

Interim Process for Requesting In-Home Supports

Effective 5/13/20

During the COVID-19 crisis, In-Home Supports has been temporarily added as a service to the ID/RD and HASCI Waivers. The service definition and specifications mirror those in the CS Waiver. The service must be self-directed and may be provided in lieu of provider managed services offered through those Waivers (i.e., Personal Care, Respite, Attendant Care, etc.). In addition, using In-Home Supports as a replacement service will require that services be authorized at the currently approved levels.

As part of an effort to allow flexibility for In-Home Support Services during the COVID-19 crisis, two additional options have been added for the service provided in all 3 Waivers:

- Family members not previously covered through the family members providing care policy are allowed to provide the service as long as the waiver participant or a responsible party is available to self-direct the service. This includes the ability for parents of minor children, legal guardians and spouses to be paid to provide the service.
- Qualifications and training can be waived when any family member is providing the service.

The procedures below are categorized into two sections. The first is for In-Home Supports being provided in any Waiver by a family member. The other outlines procedures for In-Home Supports in the ID/RD or HASCI Waiver by someone other than a family member.

In-Home Supports in ID/RD, CS or HASCI Waiver provided by a family member:

- If the person is determined to have needs that can be met through In-Home Supports, requirements for the service are reviewed with the participant and/or responsible party.
- Case Managers must be clear that the new service provisions are temporary.
- Case Managers should inform the waiver participant/responsible party that the pay rate will be \$12.15 per hour. Taxes will not be taken out and a 1099 will be issued at the end of the year. This rate is \$0.85 greater than the current In-Home Supports rate through the CS Waiver. This increase is to compensate the In-Home Supports worker for self-employment tax.
- Prior to a formal request for the service the CM must complete a packet of information including the items listed below. Although physical signatures are challenging, Case Managers are encouraged to have written acknowledgement instead of verbal signatures (i.e., email confirmation, forms reviewed on the phone and signed by mail, etc):
 - Complete the "COVID-19 Interim Pre-Screening". This will determine whether the waiver participant or chosen representative has the ability to direct services. If the screening results indicate the waiver participant or chosen representative is capable of directing services, the CM can move on to the additional requirements.
 - Review "COVID-19 Temporary Waiver of Requirements for Provision of In-Home Supports by a Family Member" form and obtain signatures.
 - Review and obtain signatures on the "COVID-19 Family In-Home Supports Worker Responsibilities Agreement"
 - Complete Demographic Information Sheet
 - Completed W-9 (<https://www.irs.gov/pub/irs-pdf/fw9.pdf>)

- Case Managers should SComm the completed packet to “DDSN, In-Home Supports.” The Case Manager will be notified when the family member has been vetted and request for In-Home Supports can be submitted.
- After the In-Home Supports provider has been vetted, Case Managers may request In-Home Supports for any consumer enrolled in the HASCI, ID/RD or CS Waivers through the normal Plan Change Request Process.
- Requests must include a current Personal Care/Attendant Care Assessment and SCDDSN Respite Assessment with the Plan Change Request. If the request is to replace currently approved hours of PC, respite and attendant care, the Assessment(s) that are current within one year may be attached instead of completing an entirely new assessment.
- The Waiver Administration Division will approve requests and ensure that the Plan and budget is updated correctly. Particular attention will be given to ensure that CS Waiver participants do not exceed the annual cost cap for services.
- Case Managers will authorize In-Home Supports using the COVID-19 paper authorization form located on Business Tools in the following folder: DDSN > Business Tools > COVID-19 INTERIM FORMS. The authorization must be written to the family member who is providing the service and must include a start and end date. The end date cannot exceed 9/30/20.
- When authorization is sent to the waiver participant and family member providing service, case managers must include a copy of the In-Home Support Worker Checklist, Daily Log/Timesheet and pay schedule.
- A copy of the authorization must be sent to the Charles Lea Center as well as the waiver participant or responsible party who is directing the care. A copy of the authorization must also be maintained in the record.

When In-Home Supports will be provided by someone other than a family member

- Procedures for In-Home Supports for CS Waiver participants who are not excluded family members that meet all qualifications and training will continue to be governed by the policy outlined in Chapter 9 of the CS Waiver manual. These caregivers will continue to be paid the \$11.30 per hour rate and Jasper will continue to process payroll taxes for the worker.
- If the person is enrolled in the ID/RD or HASCI Waiver, Case Managers should follow the process outlined in the CS Waiver Manual, Chapter 9 BUT the Case Manager should SComm the completed employment packet to the “DDSN, In-Home Supports” SComm box prior to requesting the service. The rate of pay for these workers will be \$12.15 and they will be issued at 1099 by Charles Lea.
- Requests must include a current Personal Care/Attendant Care Assessment and SCDDSN Respite Assessment with the Plan Change Request. If the request is to replace currently approved hours of PC, respite and attendant care, the Assessment(s) that are current within one year may be attached instead of completing an entirely new assessment.
- The Waiver Administration Division will approve requests and ensure that the Plan and budget is updated correctly. Particular attention will be given to ensure that CS Waiver participants do not exceed the annual cost cap for services.
- Case Managers will authorize In-Home Supports using the COVID-19 paper authorization form located on Business Tools in the following folder: DDSN > Business Tools > COVID-

19 INTERIM FORMS. The authorization must be written to the person who is providing the service and must include a start and end date.

- When authorization is sent to the waiver participant/family member providing service, case managers must include a copy of the In-Home Support Worker Checklist, Daily Log/Timesheet and pay schedule.

COVID-19 INTERIM SCREENING FOR DIRECTION OF IN-HOME SUPPORT BY THE INDIVIDUAL OR ANOTHER

When In-Home Support is determined to be needed, In-Home Support (IHS) Screening must be completed to determine who can direct the service. This screening must be completed prior to service authorization.

The IHS Screening is designed to determine the waiver participant's likely ability to consent regarding services and to help determine the participant's likely ability to direct his/her own services.

To "consent" generally means that the waiver participant can:

- Appreciate the nature and implication of his/her condition; and
- Appreciate the nature and implication of IHS services; and
- Make reasoned decisions regarding those services in an unambiguous manner.

Waiver participants must be able to consent in order to direct their own services and/or when desired, must be able to consent to allow another (a representative) to direct his/her services.

The IHS Screening is also designed to determine who may act as a representative and the representative's likely ability to act in the participant's best interest.

A. When the waiver participant wants to direct his/her own care, section I of the IHS Screening must be completed. Based on the responses to the questions and using professional judgment, a recommendation must be made. The recommendation and any comments regarding it must be reflected in Section III of the screening form. The recommendation may be that:

- The person should be allowed to direct his/her own IHS; or,
- The person should not be allowed to direct his/her own HIS.

If the latter is recommended (should not self-direct), this recommendation must be presented to the Agency's Human Rights Committee (HRC) for review. If the HRC concurs with the recommendation, self-direction of IHS will not be allowed. If the HRC does not concur with the decision, self-direction of IHS will be allowed.

B. If the waiver participant has expressed a desire for another (a representative) to direct his/her IHS, the IHS Screening (all sections) must be completed. Based on the responses and using professional judgment, a recommendation must be made.

If the person is determined to be able to consent and the representative is determined to likely act in the participant's best interest, then representative direction should be allowed.

If, it is determined that the participant is unable to consent or that the representative is unlikely to act in the participant's best interest, then representative-direction should not be allowed.

If representative-direction is desired but not recommended, the recommendation must be reviewed by the Agency's HRC. If the HRC concurs with the recommendation, representative-direction will not be allowed. If the HRC does not concur with the recommendation, representative-direction will be allowed.

C. If representative-direction is requested by someone other than the participant, the IHS Screening must be completed. If the participant is determined to be able to consent, this request should be considered according to the protocol included in Section B of this document. If the person is determined to be unable to consent, the responses in section II of the screening must be considered and using professional judgment, a recommendation made regarding representative-direction.

If the participant is unable to consent and the representative is unlikely to act in the person's best interest, representative-direction will not be allowed.

If the participant is unable to consent and the representative is likely to act in the participant's best interest, then representative-direction should be allowed. This recommendation must be reviewed by the Agency's HRC. If the HRC concurs with the recommendation, then representative-direction will be allowed. If they do not concur with the decision, representative-direction will not be allowed.

In accordance with the SC Adult Health Care Consent Act (The Act), when an adult who is certified by two (2) physicians to be unable to consent, a representative can be named to consent on the individual's behalf. If an individual is certified by two (2) physicians to be unable to consent and based on the Act a representative is named, the representative may direct the participant's IHS. Documentation from the physicians must be on file and the certification must be made before representative-direction is allowed. The IHS Screening will not be used when a representative is named in accordance with the Act.

SC Department of Disabilities and Special Needs Direction of In-Home Support Screening

Person's name: _____

This screening must be completed prior to authorization of In-Home Support.

This screening is being completed because *(check only one)*:

- This person has expressed a desire to direct his/her own IHS.
- This person expressed a desire for someone else, a representative, to direct his/her IHS.
- Someone has expressed a desire to direct this person's IHS (i.e., be this person's representative).

I. THE PERSON

What are this person's current diagnoses?

- Intellectual Disability: Indicate level: _____
- Related Disability: Specify: _____
- Others: Specify: _____

Check the statement that best describes the person's ability to communicate:

- Verbal communication with little or no difficulty being understood by others and/or little or no difficulty understanding others.
- Verbal communication that is not easily understood by others and/or difficulty understanding others.
- Severely limited verbal communication or is basically nonverbal; uses alternative method of communicating such as sign language, writing, pictures, electronic systems, gesturing or pointing; little or no difficulty understanding others.
- Nonverbal; little or no expressive communication; does not use communication devices.
- Unable to communicate.

Can this person understand/follow simple instructions or questions? Yes No

Can this person understand/follow complex (two or more parts) instructions or questions? Yes No

Can this person read at the 5th grade level (for example can the person read the local newspaper)? Yes No

During the past **12 months** has this person *(check any that apply)*:

- Resisted care or assistance; been noncompliant with medical regime
- Been verbally aggressive or had any emotional outbursts
- Been physically aggressive
- Injured, attempted to injure, threatened/verbalized desire to injure him/herself

Does this person appreciate/understand the nature and implications of his/her own condition? Yes No

Does this person understand In-Home Support services? Yes No

If representative-direction of IHS is desired, continue. If representative-direction of IHS is not desired, skip to section III.

II. THE REPRESENTATIVE

If a representative is desired, indicate if the person has:

- An attorney-in-fact appointed by this person in a durable power of attorney executed pursuant to S. C. Code Ann. § 62-5-501. If yes, name of attorney-in-fact: _____
- A person given priority to make health care decisions for this person. If yes, name: _____
- A spouse unless the spouse and the person are separated. If yes, name of spouse: _____

A parent or adult child. If yes, name of parent/child: _____

An adult sibling, grandparent, or adult grandchild. If yes, name: _____

Other relative by blood or marriage who reasonably is believed to have a close personal relationship with this person.
If yes, name: _____

Is the proposed representative listed in the preceding question? Yes No

If yes, name of proposed representative: _____

Does the proposed representative live with the person? Yes No

If no, is the representative available at all times IHS will be provided? Yes No

Has the proposed representative agreed to supervise the IHS provider? Yes No

Is the proposed representative able to advocate for the person? Yes No

Is the proposed representative able to communicate with little or no difficulty regarding the person's needs? Yes No

Does the proposed representative understand the nature and implications of this person's condition? Yes No

Does the proposed representative understand In-Home Support services? Yes No

III. THE RECOMMENDATION

Based on the findings of this screening, the following is recommended:

This person should direct his/her own care.

While self-direction is desired, it should not be allowed. *[Human Rights Committee (HRC) review required]*

This person's desire for the named representative to direct his/her HIS should be allowed.

While desired by the person, direction by the named representative should not be allowed. *[HRC review required]*

This person is unable to consent. The representative named should be allowed to direct this person's IHS. *[HRC review required]*

This person is unable to consent. The representative named should not be allowed to direct this person's IHS. *[HRC review required]*

This person is able to consent. Direction by the named representative is not desired and therefore should not be allowed.

Comments regarding the recommendation:

Completed By (*print name and title*): _____

Signature of person completing

Date: _____

**COVID-19 Temporary Waiver of Requirements for the Provision of
In-Home Supports by a Family Member**

Emergency operations during the COVID-19 Pandemic allow the temporary provision of In-Home Supports by family members of waiver participants. During the state of emergency, the waiver participant and his/her primary caregiver/representative are permitted to waive some specific requirements for provision of In-Home Supports.

Name of Waiver Participant: _____

Medicaid Number: _____

Name of Family Member Providing In-Home Supports: _____

Relationship to Waiver Participant: _____

The In-Home Supports worker must meet the following requirements which **cannot** be waived:

- a. Demonstrate the ability to read, write, and speak English.
- b. Be fully ambulatory.
- c. Be capable of aiding in the activities of daily living.
- d. Be physically capable of performing duties which may require physical exertion such as lifting, transferring, etc.
- e. Be capable of following the personal care needs form with the Waiver Participant and/or representative supervision.
- f. Be at least 18 years of age.
- g. Be capable of following billing procedures and completing required paperwork.

The waiver participant and primary caregiver/representative are permitted to waive the qualification and training requirements for a **family member** to provide this service.

The participant or primary caregiver agrees to direct the service and is responsible for either **verifying** or **waiving** the following qualifications for the In Home Supports Caregiver *(please initial your choice)*:

Agree to Waive		Do Not Agree to Waive
<input type="checkbox"/>	I agree to waive the requirement for verification that the selected family member who will provide In-Home Supports has no conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner).	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for completion of a DSS Registry check verifying the selected family member who will provide In-Home Supports has no known conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children’s Code, S.C. Code Ann. Title 20, Chapter 7).	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for completion of a SLED background check to verify the family member who will provide In-Home Supports has no conviction for any crime against another person and no felony conviction of any kind.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for verification that the selected family member who will provide In-Home Supports has no record of exclusion or suspension from the Medicare or Medicaid Programs.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for Basic First Aid certification of the selected family member who will provide In-Home Supports.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the provision of references by the selected family member who will provide In-Home Supports.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for a Tuberculin (PPD) test of the selected family member who will provide In-Home Supports.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the selected family member who will provide In-Home Supports to have training in the area of confidentiality.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the selected family member who will provide In-Home Supports to have training in the area of supervision.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the selected family member who will provide In-Home Supports to have training in the area of prevention of abuse and neglect.	<input type="checkbox"/>

Waiver Participant/Responsible Party Signature

Date: _____

IN-HOME SUPPORTS WORKER RESPONSIBILITIES AGREEMENT
FOR THE TEMPORARY PROVISION OF IN HOME SUPPORTS BY A FAMILY MEMBER
DURING COVID-19 CRISIS

Waiver Participant: _____ Medicaid #: _____

In-Home Supports Worker: _____

As a **temporary** provider of In-Home Supports and a **family member** of the noted waiver participant, I understand that:

1. **The provision of In-Home Support services in the ID/RD and HASCI Waiver is temporary and will only be allowed during the COVID-19 State of Emergency.** Service authorizations will have a start and end date and I understand that I will not be paid for services after the end date of the authorization.
2. **The provision of In-Home Support by a family member who is excluded by the Relatives/Family Members Serving as Paid Caregivers of Certain Medicaid Waiver Services (DDSN Directive 736-01-DD) is temporary and will only be allowed during the COVID-19 State of Emergency.** This includes spouses, parents of minor children, foster parents of minor children, step-parents of minor children and legal guardians of both minors and adults, Service authorizations will have a start and end date and I understand that I will not be paid for services after the end date of the authorization.
3. **The waiver of qualifications and training for family members providing In-Home Support services is temporary and will only be allowed during the COVID-19 State of Emergency.** Service authorizations will have a start and end date and I understand that I will not be paid for services after the end date of the authorization.
4. In-Home Supports cannot be provided for more than 40 hours per week by any one In-Home Supports provider. The work week is defined as Midnight Sunday to 11:59pm Saturday.
5. In-Home Support services include:
 - a. Support of activities of daily living, (e.g., assistance with bathing, dressing, feeding, personal grooming, personal hygiene, transferring and mobility);
 - b. Meal or snack preparation, planning and serving, cleaning up afterwards, following specially prescribed diets as necessary and encouraging participants to adhere to any specially prescribed diets;
 - c. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out the trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms) and activities as needed to maintain the participant in a safe and sanitary environment. Housekeeping only includes areas specific to the participant such as the participant's bedroom, bathroom, etc.;
 - d. Shopping assistance, essential errands, and escorting participant to medical services;

- e. Assistance with communication, which includes, but is not limited to placing a phone within participant's reach and physically assisting participant with the use of the phone, and orientation to daily events;
 - f. Monitoring medication, (e.g., the type that would consist of informing the participant it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate). It does not mean that the worker is responsible for giving the medicine; however, it does not preclude the worker from handing the medicine container or medicines already set up in daily containers to the participant.
6. I am responsible for maintaining individual participant records. These records are subject to the confidentiality rules for all Medicaid Providers and health care providers and shall be made available to DDSN upon request. Records shall include the following:
- a. Both current and historical Service Authorization and Termination Forms.
 - b. The Daily Log which will include any records of occurrences in which the worker did not provide services for the specified number of hours.
7. If the participant, responsible party, or I identify In-Home Support duties that would be beneficial to the participant's care, but are not specified on the Authorization Form from the DDSN Case Manager, the DDSN Case Manager must be contacted to discuss the possibility of adding those duties. **These duties MAY NOT include skilled medical care.** It will be the DDSN Case Manager's responsibility to decide whether the participant's Plan should be amended/new authorization completed including these duties. The DDSN Case Manager will have three (3) working days of the receipt of my or the participant's request to modify/amend the Authorization or Personal Care Needs Form.
8. It is my responsibility to notify the DDSN Case Manager of the following:
- a. A change in the participant's condition.
 - b. The death of the participant.
 - c. A participant's relocation out of service area.
 - d. The participant no longer wishes to participate in In-Home Support services.
 - e. Knowledge of participant's Medicaid ineligibility.
 - f. My wish to terminate as the provider of In-Home Support services.
 - g. The responsible party's desire to no longer serve in that role.
 - h. My inability to provide In-Home Support services as authorized--**THIS MUST BE DONE IMMEDIATELY BY TELEPHONE** even though the participant has a backup plan.
9. In the event that I am unable to reach the participant, the responsible party, or the Case Manager, it is my responsibility to notify the participant's designated emergency contact until the participant, responsible party, and the DDSN Case Manager can be reached. The emergency contact may be part of the participant's backup plan. The emergency contact should be listed in the participant's safety checklist and/or be requested by me to be kept with the participant's records at my home.
10. I must adhere to basic infection control procedures at all times while providing In-Home Support services.

11. If I serve a DDSN Waiver participant I am responsible for signing and completing all paperwork required. The Charles Lea Center will be the mandatory fiscal agent for each DDSN Waiver participant who chooses consumer-directed or responsible party-directed services.
12. If I serve a DDSN Waiver participant, all hours should be totaled and biweekly comments written **prior** to obtaining the participant's signature on the In-Home Support Care Daily Log. I am also responsible for maintaining copies of the completed and signed Daily Log for Medicaid and tax audit purposes. I am responsible for sending copies of the completed and signed Daily Logs to the Charles Lea Center by mail, fax or email. I am responsible for submitting the Daily Logs to the Charles Lea Center as specified; they will be responsible for issuing my checks and will issue me a 1099 at the end of the year. I will be responsible for paying taxes on the income.
13. If I serve a DDSN waiver participant, the Worker Care Daily Log(s) will be used for reimbursement purposes. **The In-Home Support Care Daily Log(s) cannot be filed and reimbursement will not be paid until the DDSN Case Manager authorizes the service and I have provided the service.**
14. I understand that no services may be provided while a participant is in the hospital/nursing home/jail.
15. I understand the participant or responsible party is responsible for directing this service. I understand I am **not** an employee of the South Carolina Department of Health and Human Services (SCDHHS), the South Carolina Department of Disabilities and Special Needs (DDSN), or any other state agency.

I certify I am fully ambulatory. I also verify I can read, write, and speak English. I also realize it is against federal law to delegate my role as an individual Medicaid/DDSN Provider to another caregiver.

By my signature below, I understand and acknowledge all of the above requirements.

_____ Date: _____
 In-Home Supports Worker Signature

_____ Date: _____
 Participant/Responsible Party Signature

South Carolina Department of Disabilities and Special Needs

COVID-19 In-Home Supports Worker
Demographic Information Sheet

Name of Person Providing In-Home Supports: _____

Address of In-Home Supports Worker (include zip code): _____

Social Security Number of Person Providing In-Home Supports: _____

Telephone Number (include area code and extension (if applicable)): _____

Emergency Number (include area code and extension (if applicable)): _____

Email Address: _____

Waiver Participant's Name: _____

Waiver Participant's Medicaid Number: _____

Waiver Participant's Address (include zip code): _____

COVID-19 INTERIM SCREENING FOR DIRECTION OF IN-HOME SUPPORT BY THE INDIVIDUAL OR ANOTHER

When In-Home Support is determined to be needed, In-Home Support (IHS) Screening must be completed to determine who can direct the service. This screening must be completed prior to service authorization.

The IHS Screening is designed to determine the waiver participant's likely ability to consent regarding services and to help determine the participant's likely ability to direct his/her own services.

To "consent" generally means that the waiver participant can:

- Appreciate the nature and implication of his/her condition; and
- Appreciate the nature and implication of IHS services; and
- Make reasoned decisions regarding those services in an unambiguous manner.

Waiver participants must be able to consent in order to direct their own services and/or when desired, must be able to consent to allow another (a representative) to direct his/her services.

The IHS Screening is also designed to determine who may act as a representative and the representative's likely ability to act in the participant's best interest.

A. When the waiver participant wants to direct his/her own care, section I of the IHS Screening must be completed. Based on the responses to the questions and using professional judgment, a recommendation must be made. The recommendation and any comments regarding it must be reflected in Section III of the screening form. The recommendation may be that:

- The person should be allowed to direct his/her own IHS; or,
- The person should not be allowed to direct his/her own HIS.

If the latter is recommended (should not self-direct), this recommendation must be presented to the Agency's Human Rights Committee (HRC) for review. If the HRC concurs with the recommendation, self-direction of IHS will not be allowed. If the HRC does not concur with the decision, self-direction of IHS will be allowed.

B. If the waiver participant has expressed a desire for another (a representative) to direct his/her IHS, the IHS Screening (all sections) must be completed. Based on the responses and using professional judgment, a recommendation must be made.

If the person is determined to be able to consent and the representative is determined to likely act in the participant's best interest, then representative direction should be allowed.

If, it is determined that the participant is unable to consent or that the representative is unlikely to act in the participant's best interest, then representative-direction should not be allowed.

If representative-direction is desired but not recommended, the recommendation must be reviewed by the Agency's HRC. If the HRC concurs with the recommendation, representative-direction will not be allowed. If the HRC does not concur with the recommendation, representative-direction will be allowed.

C. If representative-direction is requested by someone other than the participant, the IHS Screening must be completed. If the participant is determined to be able to consent, this request should be considered according to the protocol included in Section B of this document. If the person is determined to be unable to consent, the responses in section II of the screening must be considered and using professional judgment, a recommendation made regarding representative-direction.

If the participant is unable to consent and the representative is unlikely to act in the person's best interest, representative-direction will not be allowed.

If the participant is unable to consent and the representative is likely to act in the participant's best interest, then representative-direction should be allowed. This recommendation must be reviewed by the Agency's HRC. If the HRC concurs with the recommendation, then representative-direction will be allowed. If they do not concur with the decision, representative-direction will not be allowed.

In accordance with the SC Adult Health Care Consent Act (The Act), when an adult who is certified by two (2) physicians to be unable to consent, a representative can be named to consent on the individual's behalf. If an individual is certified by two (2) physicians to be unable to consent and based on the Act a representative is named, the representative may direct the participant's IHS. Documentation from the physicians must be on file and the certification must be made before representative-direction is allowed. The IHS Screening will not be used when a representative is named in accordance with the Act.

SC Department of Disabilities and Special Needs Direction of In-Home Support Screening

Person's name: _____

This screening must be completed prior to authorization of In-Home Support.

This screening is being completed because *(check only one)*:

- This person has expressed a desire to direct his/her own IHS.
- This person expressed a desire for someone else, a representative, to direct his/her IHS.
- Someone has expressed a desire to direct this person's IHS (i.e., be this person's representative).

I. THE PERSON

What are this person's current diagnoses?

- Intellectual Disability: Indicate level: _____
- Related Disability: Specify: _____
- Others: Specify: _____

Check the statement that best describes the person's ability to communicate:

- Verbal communication with little or no difficulty being understood by others and/or little or no difficulty understanding others.
- Verbal communication that is not easily understood by others and/or difficulty understanding others.
- Severely limited verbal communication or is basically nonverbal; uses alternative method of communicating such as sign language, writing, pictures, electronic systems, gesturing or pointing; little or no difficulty understanding others.
- Nonverbal; little or no expressive communication; does not use communication devices.
- Unable to communicate.

Can this person understand/follow simple instructions or questions? Yes No

Can this person understand/follow complex (two or more parts) instructions or questions? Yes No

Can this person read at the 5th grade level (for example can the person read the local newspaper)? Yes No

During the past **12 months** has this person *(check any that apply)*:

- Resisted care or assistance; been noncompliant with medical regime
- Been verbally aggressive or had any emotional outbursts
- Been physically aggressive
- Injured, attempted to injure, threatened/verbalized desire to injure him/herself

Does this person appreciate/understand the nature and implications of his/her own condition? Yes No

Does this person understand In-Home Support services? Yes No

If representative-direction of IHS is desired, continue. If representative-direction of IHS is not desired, skip to section III.

II. THE REPRESENTATIVE

If a representative is desired, indicate if the person has:

- An attorney-in-fact appointed by this person in a durable power of attorney executed pursuant to S. C. Code Ann. § 62-5-501. If yes, name of attorney-in-fact: _____
- A person given priority to make health care decisions for this person. If yes, name: _____
- A spouse unless the spouse and the person are separated. If yes, name of spouse: _____

A parent or adult child. If yes, name of parent/child: _____

An adult sibling, grandparent, or adult grandchild. If yes, name: _____

Other relative by blood or marriage who reasonably is believed to have a close personal relationship with this person.
If yes, name: _____

Is the proposed representative listed in the preceding question? Yes No

If yes, name of proposed representative: _____

Does the proposed representative live with the person? Yes No

If no, is the representative available at all times IHS will be provided? Yes No

Has the proposed representative agreed to supervise the IHS provider? Yes No

Is the proposed representative able to advocate for the person? Yes No

Is the proposed representative able to communicate with little or no difficulty regarding the person's needs? Yes No

Does the proposed representative understand the nature and implications of this person's condition? Yes No

Does the proposed representative understand In-Home Support services? Yes No

III. THE RECOMMENDATION

Based on the findings of this screening, the following is recommended:

This person should direct his/her own care.

While self-direction is desired, it should not be allowed. *[Human Rights Committee (HRC) review required]*

This person's desire for the named representative to direct his/her HIS should be allowed.

While desired by the person, direction by the named representative should not be allowed. *[HRC review required]*

This person is unable to consent. The representative named should be allowed to direct this person's IHS. *[HRC review required]*

This person is unable to consent. The representative named should not be allowed to direct this person's IHS. *[HRC review required]*

This person is able to consent. Direction by the named representative is not desired and therefore should not be allowed.

Comments regarding the recommendation:

Completed By (*print name and title*): _____

Signature of person completing

Date: _____

**COVID-19 Temporary Waiver of Requirements for the Provision of
In-Home Supports by a Family Member**

Emergency operations during the COVID-19 Pandemic allow the temporary provision of In-Home Supports by family members of waiver participants. During the state of emergency, the waiver participant and his/her primary caregiver/representative are permitted to waive some specific requirements for provision of In-Home Supports.

Name of Waiver Participant: _____

Medicaid Number: _____

Name of Family Member Providing In-Home Supports: _____

Relationship to Waiver Participant: _____

The In-Home Supports worker must meet the following requirements which **cannot** be waived:

- a. Demonstrate the ability to read, write, and speak English.
- b. Be fully ambulatory.
- c. Be capable of aiding in the activities of daily living.
- d. Be physically capable of performing duties which may require physical exertion such as lifting, transferring, etc.
- e. Be capable of following the personal care needs form with the Waiver Participant and/or representative supervision.
- f. Be at least 18 years of age.
- g. Be capable of following billing procedures and completing required paperwork.

The waiver participant and primary caregiver/representative are permitted to waive the qualification and training requirements for a **family member** to provide this service.

The participant or primary caregiver agrees to direct the service and is responsible for either **verifying** or **waiving** the following qualifications for the In Home Supports Caregiver *(please initial your choice)*:

Agree to Waive		Do Not Agree to Waive
<input type="checkbox"/>	I agree to waive the requirement for verification that the selected family member who will provide In-Home Supports has no conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner).	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for completion of a DSS Registry check verifying the selected family member who will provide In-Home Supports has no known conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children’s Code, S.C. Code Ann. Title 20, Chapter 7).	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for completion of a SLED background check to verify the family member who will provide In-Home Supports has no conviction for any crime against another person and no felony conviction of any kind.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for verification that the selected family member who will provide In-Home Supports has no record of exclusion or suspension from the Medicare or Medicaid Programs.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for Basic First Aid certification of the selected family member who will provide In-Home Supports.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the provision of references by the selected family member who will provide In-Home Supports.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for a Tuberculin (PPD) test of the selected family member who will provide In-Home Supports.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the selected family member who will provide In-Home Supports to have training in the area of confidentiality.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the selected family member who will provide In-Home Supports to have training in the area of supervision.	<input type="checkbox"/>
<input type="checkbox"/>	I agree to waive the requirement for the selected family member who will provide In-Home Supports to have training in the area of prevention of abuse and neglect.	<input type="checkbox"/>

Waiver Participant/Responsible Party Signature

Date: _____

IN-HOME SUPPORTS WORKER RESPONSIBILITIES AGREEMENT
FOR THE TEMPORARY PROVISION OF IN HOME SUPPORTS BY A FAMILY MEMBER
DURING COVID-19 CRISIS

Waiver Participant: _____ Medicaid #: _____

In-Home Supports Worker: _____

As a **temporary** provider of In-Home Supports and a **family member** of the noted waiver participant, I understand that:

1. **The provision of In-Home Support services in the ID/RD and HASCI Waiver is temporary and will only be allowed during the COVID-19 State of Emergency.** Service authorizations will have a start and end date and I understand that I will not be paid for services after the end date of the authorization.
2. **The provision of In-Home Support by a family member who is excluded by the Relatives/Family Members Serving as Paid Caregivers of Certain Medicaid Waiver Services (DDSN Directive 736-01-DD) is temporary and will only be allowed during the COVID-19 State of Emergency.** This includes spouses, parents of minor children, foster parents of minor children, step-parents of minor children and legal guardians of both minors and adults, Service authorizations will have a start and end date and I understand that I will not be paid for services after the end date of the authorization.
3. **The waiver of qualifications and training for family members providing In-Home Support services is temporary and will only be allowed during the COVID-19 State of Emergency.** Service authorizations will have a start and end date and I understand that I will not be paid for services after the end date of the authorization.
4. In-Home Supports cannot be provided for more than 40 hours per week by any one In-Home Supports provider. The work week is defined as Midnight Sunday to 11:59pm Saturday.
5. In-Home Support services include:
 - a. Support of activities of daily living, (e.g., assistance with bathing, dressing, feeding, personal grooming, personal hygiene, transferring and mobility);
 - b. Meal or snack preparation, planning and serving, cleaning up afterwards, following specially prescribed diets as necessary and encouraging participants to adhere to any specially prescribed diets;
 - c. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out the trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms) and activities as needed to maintain the participant in a safe and sanitary environment. Housekeeping only includes areas specific to the participant such as the participant's bedroom, bathroom, etc.;
 - d. Shopping assistance, essential errands, and escorting participant to medical services;

- e. Assistance with communication, which includes, but is not limited to placing a phone within participant's reach and physically assisting participant with the use of the phone, and orientation to daily events;
 - f. Monitoring medication, (e.g., the type that would consist of informing the participant it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate). It does not mean that the worker is responsible for giving the medicine; however, it does not preclude the worker from handing the medicine container or medicines already set up in daily containers to the participant.
6. I am responsible for maintaining individual participant records. These records are subject to the confidentiality rules for all Medicaid Providers and health care providers and shall be made available to DDSN upon request. Records shall include the following:
- a. Both current and historical Service Authorization and Termination Forms.
 - b. The Daily Log which will include any records of occurrences in which the worker did not provide services for the specified number of hours.
7. If the participant, responsible party, or I identify In-Home Support duties that would be beneficial to the participant's care, but are not specified on the Authorization Form from the DDSN Case Manager, the DDSN Case Manager must be contacted to discuss the possibility of adding those duties. **These duties MAY NOT include skilled medical care.** It will be the DDSN Case Manager's responsibility to decide whether the participant's Plan should be amended/new authorization completed including these duties. The DDSN Case Manager will have three (3) working days of the receipt of my or the participant's request to modify/amend the Authorization or Personal Care Needs Form.
8. It is my responsibility to notify the DDSN Case Manager of the following:
- a. A change in the participant's condition.
 - b. The death of the participant.
 - c. A participant's relocation out of service area.
 - d. The participant no longer wishes to participate in In-Home Support services.
 - e. Knowledge of participant's Medicaid ineligibility.
 - f. My wish to terminate as the provider of In-Home Support services.
 - g. The responsible party's desire to no longer serve in that role.
 - h. My inability to provide In-Home Support services as authorized--**THIS MUST BE DONE IMMEDIATELY BY TELEPHONE** even though the participant has a backup plan.
9. In the event that I am unable to reach the participant, the responsible party, or the Case Manager, it is my responsibility to notify the participant's designated emergency contact until the participant, responsible party, and the DDSN Case Manager can be reached. The emergency contact may be part of the participant's backup plan. The emergency contact should be listed in the participant's safety checklist and/or be requested by me to be kept with the participant's records at my home.
10. I must adhere to basic infection control procedures at all times while providing In-Home Support services.

11. If I serve a DDSN Waiver participant I am responsible for signing and completing all paperwork required. The Charles Lea Center will be the mandatory fiscal agent for each DDSN Waiver participant who chooses consumer-directed or responsible party-directed services.
12. If I serve a DDSN Waiver participant, all hours should be totaled and biweekly comments written **prior** to obtaining the participant's signature on the In-Home Support Care Daily Log. I am also responsible for maintaining copies of the completed and signed Daily Log for Medicaid and tax audit purposes. I am responsible for sending copies of the completed and signed Daily Logs to the Charles Lea Center by mail, fax or email. I am responsible for submitting the Daily Logs to the Charles Lea Center as specified; they will be responsible for issuing my checks and will issue me a 1099 at the end of the year. I will be responsible for paying taxes on the income.
13. If I serve a DDSN waiver participant, the Worker Care Daily Log(s) will be used for reimbursement purposes. **The In-Home Support Care Daily Log(s) cannot be filed and reimbursement will not be paid until the DDSN Case Manager authorizes the service and I have provided the service.**
14. I understand that no services may be provided while a participant is in the hospital/nursing home/jail.
15. I understand the participant or responsible party is responsible for directing this service. I understand I am **not** an employee of the South Carolina Department of Health and Human Services (SCDHHS), the South Carolina Department of Disabilities and Special Needs (DDSN), or any other state agency.

I certify I am fully ambulatory. I also verify I can read, write, and speak English. I also realize it is against federal law to delegate my role as an individual Medicaid/DDSN Provider to another caregiver.

By my signature below, I understand and acknowledge all of the above requirements.

_____ Date: _____
 In-Home Supports Worker Signature

_____ Date: _____
 Participant/Responsible Party Signature

South Carolina Department of Disabilities and Special Needs

Waiver: ID/RD HASCI CS

COVID-19 Temporary Authorization for In-Home Support

Referred To: _____

Individual's Name: _____

Date of Birth: _____ Medicaid Number: _____

Address (include zip code): _____

You are hereby authorized to provide:

In-Home Support (T2025)

Start Date: _____

End Date (no later than September 30, 2020): _____

Authorized Total: _____ Units per Week [one (1) unit = one (1) hour]

Only the number of units rendered may be billed.

Please note: This nullifies any previous authorization to this provider for attendant care/personal assistance services.

The service is authorized for the individual named above. The services requested include the following:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Exercise/Activity | <input type="checkbox"/> Grooming |
| <input type="checkbox"/> Household Chores | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Meals Planning and Preparation | |
| <input type="checkbox"/> Oral Hygiene | <input type="checkbox"/> Skin Care | <input type="checkbox"/> Toileting | <input type="checkbox"/> Transportation |

Comments:

DSN Board/Provider Name (print): _____

Case Manager's Name (print): _____

Address (include zip code): _____

Phone Number (include area code and extension (if applicable)): _____

Email Address: _____

Case Manager's Signature

Date: _____

COVID-19 IN-HOME SUPPORT WORKER CHECKLIST

DAILY	Complete Daily Timesheets. *Don't forget to use AM or PM by your times in and out. ** No services may be provided when participant is in the hospital/nursing home. ***Please Note: The combined hours provided by all In-Home Support Workers <u>CANNOT</u> exceed 40 hours in one week.		
BIWEEKLY	Have participant check for accuracy and sign daily log. Make three copies of the Daily Timesheets. <i>One copy of the completed and signed timesheet must be received by Charles Lea Center no later than Monday of the week following the ending date.</i> The Charles Lea Center will process your check.	<u>Email:</u> acctreports@charleslea.org <u>Mailing Address:</u> Account Reports 195 Burdette Street Spartanburg, SC 29307 <u>OR</u> <u>Fax:</u> 1-864-562-2116	You may reach the <u>Charles Lea Center</u> by calling the following numbers: 1-864-585-0322 Speak to: Laura Folts (Ext. 2266)
MONTHLY	Mail or email copies of Daily Logs for each week to the Case Manager at the end of every month.		
ANNUALLY	Charles Lea Center will issue 1099 Forms by January 31, 2021.		

For payroll problems contact: Charles Lea Center at: **1-864-585-0322 – Speak to Laura Folts at Ext. 2266**

COVID-19 IN-HOME SUPPORT WORKER DAILY LOG

Participant Name: _____ Medicaid #: _____ Worker Name: _____

DAILY TASK	S	M	T	W	TH	F	ST	S	M	T	W	TH	F	ST
Write in Dates →														
PROVIDE/ASSISTANCE WITH ADL'S														
** Bathing														
** Dressing														
** Grooming														
** Personal Hygiene														
** Transferring and Mobility														
** Assist with Commode/Urinal/Bedpan														
PREPARE AND SERVE MEAL/SNACK														
GENERAL HOUSEKEEPING														
** <input type="checkbox"/> Vacuum <input type="checkbox"/> Mop <input type="checkbox"/> Dust														
** <input type="checkbox"/> Sweep <input type="checkbox"/> Trash														
** <input type="checkbox"/> Clean Kitchen <input type="checkbox"/> Clean Oven/Stove														
** <input type="checkbox"/> Defrost/Clean Refrigerator														
** <input type="checkbox"/> Laundry <input type="checkbox"/> Clean Bathroom														
** Clean Participant's Immediate Living Area														
SHOPPING ASSISTANCE														
** <input type="checkbox"/> Errands <input type="checkbox"/> Escort														
ASSISTANCE WITH COMMUNICATION														
MONITORING OF PARTICIPANT'S														
** <input type="checkbox"/> Vital Signs <input type="checkbox"/> Skin Condition														
** <input type="checkbox"/> Fluid Intake <input type="checkbox"/> Loss of Appetite														
REMIND TO TAKE MEDICATION														
Other:														

➔ DON'T FORGET TO PUT AM OR PM BESIDE YOUR TIMES IN AND OUT (BELOW) ◀

DAY	DATE	1st TIME IN	1st TIME OUT	2nd TIME IN	2nd TIME OUT	TOTAL # HOURS	Biweekly Summary of Participant's Condition
Sun							
Mon							
Tues							
Wed							
Thu							
Fri							
Sat							
Sun							
Mon							
Tue							
Wed							
Thu							
Fri							
Sat							

TOTAL # HOURS FOR 14 DAYS

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(Participant or Representative Signature)

(In-Home Support Worker Signature)

COVID-19 In-Home Supports Pay Schedule

From Sunday	To Saturday	DUE to Charles Lea before 4:00PM	Pay Date
5/17/2020	5/30/2020	6/1/2020	6/4/2020
5/31/2020	6/13/2020	6/15/2020	6/18/2020
6/14/2020	6/27/2020	6/29/2020	7/2/2020
6/28/2020	7/11/2020	7/13/2020	7/16/2020
7/12/2020	7/25/2020	7/27/2020	7/30/2020
7/26/2020	8/8/2020	8/10/2020	8/13/2020
8/9/2020	8/22/2020	8/24/2020	8/27/2020
8/23/2020	9/5/2020	9/7/2020	9/10/2020
9/6/2020	9/19/2020	9/21/2020	9/24/2020
9/20/2020	10/3/2020	10/5/2020	10/8/2020

NOTICE
Deadline is limited to current pay period only.

Current time sheets can be submitted anytime between the last day worked in the two-week pay period, but **NO LATER than 4:00pm on Monday** following the Saturday of each two-week pay period.

Non-compliance with deadline will result in not receiving a paycheck.

Email timesheet logs to acctreports@charleslea.org; fax to 864-562-2116 or mail to: Charles Lea Center Attn: Account Reports, 195 Burdette Street, Spartanburg, SC 29307.
 You may reach Laura Folts at 1-864-585-0322, Ext. 2266 if you have questions.

- ✓CHECK YOUR LOG BEFORE SENDING....**
- ✓Are dates correct?
 - ✓Are times in/out recorded?
 - ✓Have signatures been obtained?
 - ✓Have you exceeded the authorized service hours?