 ADL or 2 IADL requirement. _____
2. Are you currently serving any clients that have 0 ADLs & 0 IADLs? If yes, please indicate the number of clients.

Goal Four

Maintain the cost efficiency of services per client per year. The 2014 baseline total cost equals \$1928.00 per WyHS client per year [which includes program income, state grant funds and local match (minimum of 5% state general funds).] See quarterly program report instructions to answer the questions.

1. Provide the total average cost per unduplicated client for WyHS services for this quarter.

Goal Five

Protect the safety of WyHS clients and confidentiality of their protected health information.

1. During this quarter, did you complete staff training on the reporting requirements for any suspected adult abuse, neglect or exploitation? _____
2. Have you reported potential adult abuse, neglect or exploitation cases this quarter? _____
3. If yes, please indicate how many this quarter. _____
4. Does your organization sit on or participate with your local APS team? _____
5. During this quarter, did you complete staff training on HIPAA? _____

Program Information

Please provide the number of units your organization provided for each of the following services:
(Please provide supporting SAMS report)

Care Coordination	
Personal Care	
Homemaker	
Chore	
Respite	
PERS	
Adult Daycare	
Hospice	
Home Modification	
Medication Setup	



Wyoming Home Services (WyHS) Program 2015/2016 Suggested Client Sliding Scale Fees

Effective from July 1 through June 30



Household Income per month		\$980-\$1,219	\$1,220-\$1,488	\$1,489-\$1,811	\$1,812-\$2,234	\$2,235 +
Care Coordination	Per occurrence	10% of cost	15% of cost	20% of cost	30% of cost	40% of cost
Licensed Nurse Care Coordination	Per occurrence	15% of cost	20% of cost	25% of cost	35% of cost	45% of cost
Personal Care	Per hour	\$7.00	\$9.00	\$11.00	\$17.00	\$22.00
Homemaker/Chore	Per hour	\$4.00	\$6.00	\$8.00	\$10.00	\$16.00
In-home Respite	Per hour	\$5.00	\$7.00	\$9.00	\$11.00	\$16.00
Hospice/Facility Services	Per occurrence	10% of cost	15% of cost	20% of cost	25% of cost	30% of cost
PERS Installation	One time	20% of cost	40% of cost	60% of cost	80% of cost	FULL COST
PERS Maintenance	Per month	20% of cost	40% of cost	60% of cost	80% of cost	FULL COST
Adult Day Care Services	Per occurrence	10% of cost	15% of cost	20% of cost	25% of cost	30% of cost

The fee is based on the household net income. Clients, who are unable to pay, will not be denied services. However, please keep in mind that the program relies on client fees to serve the most clients possible.



**AGING DIVISION – DOCUMENT 07-01-2012
AGING NEEDS EVALUATION SUMMARY (AGNES)**



Client Name _____

Site location: _____		Service provider: _____		Date: _____
Name: _____				
FIRST		MI		LAST
Nickname, if any _____				
<u>Mailing Address:</u>				
City _____		State _____		Zip Code _____
<u>Street Address:</u>				
City _____		State _____		Zip Code _____
Birth date _____		_____ Female _____ Male		
Telephone Number(s)				
Home (____) _____ - _____		cell or message (____) _____ - _____		
In the past year, have you received services from more than one Senior Center in Wyoming? _____ NO _____ YES				
• If yes, where: _____				
• Did you complete this form and sign a Release at that site? _____ NO _____ YES				
Do you have difficulty reading or writing? _____ NO _____ YES				
Do you require an interpreter or reader? _____ NO _____ YES				
Emergency Contact Information	Name of Emergency Contact Person _____			
	Mailing Address _____			
	City _____			
	State _____		ZIP code _____	
	Telephone number(s) _____			
	Relationship to you, if any _____			
Do you live in a rural area ? _____ NO _____ YES				
(Answer NO, if you live in Casper, Cheyenne, Gillette, Laramie, or Rock Springs. All other areas of state should be marked rural)				
Language spoken _____ English _____ Spanish _____ Russian _____ Other _____ Native American _____ Asian Please list other: _____			Marital Status _____ Single/Widowed _____ Married Spouse Name _____ Spouse Birth date _____	



**AGING DIVISION – DOCUMENT 07-01-2012
AGING NEEDS EVALUATION SUMMARY (AGNES)**



Client Name _____

Do you live alone ___NO ___YES	Are you a veteran? ___ NO ___ YES (served active duty and honorably discharged) Are you a spouse or dependant of a veteran? ___ NO ___ YES
Race ___ White ___ Black/African American ___ Asian, Specify nationality _____ ___ Native American ___ Pacific Islander ___ Other, please list _____	Ethnicity ___ Hispanic/Latino ___ Not Hispanic/Latino
Are you a caregiver ___ No ___ Yes Is the person you give care to: (a) over 60 (b) have Alzheimer's or Dementia (c) an adult with disabilities or (d) a minor child 18 or younger ___ No ___ Yes Person you care for: _____ Address _____ Phone Number _____ Date of Birth _____ Gender ___ Female ___ Male Relationship to You _____	Do you have a heart condition? ___ NO ___ YES Do you have diabetes? ___ NO ___ YES Have you ever had a pneumonia shot? ___ NO ___ YES Have a flu shot this year? ___ NO ___ YES Have you received information about the shingles vaccine? ___ NO ___ YES
	Is your family gross annual income at or above this amount ___ NO ___ YES FAMILY SIZE 1 - \$11,170 FAMILY SIZE 3 - \$19,090 FAMILY SIZE 2 - \$15,130 FAMILY SIZE 4 - \$23,050

Nutritional Risk Assessment (Please Circle Yes or No)

I have an illness or condition that changes the kind or amount of food I eat.	Yes ₍₂₎	No ₍₀₎
I eat fewer than two (2) meals per day.	Yes ₍₃₎	No ₍₀₎
I eat fewer than 5 servings (1/2 cup each) of fruits or vegetables or eat/drink fewer than two servings of dairy (milk/cheese) products daily.	Yes ₍₂₎	No ₍₀₎
I have 3 or more drinks of beers, wine or hard liquor every day.	Yes ₍₂₎	No ₍₀₎
I have tooth, mouth or swallowing problems that make it difficult to eat.	Yes ₍₂₎	No ₍₀₎
I eat alone most of the time.	Yes ₍₁₎	No ₍₀₎
I take 2 or more different prescribed or over-the-counter medications daily.	Yes ₍₁₎	No ₍₀₎
I am not always physically able to shop, cook and/or feed myself.	Yes ₍₂₎	No ₍₀₎
I have unintentionally lost or gained 10 pounds in the past 6 months.	Yes ₍₂₎	No ₍₀₎
Sometimes, I do not have enough money to buy food.	Yes ₍₄₎	No ₍₀₎

Nutritional Risk Score: _____

High Risk – 6 or more points Moderate Risk - 3-5 points Low Risk – 0-2 points

Type of evaluation: Short Form: B C1 D C2

Please Circle All That Apply: Long Form: E-Care Receiver CBIHS B-Care Plan required

PERSON REVIEWING FORM: _____



AGING DIVISION – DOCUMENT 07-01-2012
AGING NEEDS EVALUATION SUMMARY (AGNES)



Client Name _____

RELEASE OF INFORMATION

I hereby give my permission for _____ [SERVICE PROVIDER] to share information contained in the AGING NEEDS EVALUATION SUMMARY and other program documentation with the Aging Division and other affiliated service providers for the purpose of eligibility for the Administration on Aging and State of Wyoming grant programs such as supportive services, congregate meals, home-delivered meals, preventive services, community in-home services, family caregiver services.

Further, I understand that: By agreeing to take part in this program I give my permission to the service provider(s), Wyoming Department of Health (WDH), Aging Division, and the Administration on Aging (AoA) to share information obtained for the purpose of program evaluation and oversight.

Information received will be treated as confidential and will only be made available in accordance with the requirements of law.

I may cancel this release at any time except to the extent that action has been taken in reliance on it, and that in any event this release expires automatically one year from the date of my signature.

If I do not sign this release for the purposes described above, I may be required to pay for any services I have received or be solely responsible for payment of services.

If I am denied program services, I may be entitled to a hearing.

I have the right review and/or obtain a copy of my record including an accounting of any disclosures made from my record.

If I feel information in my record is invalid, I may make a written request for an amendment of the record. I have been provided a copy of this form.

If I feel I have been treated inappropriately, services have not been of the quality expected and/or not provided as stated in the service plan; I may contact the Wyoming Long Term Care Ombudsman at (800)-856-4398 or the WDH Aging Division at (800) 442-2766. For additional information regarding the Wyoming Department of Health's privacy policy, visit the WDH Department's HIPAA website: http://www.health.wyo.gov/main/hipaa.html or call De Anna Greene, WDH HIPAA Compliance Officer at (307) 777-8664.

Client or Representative's Signature: _____

Date: _____

Authority and Relationship of Representative (if any) to sign on Client's behalf

Witness: _____ Date: _____

Table with 2 columns: Nutritional Risk Score and -Nutrition Risk Action. Rows include 0-2 Low Risk, 3-5 Moderate Risk, and 6 or more High Risk with corresponding actions like 'Recheck in 12 months' or 'Recommend to client that he or she discuss their nutritional risk score with their health professional or dietitian.'



AGING DIVISION – DOCUMENT 07-01-2012
AGING NEEDS EVALUATION SUMMARY (AGNES)



Client Name _____

Activities of Daily Living (ADL's)

Rate client's ability to perform BATHING. (Include shower, full tub or sponge bath, exclude washing back or hair.)

- 0 Independent
2 Intermittent supervision or minimal physical assistance (stand by assistance)
4 Partial assistance (can perform some but not all of the bathing activity)
6 Total dependence

Rate client's ability to EAT.

- 0 Independent
2 Limited assistance (need assistive devices or minimal physical assistance)
4 Extensive help (client needs continuous cueing, assistance or supervision)
6 Total dependence

Rate client's ability to perform DRESSING.

- 0 Independent
1 Limited physical assistance (help with zippers, buttons and adjusting clothing)
2 Reminding, cueing or monitoring
3 Extensive assistance
4 Total dependence

Rate client's ability to perform TOILETING.

- 0 Independent
2 Reminding, cueing or monitoring
4 Limited physical assistance (help adjusting clothing or incontinence supplies)
6 Extensive assistance (wiping, cleaning or changing)
8 Total dependence

Rate client's ability to perform TRANSFER.

- 0 Independent
1 Limited physical assistance (includes assistive devices, i.e. walkers and canes)
2 Extensive assistance (care provider uses assistive devices, gait belt, etc)
3 Total dependence

Rate client's mobility IN HOME.

- 0 Independent
1 Limited Physical Assistance (includes assistive devices, walkers and canes)
2 Extensive Assistance (includes assistive devices, gait belt, wheelchair)
3 Total dependence

Instrumental Activities of Daily Living (IADL's)

Rate client's ability to PREPARE MEALS

- 0 Independent OR Prepares simple or partial meals (frozen, ready-made food, cereal, sandwich)
1 Prepares with verbal cueing or reminding
2 Prepares with minimal help (cut, open or set up)
3 Does not prepare any meals

Rate client's ability to perform SHOPPING.

- 0 Independent
2 Does with supervision, verbal cueing or reminders
4 Shops with hands-on help or assistive devices
6 Done by others or shops by phone

Rate client's ability to MANAGE MEDICATIONS.

- 0 Independent
2 Done with help some of the time
4 Done with help all of the time

Rate client's ability to MANAGE MONEY.

- 0 Completely Independent
2 Needs assistance sometimes
4 Needs assistance most of the time
6 Completely dependent

Rate client's ability to USE THE TELEPHONE.

- 0 Independent
1 Can perform with some human help
2 Cannot perform function at all without human help

Rate client's ability to perform HEAVY HOUSEWORK.

- 0 Independent
1 Needs assistance sometimes
2 Does with maximum help
3 Unable to perform tasks

Rate client's ability to perform LIGHT HOUSEKEEPING.

- 0 Independent
1 Needs assistance sometimes
2 Needs assistance most of the time
3 Unable to perform tasks

Rate client's ability to access TRANSPORTATION.

- 0 Independent
1 Done with help some of the time
2 Done by others
3 Requires ambulance

Quarter period _____

ADL TOTAL NUMBER _____

ADL TOTAL SCORE _____

Client Initial _____

Date _____

IADL TOTAL NUMBER _____

IADL TOTAL SCORE _____

ACC Initial _____



Client Name _____

No	Yes	<u>CBIHS INFORMATION</u> <u>HOME VISIT EVALUATION</u>
		Safe access to all necessary areas of home?
		Electrical hazards in home?
		Dangers on stairs or floors
		Cluttered/soiled living area
		Inadequate sewage disposal
		Inadequate/improper food storage
		Insects/rodents present
		Indoor toileting facilities
		Does client have trash removal service
		Outdoor toileting
		Problems with locks on doors and windows
		Hard to get in and out of bathroom
		Do kitchen appliances work properly
		Problems with water/hot water/plumbing issues
		Home temperature able to be controlled
		Functioning clothes washer
		Functioning clothes dryer
		Functioning telephone/cell phone
		Outside steps and walkways in good repair
		Does person feel safe in the neighborhood
		Pets in home
		Adequate food for pets
		Is client able to exit safely in an emergency
		Does client need assistance to exit in an emergency
		Fire hazards in home (frayed cords, items next to heater)
		Smoke detectors installed in home (need batteries?)
		Carbon monoxide detectors in home (need batteries?)
		Free from odors and pests
		Other hazards noted:

Comments or Notes:

Directions to the clients home for services for home services?

SPECIAL DIET:

ELIGIBILITY CHECKLIST

No	Yes	<u>Check all answers that apply:</u> <u>Home bound, eligibility for</u> <u>Home delivered meals, CBIHS</u> <u>or other in home services (Title</u> <u>III B)</u>
		Person homebound because of geographical isolation (outside the boundaries of public transportation service area.)
		Homebound on recommendation of medical practitioner.
		Homebound due to frail health, illness or disability.
		Homebound due to mental or social limitations or isolation.
		Homebound - other reason, list
		ADL (number 2 or more)
		IADL (number 2 or more)
		Other reasons: List



AGING DIVISION – DOCUMENT 07-01-2012
AGING NEEDS EVALUATION SUMMARY (AGNES)



Client Name _____

Activities of Daily Living (ADL's)

Rate client's ability to perform BATHING. (Include shower, full tub or sponge bath, exclude washing back or hair.)

- 0 Independent
- 2 Intermittent supervision or minimal physical assistance (stand by assistance)
- 4 Partial assistance (can perform some but not all of the bathing activity)
- 6 Total dependence

Rate client's ability to EAT.

- 0 Independent
- 2 Limited assistance (need assistive devices or minimal physical assistance)
- 4 Extensive help (client needs continuous cueing, assistance or supervision)
- 6 Total dependence

Rate client's ability to perform DRESSING.

- 0 Independent
- 1 Limited physical assistance (help with zippers, buttons and adjusting clothing)
- 2 Reminding, cueing or monitoring
- 3 Extensive assistance
- 4 Total dependence

Rate client's ability to perform TOILETING.

- 0 Independent
- 2 Reminding, cueing or monitoring
- 4 Limited physical assistance (help adjusting clothing or incontinence supplies)
- 6 Extensive assistance (wiping, cleaning or changing)
- 8 Total dependence

Rate client's ability to perform TRANSFER.

- 0 Independent
- 1 Limited physical assistance (includes assistive devices, i.e. walkers and canes)
- 2 Extensive assistance (care provider uses assistive devices, gait belt, etc)
- 3 Total dependence

Rate client's mobility IN HOME.

- 0 Independent
- 1 Limited Physical Assistance (includes assistive devices, walkers and canes)
- 2 Extensive Assistance (includes assistive devices, gait belt, wheelchair)
- 3 Total dependence

Instrumental Activities of Daily Living (IADL's)

Rate client's ability to PREPARE MEALS

- 0 Independent OR Prepares simple or partial meals (frozen, ready-made food, cereal, sandwich)
- 1 Prepares with verbal cueing or reminding
- 2 Prepares with minimal help (cut, open or set up)
- 3 Does not prepare any meals

Rate client's ability to perform SHOPPING.

- 0 Independent
- 2 Does with supervision, verbal cueing or reminders
- 4 Shops with hands-on help or assistive devices
- 6 Done by others or shops by phone

Rate client's ability to MANAGE MEDICATIONS.

- 0 Independent
- 2 Done with help some of the time
- 4 Done with help all of the time

Rate client's ability to MANAGE MONEY.

- 0 Completely independent
- 2 Needs assistance sometimes
- 4 Needs assistance most of the time
- 6 Completely dependent

Rate client's ability to USE THE TELEPHONE.

- 0 Independent
- 1 Can perform with some human help
- 2 Cannot perform function at all without human help

Rate client's ability to perform HEAVY HOUSEWORK.

- 0 Independent
- 1 Needs assistance sometimes
- 2 Does with maximum help
- 3 Unable to perform tasks

Rate client's ability to perform LIGHT HOUSEKEEPING.

- 0 Independent
- 1 Needs assistance sometimes
- 2 Needs assistance most of the time
- 3 Unable to perform tasks

Rate client's ability to access TRANSPORTATION.

- 0 Independent
- 1 Done with help some of the time
- 2 Done by others
- 3 Requires ambulance

Quarter period _____.

ADL TOTAL NUMBER _____

ADL TOTAL SCORE _____

Client Initial _____.

Date _____.

IADL TOTAL NUMBER _____

IADL TOTAL SCORE _____

ACC Initial _____.



AGING DIVISION – DOCUMENT 07-01-2012
AGING NEEDS EVALUATION SUMMARY (AGNES)



Client Name _____

Activities of Daily Living (ADL's)

Rate client's ability to perform BATHING. (Include shower, full tub or sponge bath, exclude washing back or hair.)

- 0 Independent
2 Intermittent supervision or minimal physical assistance (stand by assistance)
4 Partial assistance (can perform some but not all of the bathing activity)
6 Total dependence

Rate client's ability to EAT.

- 0 Independent
2 Limited assistance (need assistive devices or minimal physical assistance)
4 Extensive help (client needs continuous cueing, assistance or supervision)
6 Total dependence

Rate client's ability to perform DRESSING.

- 0 Independent
1 Limited physical assistance (help with zippers, buttons and adjusting clothing)
2 Reminding, cueing or monitoring
3 Extensive assistance
4 Total dependence

Rate client's ability to perform TOILETING.

- 0 Independent
2 Reminding, cueing or monitoring
4 Limited physical assistance (help adjusting clothing or incontinence supplies)
6 Extensive assistance (wiping, cleaning or changing)
8 Total dependence

Rate client's ability to perform TRANSFER.

- 0 Independent
1 Limited physical assistance (includes assistive devices, i.e. walkers and canes)
2 Extensive assistance (care provider uses assistive devices, gait belt, etc)
3 Total dependence

Rate client's mobility IN HOME.

- 0 Independent
1 Limited Physical Assistance (includes assistive devices, walkers and canes)
2 Extensive Assistance (Includes assistive devices, gait belt, wheelchair)
3 Total dependence

Instrumental Activities of Daily Living (IADL's)

Rate client's ability to PREPARE MEALS

- 0 Independent OR Prepares simple or partial meals (frozen, ready-made food, cereal, sandwich)
1 Prepares with verbal cueing or reminding
2 Prepares with minimal help (cut, open or set up)
3 Does not prepare any meals

Rate client's ability to perform SHOPPING.

- 0 Independent
2 Does with supervision, verbal cueing or reminders
4 Shops with hands-on help or assistive devices
6 Done by others or shops by phone

Rate client's ability to MANAGE MEDICATIONS.

- 0 Independent
2 Done with help some of the time
4 Done with help all of the time

Rate client's ability to MANAGE MONEY.

- 0 Completely independent
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4 Needs assistance most of the time
6 Completely dependent

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2 Cannot perform function at all without human help

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1 Needs assistance sometimes
2 Does with maximum help
3 Unable to perform tasks

Rate client's ability to perform LIGHT HOUSEKEEPING.

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2 Needs assistance most of the time
3 Unable to perform tasks

Rate client's ability to access TRANSPORTATION.

- 0 independent
1 Done with help some of the time
2 Done by others
3 Requires ambulance

Quarter period _____.

ADL TOTAL NUMBER _____

ADL TOTAL SCORE _____

Client Initial _____.

Date _____.

IADL TOTAL NUMBER _____

IADL TOTAL SCORE _____

ACC Initial _____.



AGING DIVISION -- DOCUMENT 07-01-2012
AGING NEEDS EVALUATION SUMMARY (AGNES)



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2 Extensive assistance (care provider uses assistive devices, gait belt, etc)
3 Total dependence

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2 Needs assistance most of the time
3 Unable to perform tasks

Rate client's ability to access TRANSPORTATION.

- 0 Independent
1 Done with help some of the time
2 Done by others
3 Requires ambulance

Quarter period _____

ADL TOTAL NUMBER _____

ADL TOTAL SCORE _____

Client Initial _____

Date _____

IADL TOTAL NUMBER _____

IADL TOTAL SCORE _____

ACC Initial _____



Aging Division
Community Living Section
Wyoming Home Services (WyHS)
Service Plan

Wyoming
 Department
 of Health

LONG TERM GOALS: (Please check ALL goals that apply)
 To prevent inappropriate or premature institutionalization;
 To maintain or increase self-sufficiency;
 To assist and enhance family and other support;
 Other: _____

Additional Programs the client is on: (Please check ALL that apply)
 Long Term Care Waiver (Medicaid)
 National Family Caregiver Support Program
 Home Health
 Other: _____

Start Date: _____ End Date: _____

Name: _____

Address: _____

City: _____, WY Zip Code: _____

Phone Number: _____ Emergency Phone: _____

Emergency Contact: _____ Address: _____

Refer to the AGNES form for the following scores

Activities of Daily Living (ADLs)	Initial Number	Score	Instrumental Activities of Daily Living (IADLs)	Initial Number	Score
(1 st)	_____	_____	(1 st)	_____	_____
(2 nd)	_____	_____	(2 nd)	_____	_____
(3 rd)	_____	_____	(3 rd)	_____	_____
(4 th)	_____	_____	(4 th)	_____	_____

Household Gross Income: \$ _____ minus (-) Medical/Prescriptions: \$ _____

Supplemental Insurance: \$ _____

Mortgage/Rent: \$ _____

Equals Household Adjusted Income: \$ _____

I agree to pay the "agreed upon" amount of \$ _____ per hour / day / month and mileage for _____ miles at _____ a mile. If I'm unable to pay the agreed amount, I will notify my Access Care Coordinator. *

By signing this SERVICE PLAN, I agree with the above plan of services; will participate in my services; and understand the consumer's rights and responsibilities. I will notify my Access Care Coordinator of any changes, needs, problems or complaints related to the provision of services. I understand that should I not receive services for 30 continuous days; that I may be discharged from the program. This information will not be shared with family/friends unless written permission is given. This information will be shared with the State of Wyoming.

SERVICE TYPE	FUNCTIONS	FREQUENCY
Care Coordination	<input type="checkbox"/> Evaluation <input type="checkbox"/> Re-Evaluation <input type="checkbox"/> Follow-Up <input type="checkbox"/> Sliding Fee Scale given/shown to the client <input type="checkbox"/> APS packet received <input type="checkbox"/> APS packet reviewed	YEARLY or CHANGE OF STATUS Every 90 days
Nursing Services: If personal care is indicated	<input type="checkbox"/> Initial Assessment <input type="checkbox"/> Re-Assessment <input type="checkbox"/> Delegation <input type="checkbox"/> Transferring <input type="checkbox"/> Dressing <input type="checkbox"/> Skin Care <input type="checkbox"/> Bathing/Showowering <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medication setup <input type="checkbox"/> Pulse Oximetry <input type="checkbox"/> Glucose	YEARLY or CHANGE OF STATUS Every 180 days
Personal Care	<input type="checkbox"/> Housekeeping <input type="checkbox"/> Shopping <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Laundry/Linen Change <input type="checkbox"/> Other: _____ <input type="checkbox"/> Snow Removal <input type="checkbox"/> Yard Maintenance <input type="checkbox"/> Other: _____	Days per week _____ Hours per day _____ Other: _____
Homemaking	<input type="checkbox"/> In-Home <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Installation <input type="checkbox"/> Monthly Service	Days per week _____ Hours per day _____ Other: _____
Chore Service	<input type="checkbox"/> Personal Emergency Response System <input type="checkbox"/> Other services that are approved under the CBHS rules	

White Care - Provider Yellow Care - Consumer Pink Care - SAMS Payment 3/2015

Consumer Signature: _____ Date: _____ ACC Signature: _____ Date: _____

Licensed Nurse/Physician Signature: (If personal care is indicated) _____ Date: _____

CLIENT RIGHTS

- The client has a right to be informed, in advance, about the services to be provided, and of any changes to the services to be provided.
- The client has the right to participate in the planning of the services changes to the services.
- The client has the right to refuse services, and to be informed of the consequences of their decision.
- The client has the right to be fully informed of the agency's policies and charges for the services, prior to receiving services.
- The client has the right to be treated with respect and dignity.
- The client has the right to have their property treated with respect.
- The client has the right to expect their personal information and records to be maintained with confidentiality.
- The client has the right to voice their grievances regarding services that are provided or fails to be provided, or regarding the lack of respect for property by anyone who is providing services, without fear of termination or retaliation.
- The client has the right to be advised of the availability of the Aging Division, Community Living Section's toll-free number (1-800-442-2766).
- The client shall be given written notice of their rights prior to the start of services.
- The client has the right to call the Ombudsman at 1-800-856-4398.

CLIENT RESPONSIBILITIES

- The client has the responsibility to keep providers aware of any change in their living situation.
- The client has the responsibility to provide accurate information to the Access Care Coordinator when he/she visits.
- The client has the responsibility to be cooperative, actively participate in the development of, and follow, their service plan, and the agreed upon fee.
- The client has the responsibility to keep appointments, or notify the providers when they are unable to keep appointments.
- The consumer has the responsibility to ask questions if the program services are unclear.



**Aging Division
Community Living Section
Wyoming Home Services (WyHS)
Individual Comprehensive Ability of Needs (ICAN)**



The purpose of the Individual Comprehensive Ability of Needs (ICAN) is to determine a client's abilities and needs.

Client Name _____ **Date** _____

Housekeeping

- 0 points 100% independent in cleaning and laundry, vacuuming, making the bed.
- 2 points Needs some help with light housekeeping, laundry, changing bedding, vacuuming.
- 4 points Needs some help with heavy housework.
- 6 points Requires all light housekeeping and laundry services provided for them.

Mobility

- 0 points Able to move about 100% independently. Able to find and follow directions. Able to get themselves out of the house independently in case of emergency.
- 2 points Requires occasional help to move about, but is usually independent.
- 3 points Able to move with a cane or a walker. Independent with a wheelchair, but would need help evacuating in an emergency.
- 4 points Mobile, but may need help due to poor vision, confusion, weakness or poor motivation.
- 5 points May need help when transferring from bed, toilet or chair.
- 6 points Requires transfer and transportation help. Needs to be turned in bed and in wheelchair.

Dressing

- 0 points 100% independent and dresses themselves appropriately.
- 4 points Requires some assistance with buttons, zippers, shoelaces, medical appliances or garments, or may need reminders, motivation or help getting started.
- 5 points Dependent on others for dressing.

Hygiene

- 0 points 100% independent in all personal care, including bathing, shaving and dressing.
- 4 points Needs some help with bathing or hygiene, or starting these tasks, or being reminded about bathing or hygiene.
- 6 points Dependent on others for most or all personal hygiene tasks.

Toileting

- 0 points 100% independent and completely continent, always able to control going to the bathroom.
- 2 points May have incontinence, a colostomy, or catheter but is 100% independent in caring for self through proper use of supplies.
- 4 points Occasionally may have problems with incontinence, colostomy or catheter care, or may need assistance in caring for self through proper use of supplies.
- 5 points May be unwilling or unable to manage own incontinence through proper use of supplies or may need physical help with toileting on a regular basis.
- 6 points Regularly and uncontrollably incontinent, dependent or unable to communicate when they need to go to the bathroom.

Nutrition

- 0 points** Prepares own meals, eats meals without help.
- 3 points** Can do some meal preparation, but needs main meal prepared daily.
- 4 points** May require help getting to meals and/or help when eating, such as opening cartons or cutting food.
- 5 points** Needs all meals prepared and served.
- 6 points** Mostly or 100% depends on others for nourishment, including being reminded to eat and/or assistance when eating.

Medications

- 0 points** 100% able to take all medications themselves.
- 2 points** Able to self-administer medications, but others may need to remind & monitor actual process.
- 4 points** Family or Home Health Agency has arranged a medication administration system with reminders and family members or others monitoring.
- 6 points** Cannot self-administer medications even with supervision. Medications need to be administered by a licensed person.

Behavior

- 0 points** Deals and reacts appropriately with emotions and stress, and interacts appropriately with others.
- 3 points** May need periodic intervention from others to help them express feelings in order to cope with stress. May require periodic intervention from others to resolve conflicts.

- 5 points May require regular intervention from others to help them express feelings and deal with periodic outbursts of anxiety or agitation.
- 6 points Great intervention is required to manage behavior. May pose a physical danger to self or to others, or is verbally or physically abusive or unacceptably uncooperative.

Mentality

- 0 points 100% aware of self, people, place and time. Memory is intact but may have occasional forgetfulness with no pattern of memory loss. Able to reason, plan and organize daily events. Has mental capacity to identify environmental needs and meet them.
- 3 points May require occasional direction or guidance in getting from place to place, or may have difficulty with occasional confusion that may result in anxiety, social withdrawal or depression. Awareness of time, place or person may be minimally impaired.
- 5 points Judgment may be poor. May try to do task that are not within capabilities. May require strong orientation assistance and reminders.
- 6 points Disoriented to time, place and person, or memory is severely impaired. Usually unable to follow directions.

Environment

- 0 points The environment is safe for providing care, none or only mild odors or trash present.
- 2 points There are odors present, some trash is present, or some dirty dishes or spoiled food.
- 4 points Strong odors present, trash on floors, animal waste present, or spoiled food in refrigerator.
- 6 points Obnoxious odors present, human and animal waste present, spoiled food and evidence of hoarding.

Fall risk

- 0 points Client has never had a fall.
- 2 points Client has had a previous fall with injury in the last year.
- 4 points Client has had multiple falls or one fall with injury requiring hospitalization in the last 6 months.
- 6 points Client has had multiple falls injury requiring hospitalization in the last 3 months.

Scale:

- 0-5 May not "need" WyHS services
- 6-40 May "need" WyHS services
- 41-65 Needs may exceed scope of WyHS services

Total Points: _____

Signature of Person Completing Form: _____

Date: _____

WyHS Task Sheet Instructions

IMPORTANT – Please note that any modifications to the top portion (listing client name, DOB, client address, phone number, emergency contact, phone number, limitations, schedule, and special instructions) and the bottom portion (client signature, staff signature, date, and created by) are prohibited. Modifications may be made to the task table, located in the middle portion of the page.

Client Name: Client's Legal Name

DOB: Client's Date of Birth

Client Address: Client's Physical Address

Phone Number: Client's Phone Number

Emergency Contact: Client's Emergency Contact Name

Phone Number: Client's Emergency Contact Phone Number

Limitations: Examples: walker, cane, oxygen, hard of hearing

Schedule: Monday 1:00-2:00

Special Instructions: Examples: Client has dog, Use back door, etc.

Date: Date services are provided

In: Time services begin

Out: Time services end

Tasks: Tasks to be performed that are specific to that client

Client initials = tasks completed: Clients should initial that tasks were completed on each visit if a client will have more than one day of services per task sheet

Staff initials = tasks completed: Staff should initial that tasks were completed on each visit if they will provide services to clients more than once per task sheet

Client Signature: Client certifies that all tasks listed above were completed. This should be signed at end of services for that task sheet

Staff signature: Staff certifies that all tasks listed above were completed. This should be signed at end of services for that task sheet

Created by: Name of ACC/Nurse that is listing specific tasks to be completed for that client.

Date: Date that ACC/Nurse created task sheet

(X) Completed: Should be used to indicate that tasks were completed

(-) Not Completed: Should be used to indicate that tasks were not completed

ADULT NURSING ASSESSMENT

Client's Name: _____

History Given by: _____ Date: _____

If Active problem, indicate plan of action under "Comments" or address on pathway.	Active	Inactive	Potential
A. Current Diagnosis (ESI)/Chief Complaints:			
B. Past History:			
C. Allergies: (environmental, drugs, food, etc.)			
Immunizations: Flu: Yes ___ No ___ Date _____ Pneumonia: Yes ___ No ___ Date _____ Tetanus: Yes ___ No ___ Date _____ Other: _____ Comments:			
E. Vital Signs: Temp _____ Resp. _____ BP (designate positions/s) _____ Pulse: Apical Rate _____ Radial Rate _____ Rhythm _____ Quality _____ Other Pulses:			
F. Life System Profile: 5-WNL; 4-Not normal, but w/o help; 3-Uses a device; 2-With Assistance; 1-Device and help; 0-Dependent 1. Activities of Daily Living (ADL) ___ Bathing ___ Transferring ___ Dressing ___ Locomotion ___ Grooming ___ Eating ___ Toileting ___ Other 2. Instrumental Activities of Daily Living (ADL) ___ Telephone ___ Money management ___ Meal Preparation ___ Shopping ___ Housework ___ Manage appointments ___ Laundry ___ Access resources ___ Medicine management			
3. Homeboundness (Check appropriate blanks) ___ Outdoor without assistance ___ Outdoors with assistance ___ Confined to house, not bed disabled ___ Bed disabled 4. Financial/Legal (check appropriate blank) ___ Independent ___ Needs assistance from _____ ___ Power of Attorney ___ Living Will ___ DNR discussed Comments:			
5. Habits: (check and describe) ___ Alcohol ___ Caffeine ___ Nicotine ___ Street drugs ___ other ___ Sleep disorder Comments:			
6. Physical Environment: (Check appropriate blanks) ___ All adequate ___ Inadequate space ___ Electrical/fire hazards ___ Structural hazards ___ Stairs ___ Interior safety hazards ___ Private water supply/sewage disposal problem ___ Transportation inadequate Comments:			

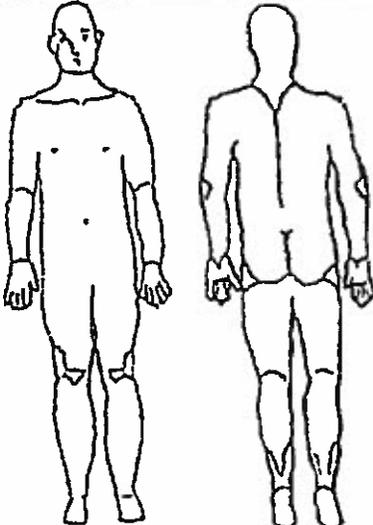
ADULT NURSING ASSESSMENT

Client's Name: _____ Date: _____

If Active problem, indicate plan of action under "Comments" or address on pathway.	Active	Inactive	Potential
<p>G. Psycho-social Profile: If no problem, leave blank, place S for subjective problem, O for objectively assessed <input type="checkbox"/> Hx of previous psych. illness <input type="checkbox"/> Mood-depression/mania/lability <input type="checkbox"/> Anxiety/agitation <input type="checkbox"/> Memory loss-short term/long term <input type="checkbox"/> Poor judgment <input type="checkbox"/> Behavior problems <input type="checkbox"/> Disorientation time/place/person <input type="checkbox"/> Hallucinations/delusions <input type="checkbox"/> Learning disabilities <input type="checkbox"/> Communication barriers <input type="checkbox"/> Emotional response to illness and care, body image <input type="checkbox"/> Growth and development <input type="checkbox"/> Interpersonal relationships <input type="checkbox"/> Socialization <input type="checkbox"/> Ethnicity</p> <p>Comments: _____</p>			
<p>H. Review of Systems/Physical Assessment: if no problem present leave blank; place S for subjective problem; O for objectively assessed problem; DNA for did not assess; A✓ in the DNA box indicates did not assess or system not reviewed. Some blanks may require specific information.</p>			
<p>1. Head: <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache 2. Eyes: <input type="checkbox"/> Vision loss (circle one) Minimal Moderate Severe Blind Not Determined <input type="checkbox"/> Glasses <input type="checkbox"/> Blurred/Double vision <input type="checkbox"/> Change in vision over last year <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> PERRL 3. Ears: <input type="checkbox"/> Hearing Loss (circle one) Minimal Moderate Severe Deaf <input type="checkbox"/> Hearing aid <input type="checkbox"/> Tinnitus 4. Mouth: <input type="checkbox"/> Gum problems <input type="checkbox"/> Chewing problems <input type="checkbox"/> Dentures (upper/lower) 5. Nose: <input type="checkbox"/> Epistaxis 6. Neck and Throat: <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing</p> <p>Comments: _____</p> <p><input type="checkbox"/> WNL <input type="checkbox"/> DNA</p>			
<p>7. Cardiovascular: <input type="checkbox"/> Palpitations <input type="checkbox"/> Dyspnea on exertion <input type="checkbox"/> BP problems <input type="checkbox"/> Varicosities <input type="checkbox"/> Claudication <input type="checkbox"/> Paroxysmal nocturnal dyspnea <input type="checkbox"/> Chest pain <input type="checkbox"/> Edema <input type="checkbox"/> Fatigues easily <input type="checkbox"/> Orthopnea # Pillows _____ <input type="checkbox"/> Murmurs <input type="checkbox"/> Cyanosis <input type="checkbox"/> Pacemaker</p> <p>Comments: _____</p> <p><input type="checkbox"/> WNL <input type="checkbox"/> DNA</p>			
<p>8. Respiratory: <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Sputum <input type="checkbox"/> Oxygen <input type="checkbox"/> Shape and Symmetry <input type="checkbox"/> Cough <input type="checkbox"/> Breath Sounds <input type="checkbox"/> Other</p> <p>Comments: _____</p> <p><input type="checkbox"/> WNL <input type="checkbox"/> DNA</p>			
<p>9. Gastrointestinal Tract: <input type="checkbox"/> Indigestion <input type="checkbox"/> Pain <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> Hernias <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Tenderness <input type="checkbox"/> Ulcers <input type="checkbox"/> Diarrhea/constipation <input type="checkbox"/> Gallbladder problems <input type="checkbox"/> Ostomy</p> <p>Comments: _____</p> <p><input type="checkbox"/> WNL <input type="checkbox"/> DNA</p>			
<p>10. Nutritional Status: <input type="checkbox"/> Weight loss or gain last 3 months (amount _____) <input type="checkbox"/> Change in appetite Diet _____ Fluid intake _____ Height _____ Weight (actual) _____ (reported) _____</p>			

ADULT NURSING ASSESSMENT

Patient's Name: _____ Date: _____

Meals prepared by _____ Comments:			
<input type="checkbox"/> WNL <input type="checkbox"/> DNA 11. Genitourinary Tract: ___ Frequency ___ Nocturia ___ Dysmenorrhea ___ Gravida/Para ___ Pain ___ Urgency ___ Lesions ___ Date last PAP test ___ Hematuria ___ Vaginal discharge/bleeding ___ Prostate disorder ___ Contraception ___ Incontinence ___ Hx hysterectomy Comments:			
<input type="checkbox"/> WNL <input type="checkbox"/> DNA 12. Breasts: (for both male and female) ___ Lumps ___ Tenderness ___ Discharge ___ Pain ___ Does Self-breast exam Comments:			
<input type="checkbox"/> WNL <input type="checkbox"/> DNA 13. Integument: ___ Hair Changes ___ Pruitus ___ Color ___ Tugor Skin condition (Record code # on body area. Indicate size to right of numbered category.) 1. Lesions ___ 2. Bruises ___ 3. Masses ___ 4. Scars ___ 5. Ulcers ___ ___ 6. Decubiti ___ 7. Pressure areas ___ 8. Incisions ___ 9. Rash ___ Comments:			
<input type="checkbox"/> WNL <input type="checkbox"/> DNA 14. Musculoskeletal Neurological: ___ Stiffness ___ Leg cramps ___ Seizure ___ Paralysis ___ PERRL ___ Swollen joints ___ Numbness ___ Tenderness ___ Amputation ___ Coordination ___ Unequal grasp ___ Deformities ___ Tremor ___ Joint pain ___ Gait ___ Temp changes ___ Headache ___ Weakness ___ Syncope ___ Balance ___ Hoarseness Comments:			
<input type="checkbox"/> WNL <input type="checkbox"/> DNA			

Active	Inactive	Potential
---------------	-----------------	------------------

ADULT NURSING ASSESSMENT

Client's Name: _____ Date: _____

<p>15. Endocrine and Hematopoietic:</p> <p><input type="checkbox"/> Polyuria <input type="checkbox"/> Polydipsia <input type="checkbox"/> Excessive bleeding or bruising <input type="checkbox"/> Skin texture <input type="checkbox"/> Intolerance to heat and cold <input type="checkbox"/> Excessive perspiration <input type="checkbox"/> Epistaxis</p> <p>Comments:</p> <p><input type="checkbox"/> WNL <input type="checkbox"/> DNA</p>			
--	--	--	--

Date of Assessment: _____ Signature of Assessor: _____

General Comments:



**NURSING DELEGATION:
INSTRUCTIONS FOR NURSING TASK**
Wyoming Department of Health, Aging Division
IHS-200

1. Client Name:	2. Date of Birth:	3. Setting:	4. Date Task Delegated:		
5. Delegated Task and Expected Outcome:					
Report Unexpected Outcomes To:					
6. Licensed Nurse Name: (PRINT)		7. Telephone Number:			
8. What to Report to the Licensed Nurse:					
Call the Licensed Nurse When:					
9. <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> ↓ Client dies ↓ Client is admitted to the Hospital, Nursing Home or institution ↓ Client condition changes ↓ Problem/unable to perform nursing task </td> <td style="width:50%; border: none; vertical-align: top;"> Other: _____ _____ _____ </td> </tr> </table>				↓ Client dies ↓ Client is admitted to the Hospital, Nursing Home or institution ↓ Client condition changes ↓ Problem/unable to perform nursing task	Other: _____ _____ _____
↓ Client dies ↓ Client is admitted to the Hospital, Nursing Home or institution ↓ Client condition changes ↓ Problem/unable to perform nursing task	Other: _____ _____ _____				
10. Health Care Provider:		11. Telephone Number:			
12. If unable to contact Licensed Nurse, report to Health Care Provider.					
EMERGENCY SERVICES, 911					
13. When to Report to 911: <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> ___ Client unresponsive ___ Client not breathing ___ Client has fallen ___ Client has uncontrolled bleeding </td> <td style="width:50%; border: none; vertical-align: top;"> ___ Other: _____ ___ Other: _____ </td> </tr> </table>				___ Client unresponsive ___ Client not breathing ___ Client has fallen ___ Client has uncontrolled bleeding	___ Other: _____ ___ Other: _____
___ Client unresponsive ___ Client not breathing ___ Client has fallen ___ Client has uncontrolled bleeding	___ Other: _____ ___ Other: _____				
14. Licensed Nurse Signature and Title:			15. Date:		

**ORIGINAL COPY – CLIENT CHART
COPY – LICENSED NURSE**



**NURSING DELEGATION:
INSTRUCTIONS FOR NURSING TASK**
Wyoming Department of Health, Aging Division
IHS-200

Instructions for completing Nurse Delegation: Instructions for Nursing Task

All fields are required.

1. **Client Name:** Enter client's legal name (first name, last name).
2. **Date of Birth:** Enter client's date of birth (month, day, year).
3. **Setting:** Indicate program (WyHS, NFCSP).
4. **Date Task Delegated:** Enter the date task is delegated.
5. **Delegated Task and Expected Outcome:** Enter the name of the task and what outcome is anticipated.
6. & 7. **Licensed Nurse Name and Telephone Number:** Print Licensed Nurse name and telephone number.
8. **What to Report to the Licensed Nurse:** If there are outcomes, listed in Section 5, that are not attained and the licensed nurse would like the CNA to report, please list here.
9. **Call the Licensed Nurse When:** If the listed items take place, please call the licensed nurse as soon as possible.
- 10 & 11. **Health Care Provider and Telephone Number:** Enter the health care provider and telephone number.
12. **If unable to contact Licensed Nurse, report to healthcare provider:** If this is not your organizations standard operation, please note how you would like the CNA to proceed.
13. **What to report to 911:** List signs and symptoms to report to 911.
14. & 15. **Licensed Nurse Signature and Title and Date:** Sign and date the document.

This form must be completed annually or if there is a change in status.
This form may be completed more frequently per provider's policy.



DOCUMENTATION OF COMPETENCY FOR CERTIFIED NURSING ASSISTANTS & HOMEMAKERS
 Wyoming Department of Health, Aging Division, Community Living Section
 IHS-100

(1) NAME:	(2) TITLE:	(3) EVALUATION 1 st 2 nd	(4) DATE
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QUALIFIED IHS SERVICE PROVIDER

The Documentation of Competency must be completed or updated a minimum of every 180 days.

	(5) SKILLS	(6) COMPETENT		(7) How Determined Skill			
		YES	NO	Observed	Verbal	Written	
Certified Nursing Assistant	Proper hand washing methods						
	Bathing techniques						
	Hair care techniques						
	Oral Hygiene techniques						
	Dress/undress client						
	Toileting						
	Caring for incontinence						
	Feed or assist with eating						
	Care of fingernails						
	Skin care						
	Other: Please list below						
	ENDORSEMENTS						
		Blood pressures					
	Temp, Pulse, Respirations						
	Pulse oximetry						
	Other: Please list below						
	Blood glucose monitor						
Homemaker/Chore	Routine housekeeping						
	Basic meal preparation						
	Bed making						
	Laundry techniques						
	Maintain a safe and sanitary environment						
	Other: Please list below						

I certify that the above named individual is competent in the identified skills, including those for endorsement(s), if checked YES. Further, I certify that I have met the professional degree or certification required.

Signature:	Credential:	Date:
Position/Title:	Agency:	Phone:

FOR PERSON VERIFYING COMPETENCY: SEE INSTRUCTIONS ON BACK

INSTRUCTIONS

INSTRUCTIONS FOR PERSON CERTIFYING INDIVIDUAL REQUESTING QUALIFIED SERVICE PROVIDER STATUS:

The person signing the Documentation of Competency (IHS-100) must be one of the following professionals for the certified nursing assistant section: physician, physician's assistant, nurse practitioner, registered nurse, or licensed practical nurse.

The person signing the Documentation of Competency (IHS-100) must be one of the following professionals or paraprofessionals for the homemaker/chore section: nurse practitioner, registered nurse, licensed practical nurse, or a state certified access care coordinator.

A new Documentation of Competency form (IHS-100) must be filled out every 180 days.

- Column (1): Name of the Certified Nursing Assistant or Homemaker
- Column (2): Title: CNA or Homemaker
- Column (3): Circle whether this is the first half or second half of the annual evaluation period
- Column (4): Indicate the date of evaluation
- Column (5) **SKILLS** – Listed is a brief explanation of each task
- Column (6) **COMPETENT** – Place an X in the YES box if the individual is found competent in this skill or mark NO if the individual did not meet the requirement for competency
- Column (7) **HOW DETERMINED SKILLS** – Place an X in the column that identifies the means by which the competency was verified:
OBSERVED –Observed the procedure
VERBAL – A detailed verbal explanation of the procedure was provided
WRITTEN – A detailed written explanation of the procedure was reviewed

**This form needs to be completed every 180 days.
Place form in Employee File.**



Wyoming Home Services & National Family Caregiver Support Program Monthly Report of Waiting Lists



Commit to your health

Please indicate the number of clients that are waiting for services for WyHS and NFCSP, services requested and the reason(s) why they are waiting. If you have NO clients waiting for services, please show a "0" on the appropriate line. Put the number of Total Unduplicated clients for WyHS in its Unduplicated Total box and the number of Total Unduplicated clients for NFCSP in its Unduplicated Total box. Please indicate the number of unduplicated individuals on the WyHS & NFCSP waiting list that are now deceased, in a nursing home and/or assisted living facility. **This form is due to the Aging Division by the 5th working day of each month**

Name of Organization _____ Report for the month of: _____

	Homemaking	Personal Care	PERS	Chore	Unduplicated Total
WyHS	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	_____ in an nursing home _____ in assisted living _____
# of unduplicated individuals on WyHS waiting list this month that are: deceased _____					

	Homemaking	Personal Care	PERS	Chore	Respite	Unduplicated Total
NFCSP	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	# of clients _____ Reasons: Funding _____ Distance _____ Worker shortage _____ Client choice _____	_____ in an nursing home _____ in assisted living _____
# of unduplicated individuals on NFCSP waiting list this month that are: deceased _____						

Signature: _____ Date: _____
 Please fax/ email this form with a cover sheet to: 307-777-5340 ATTN: Jeanne Scheneman

(Date)

(Client Name)

(Address)

(Town, State, Zip Code)

RE: Case Closure

Dear (Client's Name),

As we discussed, your services will be discontinued effective (actual date). In recent conversations, I have expressed my professional opinion that you are unsafe in your home at this time due to the fact that you need 24-hour care. The amount of assistance you need with the basic activities of daily living, such as eating and toileting are beyond the scope of the Wyoming Home Services.

Wyoming Home Services (WyHS) is a diversionary program that is designed to assist you in maintaining your independence and decide where and how you want to live. However, this must be tempered with your safety and well being in mind. Based on the recent assessment, alternative services need to be explored for your own safety.

Under Section 16, Discharge, of the Community Based In-Home Services rules and regulations, it states, "A client shall be discharged from the program if they no longer meet one or more of the following: Level of care requirements; Target group definition; Cost containment requirements as set by the grantee; The client refuses to pay the fee for service agreed upon by the client, or their legal representative, and the case manager; Wyoming Home Services are no longer appropriate; The client chooses nursing home placement or other alternatives; or the client becomes a danger to self or others.

The Long Term Care Ombudsman in your region, (Name and Number), can be contacted if you have concerns regarding the discontinuation of services

We will provide assistance in exploring alternative services if you would like to pursue this matter. If you have any questions, please contact me at (307) (000-000).

If you would like to appeal this decision, you must write to (Organization's name) Board of Directors within ten (10) days of date of this letter. The letter to the Board of Directors needs to outline your desire for an appeal of the discharge process and the reason(s) for the appeal. The Board of Directors will contact you upon receipt of your letter to begin the appeal process.

Sincerely,

Access Care Coordinator

(Date)

(Client Name)

(Address)

(Town, State Zip Code)

RE: Case Closure

Dear (Client's Name),

As we discussed, your services will be discontinued effective (actual date). As we also discussed and based on an assessment of your needs, I have expressed my professional opinion that you no longer meet the eligibility criteria for Wyoming Home Services.

Wyoming Home Services (WyHS) is a program that is designed to assist you in maintaining your independence by providing services to you in your home.

Under Section 16, Discharge, of the Community Based In-Home Services rules and regulations, it states, "A client shall be discharged from the program if they no longer meet one or more of the following: Level of care requirements; Target group definition; Cost containment requirements as set by the grantee; The client refuses to pay the fee for service agreed upon by the client, or their legal representative, and the case manager; Wyoming Home Services are no longer appropriate; The client chooses nursing home placement or other alternatives; or the client becomes a danger to self or others.

The Long Term Care Ombudsman in your region, (Name and Number), can be contacted if you have concerns regarding the discontinuation of services.

We will provide assistance in exploring alternative services if you would like to pursue this matter. If you have any questions, please contact me at (307) 000-0000.

If you would like to appeal this decision, you must write to (Organization Name) Board of Directors within ten (10) days of date of this letter. The letter to the Board of Directors needs to outline your desire for an appeal of the discharge process and the reason(s) for the appeal. The Board of Directors will contact you upon receipt of your letter to begin the appeal process.

Sincerely,

Access Care Coordinator

(Date)

(Client Name)

(Address)

(Town, State, Zip Code)

RE: Case Closure

Dear (Client's Name),

As we discussed, your services will be discontinued effective (actual date). As we discussed you have requested that we no longer provide services to you through Wyoming Home Services.

Please let us know if you need assistance in completing this transition. Also, I have enclosed my business card, and encourage you to contact us if you find your needs change and we can again provide help to you. If you have any questions, please contact me at (307) 000-0000.

Sincerely,

Access Care Coordinator



Waiting List Care Coordination Spreadsheet Instructions

This Waiting List Care Coordination spreadsheet is to keep a record of potential CBIHS clients and time spent discussing CBIHS services, sliding fee scale, and completing AGNES.

Last Name- Client's Last Name

First Name- Client's Legal First Name

Information for Services- time spent for: in person discussions, telephone discussions (should be entered using legend at top of spreadsheet)

Date of Information for Services-date ACC had discussion with client

AGNES time- time spent completing AGNES (should be entered using legend at top of spreadsheet)

Date of AGNES- date ACC completed AGNES with client

Eligible for CBIHS- yes or no

SAMS' Reports for 2015 Title III and WyHS Program Reports

Title III C1 Reports:

Quarterly
Financial
Reports

1. Services - Agency Summary Report: 2015 Quarterly – Unduplicated count by Care Program = C1 Quarterly totals for Meals and clients, you run 1st, 2nd, 3rd, and 4th Quarters for the Financial Reports Quarterly numbers. The SAMS Reports must be mailed in with the Quarterly IIC1 Financial Reports.

Quarterly
Financial
Reports

2. Services - Agency Summary Report: 2015 YTD – Unduplicated count by Care Program = C1 Year To Date totals for Meals and Clients, you run 2nd, 3rd, and 4th Quarters for the Financial Reports YTD numbers and 4th Quarter Program Report. The SAMS Reports must be mailed in with the IIC1 2nd, 3rd, and 4th Quarterly Financial Reports.

4th
Quarter
Program
Report

3. Services - Service Delivery Profile – Cross Tab: 2015 YTD – Congregate Meals nutritional risk counts
4. Services - Agency Summary Report: 2015 YTD – Clients with poverty status yes
5. Services - Agency Summary Report: 2015 YTD – clients with live alone status yes
6. Services – Agency Summary Report: 2015 YTD – clients with minority status yes
7. Services - Service Delivery Profile – Cross Tab: 2015 YTD – Congregate Meals poverty & nutritional risk counts

Title III C2 Reports:

Quarterly
Financial
Reports

1. Services - Agency Summary Report: 2015 Quarterly – Unduplicated count by Care Program = C2 Quarterly totals for Meals and clients, you run 1st, 2nd, 3rd, and 4th Quarters for the Financial Reports Quarterly numbers. The SAMS Reports must be mailed in with the Quarterly IIC2 Financial Reports.

Quarterly
Financial
Reports

2. Services - Agency Summary Report: 2015 YTD – Unduplicated count by Care Program = C2 Year To Date totals for Meals and Clients, you run 2nd, 3rd, and 4th Quarters for the Financial Reports YTD numbers and 4th Quarter Program Report. The SAMS Reports must be mailed in with the IIC2 2nd, 3rd, and 4th Quarterly Financial Reports and 4th Quarter Program Report.

4th
Quarter
Program
Report

3. Services - Service Delivery Profile – Cross Tab: 2015 YTD – HDM nutritional risk counts
4. Services - Agency Summary Report: 2015 YTD – Clients with poverty status yes
5. Services - Agency Summary Report: 2015 YTD – clients with live alone status yes
6. Services – Agency Summary Report: 2015 YTD – clients with minority status yes
7. Services - Service Delivery Profile – Cross Tab: 2015 YTD – HDM poverty & nutritional risk counts

Title III C1 & C2 – Nutritional Risk “Don't Knows” report to find out which clients need fixed. Please run this either monthly or quarterly so you can fix the Don't Knows:

1. Services - Agency Summary Report: 2015 Quarterly Nutrition Risk Don't Knows – C1 & C2

Title III B & D Reports are the same so you only have to run them once but separate the Care Programs and make a copy of the parameters.

Title III B Reports:

**Quarterly
Financial
Reports**

1. Services - Agency Summary Report: 2015 Title III B & D Quarterly – Unduplicated count by Care Program
2. Services - Agency Summary Report: 2015 Title III B & D Quarterly Report - Clients with poverty status yes
3. Services - Agency Summary Report: 2015 Title III B & D Quarterly Report – clients with live alone status yes
4. Services - Agency Summary Report: 2015 Title III B & D Quarterly Report – clients with minority status yes

**Annual
Program
Report**

5. Services – Agency Summary Report: 2015 Title III B & D FY2015 Grant Baseline Data for FFY2014. Please change the dates to 10/01/2014 – 09/30/2015 to answer the FFY2015 question.
6. Services - Agency Summary Report: 2015 Title III B & D YTD Report - Clients with poverty status yes
7. Services - Agency Summary Report: 2015 Title III B & D YTD Report – clients with live alone status yes
8. Services - Agency Summary Report: 2015 Title III B & D YTD Report – clients with minority status yes

Title III D Reports:

**Quarterly
Financial
Reports**

1. Services - Agency Summary Report: 2015 Title III B & D Quarterly – Unduplicated count by Care Program
2. Services - Agency Summary Report: 2015 Title III B & D Quarterly Report - Clients with poverty status yes
3. Services - Agency Summary Report: 2015 Title III B & D Quarterly Report – clients with live alone status yes
4. Services - Agency Summary Report: 2015 Title III B & D Quarterly Report – clients with minority status yes

**Annual
Program
Report**

5. Services – Agency Summary Report: 2015 Title III B & D FY2015 Grant Baseline Data for FFY2014. Please change the dates to 10/01/2014 – 09/30/2015 to answer the FFY2015 question.
6. Services - Agency Summary Report: 2015 Title III B & D YTD Report - Clients with poverty status yes
7. Services - Agency Summary Report: 2015 Title III B & D YTD Report – clients with live alone status yes
8. Services - Agency Summary Report: 2015 Title III B & D YTD Report – clients with minority status yes

Title III B & D ~ New Client Report:

1. Consumers - Consumers Listing Report: 2015 Title III B & D Quarterly Report – New Client Count by Care Program

Title III E Reports: Caregiver and Grandparents Raising Grandchildren

1. Services - Agency Summary Report: 2015 Quarterly – Unduplicated count by Care Program –Caregiver Program
2. Services - Agency Summary Report: 2015 Quarterly – Title III E GRG Unduplicated count by Care Program –Grandparent Raising Grandchildren Program
3. Services - Agency Summary Report: 2015 Quarterly – Clients with poverty status yes
4. Services - Agency Summary Report: 2015 Quarterly – clients with live alone status

Title III E & WyHS – New Client report

1. Consumers - Consumer Listing Report: 2015 Quarterly – New Client Counts by Care Program

Wyoming Home Services (CBIHS):

1. Services - Agency Summary Report: 2015 Quarterly – Unduplicated count by Care Program
2. Services - Service Delivery Profile – Cross Tab: 2015 Quarterly – CBIHS – ADLS
3. Services - Service Delivery Profile – Cross Tab: 2015 Quarterly – CBIHS – IADLS
4. Services - Agency Summary Report: 2015 Quarterly CBIHS Clients with ADL & IADL = 0

WYOMING DEPARTMENT OF HEALTH
AGING DIVISION

CHAPTER 1
RULES FOR COMMUNITY BASED IN-HOME SERVICES

Section 1. Authority. These rules are promulgated by the Wyoming Department of Health, Aging Division, pursuant to W.S. § 9-2-1208 et seq., W.S. § 42-2-103 (b) (viii), § 9-2-2005 (d), W.S. § 35-1-229, Laws 1991, ch221, 1 (b) section (a)(ii), and the Wyoming Administrative Procedures Act at W.S. § 16-3-101 et seq.

Section 2. Purpose. The purpose of these rules is to establish standards for the delivery of community based in-home services for adults at risk of premature institutionalization.

Section 3. Scope of Program. The goals of the program are of fostering self-sufficiency, preventing abuse, neglect or exploitation, maintaining individuals in the least restrictive safe environment, and preventing inappropriate or premature institutionalization.

(a) The program consists of the following services provided in the home:

- (i) Case management,
- (ii) Homemaking services,
- (iii) Personal care,
- (iv) Home modifications,
- (v) Chore,
- (vi) Respite,
- (vii) Hospice services, and
- (viii) Personal emergency response system.

(b) Adult day care services are provided in a licensed facility.

Section 4. Definitions.

(a) "Adult Day Care." Adult day care is a community based group program designed to meet the needs of adults with physical or mental disabilities through an individual activity care plan. It is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective setting during any part of a day, but less than 24-hour care.

- (b) **“Assessment.”** Determining the status of the client in relation to specific conditions targeted for service or related conditions that can be addressed by the program. This will be completed as specified by the Division.
- (c) **“At-risk.”** An individual unable to perform normal daily tasks independently due to multiple problems which can include, but are not limited to physical, emotional, or cognitive functioning, environment, abuse or neglect.
- (d) **“Capitation.”** A cost containment measure which places spending limits on community based in-home services funding for each client.
- (e) **“Care Plan/Service Plan.”** Documentation of the services that will be provided to meet the needs and goals of the client.
- (f) **“Case Management.”** A set of logical steps and processes of interaction within a service network which assure that a client
- (g) **“Central Registry.”** Means the registry maintained by the Wyoming Department of Family Services pursuant to W.S. § 14-3-213, which indexes perpetrators of child abuse or neglect and abuse, exploitation or abandonment of disabled adults.
- (h) **“Certified Nurse’s Aide.”** A person who is currently certified by the Wyoming State Board of Nursing.
- (i) **“Client.”** An at-risk adult who is the recipient of community based in-home services.
- (j) **“Client Assessment.”** Interviewing and observing the client, usually in the client’s home, in order to obtain information on the client’s functional capacity, available personal and social support resources, perceived problems, and services currently received from formal or informal sources.
- (k) **“Days.”** Calendar days.
- (l) **“Department.”** The Wyoming Department of Health.
- (m) **“Division.”** The Wyoming Aging Division.
- (n) **“Fiscal Year.”** An accounting period of twelve months starting July 1 through June 30.
- (o) **“Grantee.”** An organization that provides services outlined in an approved grant funded by the Division.

(p) "Health Assessment." An evaluation of a client's medically related needs by a physician or physician extender.

(q) "Homemaker." A person who assists with environmental services such as, but not limited to, housekeeping, basic meal preparation, shopping, and laundry. Homemakers do not provide personal care.

(r) "Home Modifications." Minor modifications that are necessary to facilitate the ability of at-risk adults to remain in their homes and that are not available under other programs. A maximum of three hundred dollars (\$300) per client may be expended under this part for such modifications.

(s) "Hospice." A program for the terminally ill and their families given in a home or health facility which provides medical, palliative, psychological, spiritual, and supportive care and treatment.

(t) "Local Match." Local funds raised by the grantee to be used to match state and federal funds within the grantee's budget.

(u) "Outreach." Identifying and establishing contact with persons who need the services provided by the program.

(v) "Personal Care." Activities include, but not limited to, bathing, grooming, feeding, ambulating, exercising, oral hygiene, and skin care.

(w) "Personal Emergency Response System (PERS)." An electronic device worn by the client to summon emergency help.

(x) "Physician Extender." Physician Assistant (PA) and/or Advanced Practitioner of Nursing.

(y) "Respite Care." Temporary, substitute supports or living arrangements to provide a brief period of relief for caregivers.

(z) "Senior Citizen." Any person 60 years of age or older.

(aa) "Service Unit." One hour of direct service provided to the client with the exception of PERS. One service unit for PERS is defined as either an initial hook-up, the monthly service, or the termination of service.

(bb) "Sliding Fee Schedule." Payment for services rendered to eligible clients based on the ability to pay.

Section 5. Eligibility. Clients of this program must be:

(a) At least 18 years of age;

(b) Determined through an ongoing assessment to be at-risk of premature institutionalization, and;

(c) In need of program services.

Section 6. Funding.

(a) Funding for the Community Based In-Home Services Program will be disbursed statewide through contracts with the Division based on a funding formula developed by the Division.

(i) Each grantee must provide at least five (5) percent of the contracted amount, based on actual expenses, to be applied as a local match for its budget.

(ii) Program income received must be utilized as part of the grantees program budget.

(b) Resource Allocation.

(i) Ages 60 and over.

(A) Grantees must designate a minimum of eighty-five percent (85%) of the contract amount to serve clients age 60 and over.

(ii) Ages 18 through 59.

(A) Grantees may designate no more than fifteen percent (15%) of the contract amount for clients age 18 through 59.

(I) Based on documented outreach efforts and community need, grantees have the discretion to use the funds:

(1) Above for those age 60 and over.

Section 7. Client Fees. Utilizing the Division's sliding fee schedule as a guideline, clients will pay a fee for all services based on their ability to pay. Such fees will be considered program income. Clients who cannot pay will not be denied services.

(a) Clients being charged for services will be provided with monthly statements regarding the number of service units and the agreed upon fee for services.

Section 8. Personnel.

(a) Hiring Procedures:

(i) The following will apply to all Licensed Nurses, CNA's and Homemaker/Chore personnel hired at the effective date of this rule.

(A) No Licensed Nurse, CNA, or Homemaker/Chore personnel shall have been convicted of a felony or a misdemeanor related to abuse, neglect, exploitation, or abandonment of adults or children.

(B) Prior to working independently in a client's home, the following reference checks must be completed and documented in the employees' personnel file:

(I) Written documentation of at least two (2) character references from a previous employer, if any, or other knowledgeable and objective sources prior to employment or volunteering (e.g., letters of reference; notations of telephone reference checks including the name of the person(s) contacted, the date(s) of contact, the firm(s) contacted, and the result(s).

(II) The project must contact the Wyoming Department of Family Services, for all personnel who are not licensed or certified by the Wyoming State Board of Nursing, to ensure the individual does not appear on the central registry.

(III) The project must contact the Wyoming State Board of Nursing for those personnel who are licensed and/or certified by the Wyoming State Board of Nursing, to ensure the individual is in good standing with the board.

(C) Any individual who has been convicted of a felony or a misdemeanor related to abuse, neglect, exploitation, or abandonment of adults or children shall not work for the Community Based In-Home Service Program.

Section 9. Staff Development. All staff shall have a general orientation completed during the first week of employment and prior to direct client contact.

(a) The orientation shall include, but is not limited to, the following areas as related to job responsibilities:

(i) Confidentiality;

(ii) Emergency procedures;

(A) Cardio-Pulmonary Resuscitation (CPR)

(B) First Aid

(C) Universal precautions

(iii) Client rights and responsibilities;

- (iv) Elder and disabled abuse and reporting procedures;
 - (v) Communication;
 - (vi) Understanding and working with various client populations, and;
 - (vii) Understanding basic human needs.
- (b) Documentation of all personnel training shall be on file.

Section 10. Case Management. All grantees shall employ a case manager.

(a) Case Manager Qualifications. On the effective date of this rule all newly hired case managers must:

- (i) Be at least 21 years of age;
- (ii) Meet at least one of the following criteria:
 - (A) Have completed at least forty-eight (48) semester hours or seventy-two (72) quarter hours of post secondary education in health care, elderly care, health care management, facility management, or other related fields from a college or institution.
 - (B) Be a certified nursing assistant (CNA)
 - (C) Have at least two (2) years of experience in social services working with the elderly or people with disabilities.

(b) Case manager responsibilities include, but are not limited to:

- (i) Obtaining certification by the Division;
 - (A) Maintain certification by completion of twelve (12) contact hours of job related continuing education each fiscal year.
- (ii) Performing client assessments as specified in Section 12, and;
- (iii) Monitoring of all service provisions.

Section 11. Homemakers. The homemaker assists with instrumental activities of daily living, such as housekeeping and homemaking services, in order to preserve a safe, sanitary home, and to enhance family life. The homemaker does not provide any personal care.

(a) Examples of duties include, but are not limited to:

- (i) Housekeeping;

- (ii) Shopping;
- (iii) Laundry;
- (iv) Essential errands;
- (v) Basic meal preparation;
- (vi) Meal planning (except for clients on therapeutic diets), and;
- (vii) Maintaining a safe and sanitary environment.

(b) Training for Homemakers

(i) Training shall be a minimum of eight (8) hours, and shall be documented in the homemaker's personnel record.

(ii) The following training areas shall be completed before any client assignment. Training shall include:

- (A) General staff orientation as specified in Section 8;
- (B) Orientation to homemaker services, including documentation responsibilities;
- (C) Practical knowledge and skill in homemaking, and;
- (D) Maintaining a clean, safe, and health environment.

(c) Supervision of Homemakers

(i) Homemakers shall be supervised by the case manager as frequently as the client's condition requires, but at least every ninety (90) days.

- (A) The homemaker shall be present during the supervisory visit;
- (B) The supervisory visits shall occur at the client's home, and;
- (C) The supervisory visits shall be documented.

Section 12. Certified Nurse's Aide.

(a) Certified Nurses' Aides (CNA's) shall be supervised by a licensed nurse as specified by the Wyoming State Board of Nursing rules. On-site supervision shall be conducted

at least every ninety (90) days. If a CNA's services are contracted by another agent, supervision of aides will be performed by the contracting agent.

(b) After appropriate delegation under the direction of the supervising nurse, the CNA shall demonstrate the abilities to respect client's rights, adhere to legal and ethical concepts, communicate appropriately, ensure optimum client safety, practice appropriate infection control and correct body mechanics. CNA's may perform services as outlined in the Wyoming State Board of Nursing rules.

Section 13. Client Assessment. All assessments will be documented on a form approved by the Division and are preferably conducted in the client's home.

(a) **Eligibility Screening.** Prior to service provision each client shall be screened to determine eligibility based on the definition of "at-risk".

(b) **Initial Assessment.** The grantee shall conduct a written initial assessment of each client based upon the information presented by the client, family members, friends, responsible parties, or conservator and any documented health assessment, if necessary. A care/service plan will be developed based on the assessment and established goals.

(c) **Interim Assessments.** Evaluation of a client must be made by a case manager in the client's home to evaluate the quality and need to services at least every ninety (90) days. Adjustments in the care/service plan will be made as necessary.

(d) **Annual Assessment.** The case manager shall complete an assessment, utilizing the initial assessment form, at least annually or as a significant change in condition dictates.

Section 14. Care/Service Plan. During all phases of the assessment process the care/service plan shall be developed, reviewed and/or modified as indicated to meet the needs of the clients.

(a) **Care/Service Plan:**

(i) A care/service plan shall be developed by a case manager and shall consist of the following:

- (A) The specific procedures to be done;
- (B) The frequency of the procedures;
- (C) The day and approximate arrival time at the client's home, and;
- (D) Procedures to be followed in an emergency situation.

(ii) Written care/service plan instructions must be provided to the homemaker and/or personal care attendant before services are initiated.

(iii) If a change in a client's care/service plan occurs, the case manager must provide a copy of the revised care/service plan to the client. The client or legal representative must sign the revised plan.

Section 15. Maintenance of Records. The grantee must maintain a record of each client for the Community Based In-Home Services program.

(a) **Documentation.** The grantee shall ensure that the program maintains an adequate system of record keeping to comply with these rules.

(b) The record must include but is not limited to the following:

(i) All eligibility and assessment material;

(ii) Signed copy of the Division's client's rights and grievance procedure;

(iii) Documentation of all client related contact, and;

(iv) Disposition of referral, care plans, discharge and all other documentation pertinent to the client's care.

(c) Upon written consent, client records shall be shared with other facilities/agencies upon referral or discharge.

(d) All client files required by these rules shall be kept in a locked cabinet or area and retained by the grantee at least three (3) years after client termination date.

(e) All records, case files and other forms of documentation pertinent to the Community Based In-Home Services Program are considered property of the State of Wyoming.

(i) In the event a program should close, or transfer from one grantee to another, the Division shall arrange for the transfer of all program records to the appropriate grantee.

(ii) Case records shall be sealed and confidentially maintained, should the change in record custody be necessary.

Section 16. Discharge.

(a) A client shall be discharged from the program if they no longer meet one or more of the following:

(i) Level of care requirements;

(ii) Target group definition;

- (iii) Cost containment requirements as set by the grantee;
- (iv) The client refuses to pay the fee for service agreed upon by the client, or their legal representative, and the case manager;
- (v) Community Based In-Home Services are no longer appropriate;
- (vi) The client chooses nursing home placement or other alternatives, or;
- (vii) The client becomes a danger to self or others.

(b) In the above referenced items (i)-(v) grantees must provide at least fourteen (14) days written advance notice of intent to discharge.

(c) The grantee must notify the client immediately, in writing, of their right to appeal the discharge from services.

Section 17. Client's Right to Self-Determination. Clients are entitled to decide where and how they live, and whether or not they wish to receive Community Based In-Home Services and other forms of assistance. Grantees must recognize the civil rights of individuals they wish to serve and must terminate service at any time that a client refuses such services.

Section 18. Capitation. Each Community Based In-Home Services Program grantee shall develop cost caps for fiscal control.

Section 19. Confidentiality. Client confidentiality shall be maintained in conformance to the federal and state laws.

Section 20. Program Transfer. If the program is to be transferred from one grantee to another, it is the responsibility of the transferring grantee to inform clients of changes in writing within fourteen (14) days. The information provided to the client shall include, at a minimum;

- (a) Name of the new grantee, along with the name and telephone number of the contact person;
- (b) Information about potential changes in the provision of services;
- (c) Assurance that the client will not be arbitrarily dropped from the program due to the transfer;
- (d) Informing the client that a new assessment is required and will occur within ninety (90) days of transfer, and;
- (e) The date of transfer.

(i) Should the program transfer from one grantee to another, it is the new grantee's responsibility to assess all transferred clients within ninety (90) days. Grantees shall make all efforts to minimize interruption of services to transferred clients.

Section 21. Grant Application. All grants must comply with the current requirements as set forth by the Division.

Section 22. Reporting Requirements. Grantees will comply with reporting requirements as prescribed by the Division. Noncompliance may result in termination or suspension of grant/contract.

Section 23. Quality Assurance. Quality assurance assessments for Community Based In-Home Services will be implemented in a format which has been approved by the Division.

(a) Quality assurance shall be conducted at each grantee site at least every eighteen (18) months by a representative approved by the Division.

(b) All Community Based In-Home Services grantees must provide any relevant documentation and information to the Division's representative during an assessment.

Section 24. Insurance and Bonding. The grantee shall assure that all case managers, homemakers, Certified Nursing's Aide and nurses are covered by liability insurance and bonding.

Section 25. Administrative and Judicial Review.

(a) An applicant or client whose request for services is not acted upon within a reasonable time or who does not agree with the determination of ineligibility, or the provision of services or discharge from services under this program, may appeal in accordance with the Wyoming Administrative Procedure Act.

Wyoming Homes Services State Statute

9-2-1208. Community based in-home services.

(a) The department of health shall administer a state program to provide community based in-home services for Wyoming senior citizens and disabled adults eighteen (18) years of age and older. Priority shall be given to persons at risk of placement in nursing homes, assisted living or other institutional care settings and the program may serve persons who are not senior citizens if the program's services are needed to avoid institutional placement.

(b) The program authorized by this section may include but is not limited to the following in-home services:

- (i) Homemaking services;
- (ii) Personal care services;
- (iii) Respite care to relieve caregivers;

(iv) Hospice services for individuals who are not able to pay for the care due to lack of income or assets and are not able to qualify for hospice services under the Medicaid program; and

- (v) Adult daycare.

(c) The department shall:

(i) Establish a schedule of fees for services provided based upon the client's ability to pay;

(ii) Prescribe conditions of eligibility for services under this section based upon a client evaluation; and

(iii) Promulgate rules and regulations necessary for the administration of the program;

(iv) Repealed By Laws 2007, Ch. 57, 2.