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**Connecticut Home Care Program for Elders, Standards for
Access Agencies and Assisted Living Service
Agencies Program Requirements**

Sec. 17b-342-1. Connecticut home care program for elders; standards for access agencies and requirements for assisted living service agencies

(a) Scope

The purpose of sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies is to describe non-financial program requirements, services available and limitations under the Connecticut Home Care Program for Elders. This program provides home health services, community based services and assisted living services funded under a waiver to the Medicaid program and under a program funded with an appropriation by the General Assembly. The financial eligibility requirements for these three parts of the program differ and are specified under sections 2540.92 and 8040 to 8040.50, inclusive, of the Uniform Policy Manual of the Department of Social Services. This program includes all clients transferred from the following programs as of July 1, 1992: Promotion of Independent Living for the Elderly, Department on Aging Home Care Demonstration Project and Long Term Care Preadmission Screening and Community Based Services Program. Sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies also establish standards and requirements for access agencies and assisted living service agencies which operate under the Connecticut Home Care Program for Elders and the Connecticut Partnership for Long Term-Care.

(b) Definitions

As used in sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies the following definitions apply:

(1) "Access Agency" means an organization which assists individuals in receiving home and community based services by conducting assessments and developing plans of care tailored to the needs of the individuals and making arrangements with service providers. If needed by the individuals the access agency shall also coordinate services and monitor the quality of the services over an extended period, but the access agency shall not be a provider of services, other than to provide care management to department clients that are approved for program participation. An access agency shall have a governing body which assumes all financial and programmatic responsibility for the agency's activities and shall meet the requirements pursuant to section 17b-342-1(h) of the Regulations of Connecticut State Agencies and the provisions set forth in a legal contractual provider agreement;

(2) "Applicant" means an elderly person who directly or through any representative, including but not limited to, a guardian, conservator, family member, physician, social worker or discharge planner completes a Home Care Request Form and submits it to the department or indicates to the department a desire to be considered for services under the Connecticut Home Care Program;

(3) "Assisted Living Services Agency" or "ALSA" means an agency authorized to provide and arrange for the delivery of assisted living services to clients. The participating ALSA shall be licensed with the Department of Public Health and shall enter into a contract with a managed residential care facility that has been approved for participation and be an enrolled service provider with the Department of Social Services. The ALSA shall comply with the standards and requirements in section 19-13-D105 of the Regulations of Connecticut State Agencies;

(4) "Assisted living services" means a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual

needs of clients who need help with activities of daily living and instrumental activities of daily living in managed residential care facilities approved for participation. Services are delivered in a service package model within a specific service cost package level;

(5) “Assessment” means a comprehensive written evaluation of an individual’s medical, psychosocial and economic status, degree of functional impairment and related service needs. For the purposes of the Connecticut Home Care Program, this assessment shall include a face-to-face interview and shall utilize a standard assessment tool approved by the department;

(6) “Average nursing facility cost” means a weighted average calculated by multiplying the nursing facility Medicaid rates in effect on July 1 of that calendar year for each facility by their respective number of days, adding the products and then dividing that total by the total patient days, and reducing the result by the average applied income for nursing facility patients. This figure shall be used when calculating the cost limits for fee-for-service;

(7) “Client” means a person who has met the requirements for eligibility and enrolled as an active participant in the program;

(8) “Commissioner” means the Commissioner of Social Services or his or her designee;

(9) “Community based services” includes but is not limited to care management, adult day services, assisted living services, chore services, companion services, elderly foster care, home delivered meals, homemaker services, laundry services, mental health counseling, minor home modification services, respite care, transportation and personal emergency response systems;

(10) “Connecticut Home Care Program” or “the Program” means the program operated for elders pursuant to section 17b-342 of the Connecticut General Statutes. This program was formerly known as the Long Term Care Facility Preadmission Screening and Community Based Services Program and includes all home care clients who were transferred from the former Department on Aging and the department’s Fairfield pilot program clients;

(11) “Cost of home care services” means the total amount of direct costs in state administered public funds expended to provide the home health and community based services set forth in sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies;

(12) “Day” means calendar day;

(13) “Department” or “DSS” means the Department of Social Services, its employees and agents;

(14) “Elder” or “elderly person” means an individual 65 years of age or older and a resident in the State of Connecticut;

(15) “Emergency admission” means that an individual has been determined by the department to be in need of protective services and is referred to a nursing facility for admission by an appropriate state agency pursuant to the provisions of section 17b-450 to 17b-460, inclusive, of the Connecticut General Statutes. This does not include nursing home placements from the community in which the family desires to make the placement as soon as possible because of an applicant’s deteriorating health condition;

(16) “Fee-for-service” means a service delivery system which a cost-and-payment methodology is used for services rendered to care-managed and self-directed clients who receive benefits under the Medicaid waiver or state- funded portions of the

program, except those services rendered to clients participating in the assisted living services component of the program;

(17) "Health care professional" means a Connecticut licensed physician, Connecticut licensed nurse, social worker or hospital discharge planning personnel;

(18) "Health screen form" means a department form used to determine whether an individual is at risk of institutionalization and if the individual meets the functional criteria for the program. This form includes information regarding the person's physical (functional and medical) and psycho-social status;

(19) "Home care request form" means a department form used to indicate if an applicant appears to be financially eligible and wishes to apply for the Connecticut Home Care Program;

(20) "Home care services" means any combination of community based services and home health services as defined in sections 17b-342-1(b)(9) and (21) of the Regulations of the State Agencies which enable elders to live in noninstitutional settings. Such services may be provided to elders living in private homes, congregate housing, assisted living demonstration project facilities, housing and urban development facilities, private facilities and homes for the aged and other community living situations as long as the services needed are not considered a regular component of the services of the community living situation;

(21) "Home health services" for the purposes of the Connecticut Home Care Program means those medical procedures included in the definition of home health services under the Medicaid program. Home health services provided under the Connecticut Home Care Program shall be defined in the same way and covered to the same extent as they are under the Medicaid program;

(22) "Hospital" means a general short term or chronic disease hospital licensed by the Department of Public Health pursuant to section 19a-490(b) of the Connecticut General Statutes;

(23) "Medicaid recipient" means an individual who has been determined eligible for Medicaid benefits;

(24) "Nursing facility" means a facility licensed by the Department of Public Health pursuant to section 19a-490(c) of the Connecticut General Statutes as a chronic and convalescent nursing home or rest home with nursing supervision and certified to participate in the Medicaid program as a nursing facility as evidenced by a Medicaid provider agreement between the department and the facility. For purposes of this section, the term "nursing facility" does not include an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or any other residential or inpatient health care facility;

(25) "Person" means an individual applicant or elder client enrolled in the Connecticut Home Care Program and a representative authorized to act on the applicant or client's behalf including guardians, conservators or other legally authorized representatives;

(26) "Plan of care" means a written individualized plan of home care services which specifies the type and frequency of all services and funding sources required to maintain the individual in the community, the names of the service providers and the cost of services, regardless of whether or not there is an actual charge for the service. The plan of care shall include any in-kind services and any services paid for by the client or the client's representative;

(27) "Re-evaluation" means a review of the functional and financial status of an applicant or client for the purpose of establishing functional and financial eligibility and determination of needs for consideration for program participation;

(28) “Related party” means an entity which is associated with another by common ownership or control. Control of or by another entity exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider or organization serving the provider;

(29) “Relative” means spouse, natural parent, child, sibling, adoptive child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, grandparent and grandchild;

(30) “Risk of institutionalization” means that the individual is in danger of hospitalization or nursing facility placement due to his or her medical, functional or cognitive status but would be able to remain at home, without the creation of an unacceptable risk to the safety of the individual or others, if home care services were provided. This definition includes individuals who are currently institutionalized and who are at risk of continued institutionalization unless home care services are provided;

(31) “Self-directed care” means the ability of the client to be responsible for the self-direction, coordination and arrangement of his or her plan of care under the fee-for-service delivery option of the program;

(32) “Standard assessment tool” means a department form used to conduct an initial assessment and re-evaluation of applicants and clients for the purpose of establishing functional eligibility and determination of needs for consideration for program participation;

(33) “Status review” means a review of the functional and cognitive status of a client enrolled in the program based on a face-to-face interview in order to reevaluate the plan of care and program participation when the individual is not receiving ongoing monitoring by an access agency or services through any program component;

(34) “State administered public funds” means direct payments of state or federal funds allocated by a state agency to an individual or to an agency to pay for medical or social services required to be provided under an individual’s plan of care;

(35) “Unacceptable risk” means a situation which places an individual’s life or health in immediate jeopardy. In determining whether an unacceptable risk exists, the department shall take into account the provider’s professional standards, the client’s needs and the client’s informed viewpoint with regard to the potential risk;

(36) “Waiting list” means a record maintained by the department for the Connecticut Home Care Program that includes the names of the applicants seeking to be screened for program participation and specifies the date the contact was made. The department may maintain separate waiting lists, regional or statewide, depending on the program component and type of service.

(c) General

(1) The purposes of the Connecticut Home Care Program are to:

(A) Assess whether cost-effective home care services can be offered to elders who are at risk of institutionalization;

(B) determine, prior to admission to a nursing facility whether the elder does or does not need nursing facility services;

(C) authorize department payment for elders for nursing facility care or home care services if appropriate; and

(D) provide a full range of community based services, home care services and assisted living services to eligible individuals who choose to remain in the community, if such services are appropriate, available and cost effective.

(2) The program application process shall consist of:

(A) A financial eligibility determination in accordance with section 17b-10-1 of the Regulations of Connecticut State Agencies and the department's Uniform Policy Manual sections 8040 and 2540.

(B) an initial determination as to the elder's needs, which shall include the category of services needed, the elder's functional eligibility and potential service options under the program. The initial determination shall be conducted by department staff based on completion or review of the health screen form.

(i) As a result of a review of the health screen form, the department shall determine:

(aa) Whether the elderly person meets the functional level for admission to the program;

(bb) whether the elderly person needs care that would otherwise be provided in a nursing facility;

(cc) which program component and category of services may be appropriate and authorized for the person in the community;

(dd) whether an initial assessment is deemed appropriate. The assessment shall be conducted only after the elder or the elder's representative gives written consent. The assessment shall include, but not be limited to: Explaining Program participation to the elder or the elder's representative; explaining client's rights and responsibilities; explaining the state's recovery policy; confirming client's functional eligibility and financial information; determining if the elder can be offered a cost-effective plan of care to enable the elder to remain in the community without creating an unacceptable risk to the elder or others;

(ee) whether the elderly person should be admitted to a nursing facility without an assessment; and

(ff) whether the elderly person requires assistance in the completion of the financial application or other assistance to establish program eligibility and participation. This does not relinquish the elderly person's responsibility to comply with all program requirements necessary to determine eligibility and program participation.

(ii) Initial determination as to the elder's needs, the category of services and functional level based on the health screen form shall be valid for sixty (60) days unless the department receives information which indicates that a person's condition has changed significantly.

(iii) The health screen form shall also be used to verify recommendations for short term placement. For purposes of this section, a short term placement means a maximum stay of ninety (90) days for rehabilitative or recuperative care which is expected to result in the person's return to the community.

(C) a referral to other sources of assistance, including authorization for admission to a nursing facility without an assessment, if appropriate.

(D) The department shall send a screening outcome letter to the applicant to provide notice of the initial functional and financial screening determination issued and to advise the applicant of their rights.

(3) Determination of Need

(A) The determination as to whether the elder is at risk of institutionalization or needs services that would otherwise require institutionalization shall be made by the department based upon an evaluation of the completed health screen and an assessment, if deemed appropriate.

(B) The basis for determining the level, type, frequency and cost of services and funding source that an elder may receive under the program shall be determined by their financial and functional eligibility and need for services.

(C) Functional eligibility means the elder must be at risk of institutionalization and needs assistance with at least one critical need. For the purposes of eligibility, critical needs are defined as “activities of daily living” which are hands-on-activities or tasks that are essential for a client’s health and safety. These include, but are not limited to; bathing, dressing, transferring, toileting (bowel or bladder), feeding, meal preparation, administration of medication or ambulation.

(4) Category types

The following three category types define the funding sources which pay for the client’s community based services and home health services. The category types apply to care managed cases, self directed cases and the assisted living service program component.

(A) Category Type 1:

This category applies to elders who are at risk of institutionalization but who might not immediately enter a hospital or nursing facility in the absence of the program. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in section 17b-10-1 of the Regulations of Connecticut State Agencies and the department’s Uniform Policy Manual section 8040. Some clients under Category Type 1 may be Medicaid recipients because they do not meet the functional criteria for the Medicaid waiver portion of the program.

(B) Category Type 2:

This category applies to elders who would otherwise require admission to a nursing facility on a short or long term basis. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in the department’s Uniform Policy Manual section 8040.

(C) Category Type 3:

This category applies to elders who, but for the provision of home care services, would require nursing facility care funded by Medicaid. This category type is available to elders who meet the financial and functional eligibility criteria for Medicaid under the federal waiver as defined in the department’s Uniform Policy Manual section 2540.92.

(D) The program category type identifies the maximum funding level available for all program clients. The access agencies, department staff and assisted living service agencies shall specify the category type on the client’s plan of care in the funding source section.

(5) The determination of services for the program’s fee-for-service and assisted living services option consists of:

(A) Completion of an initial assessment by the access agency or the department;

(B) a determination if program participation is feasible;

(C) a determination of what service options under the program are appropriate;

(D) development of a plan of care for care managed cases by the access agency or the department. For clients participating in the assisted living service option, the assisted living service agency shall develop the plan of care;

(E) a determination as to the feasibility and cost-effectiveness of home care services, if deemed appropriate; and

(F) authorization for community based services and home health services in the community.

(d) **Initial Assessment and Plan of Care**

(1) A person who is determined by the department to appear to meet the financial and functional eligibility criteria of the Connecticut Home Care Program shall be referred by the department to an access agency or the department's staff for an initial assessment as defined in section 17b-342-1 (b)(5) of the Regulations of Connecticut State Agencies. The results of the initial assessment shall be used to:

(A) Determine or verify the following:

- (i) Whether program participation is feasible;
- (ii) whether the elderly person's financial information;
- (iii) whether the elderly person's functional eligibility;

(iv) whether the assisted living services option is appropriate; if appropriate the access agency, department staff or department designee will complete an initial assessment and forward the paperwork to the department for review and processing;

(v) whether the fee-for-service option is appropriate; if appropriate, verify the elderly person's category of services for fee-for-service;

(vi) the individualized plan of care based on the cost limits for care-managed or self-directed care cases under fee-for-service; and

(vii) if the elder resides in an assisted living facility, develop an individualized plan of care based on the service package levels under the program's assisted living services option; and

(B) develop an individual plan of care. The access agencies, department, assisted living service agencies or department designee, when developing a plan of care, shall verify the elderly person's category type, category of services, level of service and financial information according to the following provisions:

(i) Determine the feasibility and cost-effectiveness of meeting the elderly person's care needs with home care services, pursuant to section 17b-342-3(b) of the Regulations of Connecticut State Agencies;

(ii) include a thorough exploration of all available services and funding resources;

(iii) establish an appropriate service delivery mix and arrangement which is non-duplicative and not overlapping (i.e. two similar services being provided at the same time);

(iv) clients shall only receive home care services through one of the following program service options: Fee-for-service (care-managed or self-directed) or assisted living services, if appropriate; and

(v) applicants or clients shall receive home care services through only one department program or state agency.

(2) Such person shall be given the opportunity to participate, to the extent possible, in the development of his or her plan of care.

(3) When carrying out its responsibilities for the initial assessment and development of the plan of care under the Connecticut Home Care Program, the department, the access agency, department staff or department designee may collaborate with other health care professionals providing services to the person to avoid the duplication of services. The access agencies, assisted living service agencies, department staff or department designee may, to the extent permitted by section 17b-342 of the Connecticut General Statutes, involve other service providers in the completion of the assessment and care plan development.

(4) Written notice of the outcome of the assessment shall be provided to the applicant and to hospital discharge planning personnel in the case of hospitalized patients. The applicant shall also be notified of appeal rights and procedures, in accordance with the department's Uniform Policy Manual sections 8040 and 1570.

(5) If the person refuses to participate in the assessment, or does not agree to accept a plan of care approved by the department, services shall not be available under the Connecticut Home Care Program.

(6) If the department determines that a plan of care is feasible and cost-effective under the program, the elderly person may remain in the community with assistance provided under the Connecticut Home Care Program. If home care is desired, the plan of care shall be authorized by the department.

(7) For the Connecticut Home Care Program, all home care services shall be included as part of a written plan of care developed initially and updated regularly by the access agency, the assisted living service agency, department staff or department designee. The plan of care shall specify the start date of services, services to be provided, category type of services, frequency, cost, funding source and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person's needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement. For any services where the client would be at risk if the schedule of the service varied, a back-up plan shall be identified in the total plan of care. Services not included as part of the approved plan of care or not covered by sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies are not eligible for reimbursement from the Connecticut Home Care Program.

(8) The client's individualized plan of care must be signed by the client or the client's representative and the access agency staff, assisted living agency staff, department staff or department designee.

(9) Services that shall be covered by another payer, including but not limited to, any covered services through Medicare, private insurance or long-term care insurance, shall be included in the plan of care.

(10) In-kind services performed by family members, volunteer groups, community action agencies or any other person or entity shall be included as part of the client's plan of care.

(e) Status Reviews

(1) Status reviews shall be provided for clients enrolled in the program in order to re-evaluate the client's status and the plan of care. Status reviews may be conducted by the access agencies, assisted living service agencies (only when authorized by the department), department staff, department designee or agencies which provide home health services or adult day health services as described in sections 17b-342-2(b) and (h) of the Regulations of Connecticut State Agencies. The staff who conduct the status reviews shall be either registered nurses or social services workers who meet the requirements pursuant to subsections (h)(1)(A) and (B) of this section.

(2) For each client there shall be no more than one agency at any time, designated by the department, which shall be responsible for status reviews. When care management services by an access agency have been temporarily interrupted due to an institutional stay, a status review may be conducted by the access agency, department staff or department designee. When ongoing care management services have been suspended, the department shall determine in advance which agency may conduct any necessary status reviews taking into consideration the needs and preferences of the client, if deemed feasible and allowed under the program.

(3) Status reviews shall be provided only when care management services by the access agency are not authorized, when deemed appropriate by the department and are limited to the following situations:

(A) No more than one time during a hospital stay which is less than or equal to 45 days;

(B) No more than one time during a nursing facility stay which is less than or equal to 45 days;

(C) No more than one time every twelve months for annual reassessment of a person not receiving care management from an access agency; and

(D) In other circumstances, when there is prior authorization by the department, such as when an elder is being reevaluated to consider having the care management from the access agency, department staff, or department designee reinstated after a lapse of more than two months in this service or when an elder is being reevaluated by the access agency, department staff or department's designee for reinstatement of program services following a nursing facility or hospital stay of more than 45 days.

(f) Forms

(1) The department shall promulgate a uniform assessment tool and all required program-related forms, including a home care request form, financial application form, a health screen form and client notices.

(2) Program information and forms shall be distributed by the department to all nursing facilities and hospitals in the State and to other providers that have contact with the elderly. Other providers may receive program information and forms upon request.

(g) Information Submission

Persons seeking home care services may initiate a screening for program participation by submitting a Home Care Request Form or by calling the department. Individuals or client representatives are responsible for assuring that all information necessary for determining eligibility including, but not be limited to, completing and submitting a program financial application and providing any required verifications, is submitted on their behalf to the department. Authorization for home care services shall not be granted, nor a plan of care implemented, until complete information has been provided and a financial and functional eligibility determination has been issued by the department. Failure to provide required information and non-cooperation with any of the program requirements shall be grounds for denial or discontinuance from the Connecticut Home Care Program.

(h) Requirements of an access agency

(1) An access agency shall ensure the selection of qualified staff.

(A) The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

(B) Care managers shall have the following additional qualifications:

(i) Demonstrated interviewing skills which include the professional judgment to probe as necessary uncover underlying concerns of the applicant;

(ii) demonstrated ability to establish and empathic relationships;

(iii) experience in conducting social and health assessments;

(iv) knowledge of human behavior, family/caregiver dynamics, human development and disabilities;

(v) awareness of community resources and services;

(vi) the ability to understand and apply complex service reimbursement issues; and

(vii) the ability to evaluate, negotiate and plan for the costs of care options.

(C) Care management supervisors shall meet all the qualifications of a care manager plus have demonstrated supervisory ability, and at least one year of specific experience in conducting assessments, developing care plans and monitoring home and community based services.

(2) An access agency shall ensure that care managers are appropriately trained and supervised.

(A) An access agency shall provide or arrange for orientation and initial and ongoing training for care managers and care management supervisors, including training in the use of the assessment tool, required program forms, program requirements and in all aspects of program operation.

(B) An access agency shall provide or arrange for appropriate supervision and clinical consultation for care managers. For care managers with a social service background, the access agency shall have nursing staff available for consultation during normal business hours; for care managers with a nursing background, the access agency shall have a social services staff available for consultation during normal business hours.

(3) An access agency shall have the following additional responsibilities:

(A) Establish working relationships with existing service providers and provide community education regarding the care management role;

(B) Establish a quality assurance process subject to approval by the department or the Office of Policy and Management, which includes at a minimum review of client records (without client identifiers) by professionals not employed by the agency and annual evaluation of client satisfaction;

(C) Maintain client records and administrative records to support agency activities and data collection activities;

(D) Under the Connecticut Home Care Program, subcontract with vendors to provide services needed in the plan of care;

(E) Under the Connecticut Home Care Program, submit claims through the department's claims processing agent; and

(F) Under the Connecticut Home Care Program, reimburse subcontractors when appropriate.

(4) An access agency shall establish a written client bill of rights and responsibilities to be provided to the client or the client's representative at the time of admission to the program. At a minimum, the bill of rights shall state that the clients have the following rights:

(A) To be treated as an adult with respect and dignity;

(B) to be fully informed about all services, charges and choices available through the access agency;

(C) to participate in and have control over the plan of care to the greatest extent possible;

(D) to be treated fairly by the department regardless of client's race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, physical disability, learning disability or source of payment;

(E) to have any problems or questions addressed and resolved in a timely manner;

(F) to have all personal, financial and medical information treated in a confidential manner and released only as necessary to authorized persons;

(G) to choose among all qualified and available service providers;

(H) to file a grievance with the access agency or the department without fear of discrimination or reprisal; and

(I) to achieve maximum self-direction and choice in lifestyle as long as this does not create an unacceptable risk.

(5) All access agency offices serving participants in the Connecticut Home Care Program shall be located within the State of Connecticut and be accessible to the public.

(6) The access agency shall have a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24-hour basis.

(7) The access agency shall establish a grievance procedure for home care clients who are aggrieved by adverse decisions of the access agency. The procedure shall specify that a decision shall be made by the access agency within 15 calendar days after a grievance is received from a client and sooner in the case of an emergency. The procedure shall also outline steps for requesting a fair hearing by the department or other funding source in the event that the issue is not resolved within the access agency.

(8) The access agency shall have the capacity to provide or arrange necessary services for individuals who are non-English speaking, hearing impaired or who have other special needs.

(i) Requirements of an Assisted Living Service Agency.

(1) The ALSA shall ensure the selection of qualified staff and comply with the requirements set forth in section 19-13-D105 of the Regulations of Connecticut State Agencies.

(A) The ALSA staff shall be employed by a licensed assisted living service agency. The staff shall be responsible for annual re-evaluation, development of plans of care, arrangement and delivery of core services, oversight of the delivery of core services and shall provide ongoing monitoring of clients.

(B) The ALSA staff that provide direct client services shall have additional qualifications as specified in section 17b-342-1(h)(1)(B)(i) to (vii) of the Regulations of Connecticut State Agencies.

(2) The ALSA shall ensure that all staff are appropriately trained and supervised.

(A) The ALSA shall provide or arrange for orientation and ongoing training for staff in all applicable department requirements, including training in the use of the assessment tool.

(B) The ALSA shall provide or arrange for appropriate supervision and clinical consultation for staff during normal business hours and after hours if needed to respond to client emergencies.

(3) The ALSA shall have additional responsibilities as specified in subsection 17b-342-1(h)(3) of the Regulations of Connecticut State Agencies.

(4) The ALSA shall provide required reports to the department, including but not limited to, reports on specific data collection. Reports shall be submitted to the department no later than the fifteenth day of every month. The reports shall include data from the preceding month.

(5) The ALSA shall establish a written bill of client rights and responsibilities, which shall be provided to each person at the time of admission to the program as specified in section 17b-342-1(h)(4) of the Regulations of Connecticut State Agencies.

(6) All ALSAs serving participants in the Connecticut Home Care Program shall be located within the State of Connecticut and be accessible to the public.

(7) The ALSA shall have a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24 hour basis.

(8) The ALSA shall establish a grievance and appeal procedure for clients who are aggrieved by adverse decisions of the ALSA. The procedure shall specify that a decision shall be made by the ALSA within 15 calendar days after a grievance is received from a client and sooner in the case of an emergency. The procedure shall also outline steps for requesting a fair hearing by the department or other funding source in the event that the issue is not resolved within the ALSA.

(9) The ALSA shall have the capacity to provide or arrange necessary services for individuals who are non-English speaking, hearing impaired or who have other special needs.

(Effective July 8, 1998; amended September 3, 2010)

Sec. 17b-342-2. Services covered under the connecticut home care program for elders

The following services are available to elders who are determined eligible for the Connecticut Home Care Program either under the criteria for the Medicaid Waiver portion or the state-funded portion of the program. These services are also covered under fee-for-service and the assisted living services component of the program. The amount of services available or allowed shall be based on the category of service or service package level assessed in accordance with sections 17b-342-1 to section 17b-342-3, inclusive, of the Regulations of Connecticut State Agencies and shall be documented in the approved plan of care.

(a) Care Management Services

(1) Description

Care management services are only authorized through department-contracted access agencies or department designee. Care management services include those activities that involve implementation, coordination, monitoring and reassessment of care managed cases. Care management is a client-centered service that respects clients' rights, values and preferences. The care manager assists the client in coordinating all types of assistance to meet the individual's needs, monitoring the quality of services provided and using resources efficiently.

(2) Provider Participation

All providers reimbursed for care management services shall be access agencies as defined in section 17b-342-1(b)(1) of the Regulations of Connecticut State Agencies or ALSAs as defined in section 17b-342-1(b)(3) of the Regulations of Connecticut State Agencies and shall meet all provider enrollment requirements. This provision is not meant to restrict home health and other providers from providing such services to the extent required or authorized under their license. However, only department-contracted access agencies or ALSAs may receive reimbursement for this activity as a distinct service. The requirement for providers to be access agencies shall not prohibit the department from using its own staff to provide care management services in accordance with section 17b-342-2(b) of the Regulations of Connecticut State Agencies.

(3) Services Covered

(A) When authorized, the department shall reimburse the access agency or ALSA for care management services which include contacts with the clients, family, members of their informal support networks or service providers, as deemed necessary. The care manager shall monitor clients of the Connecticut Home Care Program who receive ongoing care management by an access agency or ALSA as follows:

(i) Making contact at least monthly with the client, family or provider by telephone or by a home visit, depending upon the client's needs;

(ii) making home visits to the client as needed and at least every six months to determine the appropriateness of the service plan and to assess changes in the client's condition;

(iii) conducting a formal reassessment of the client's health, functional and financial status and service needs every twelve months, utilizing a standardized assessment tool;

(iv) responding to changes in client needs as they occur by making appropriate changes in the type, frequency, cost or provider of services needed for the client to remain safely in the community within the limitations of service availability. This includes ongoing reassessment as needed to assure appropriateness of the plan of care, continued financial eligibility, category of service and quality of care; and

(v) providing information and service referral or access to appropriate resources on a 24 hour per day basis, including responding to emergencies.

(B) Care management services may be delivered in the person's home, in the community, in a community agency or other non-institutional settings as appropriate.

(4) Need for Service

(A) For the Connecticut Home Care Program, the need for ongoing care management services by an access agency is identified in conjunction with establishment of eligibility for the program. Upon completion of an assessment and development of a plan of care, the access agency shall confirm the risk of institutionalization and shall further establish that:

(i) The person can be appropriately served in the community without the creation of an unacceptable risk to the person or others;

(ii) the person chooses to remain in the community rather than be admitted to a nursing facility;

(iii) as specified in the person's plan of care, the total state administered funds of home care services specified in the client's plan of care do not exceed the limits set forth in section 17b-342-3(c) of the Regulations of Connecticut State Agencies;

(iv) the client has been informed of the assisted living services component and offered participation if feasible; and

(v) a review to determine if there is an ongoing need for care-management has been done and the client has been advised of the self-directed care option, if appropriate.

(B) For the Connecticut Home Care Program, ongoing care management services by an access agency may be suspended for a client who meets the following criteria:

(i) The client's functional and cognitive status have been determined to be stable (this can include the presence of chronic health problems if the conditions are under control and do not require involvement by an access agency);

(ii) the department determines that the person or the caregiver is able to assume responsibility for coordinating and monitoring services; or

(iii) the client is determined appropriate for the self-directed care or assisted living services component under the program.

(5) Authorization Process

(A) Care management services shall be included as part of the written plan of care and authorized by the department in order to be reimbursed under the Connecticut Home Care Program.

(B) When care management services by an access agency have been suspended, the client may continue to receive other home care services through the Connecticut

Home Care Program. The department shall require renewals of orders for such home care services annually and complete annual redeterminations of eligibility for the program in order to continue services. If the client's condition becomes unstable and the client continues to reside in the community, the department may reinstate ongoing monitoring by an access agency including, but not limited to, transferring the client from the self-directed or the assisted living service component of the program to the access agency with services provided through fee-for-service, if feasible and allowed under the program.

(6) Limitations

In order to receive payment for care management services under the Connecticut Home Care Program, the access agency shall be in compliance with all terms of its contract with the department and in addition shall assure that home care service providers meet standards of quality as established in section 17b-342-2(b) to section 17b-342-2(o), inclusive, of the Regulations of Connecticut State Agencies and have documented such compliance to the access agency. The department shall not reimburse for care management services:

(A) Provided prior to completion of the assessment and development of an approved plan of care;

(B) provided while the elderly person is in a hospital, nursing facility or out of the state;

(C) provided to clients who are authorized for self-directed care;

(D) provided to clients who are program participants under the assisted living service component; or

(E) provided to clients who have been determined ineligible for program participation by the department and the access agency has been notified of such decision.

(b) Adult Day Health Services

(1) Description

Adult day health services are provided through a community-based program designed to meet the needs of cognitively and physically impaired adults through a structured, comprehensive program that provides a variety of health, social and related support services including, but not limited to, socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of a day. There are two different models of adult day health services: The social model and the medical model. Both models shall include the minimum requirements described in subsection (b)(2) of this section. In order to qualify as a medical model, adult day health services shall also meet the requirements described in subsection (b)(3) of this section.

(2) Provider Participation

In order to receive payment for adult day health services provided under the Connecticut Home Care Program, an adult day health provider shall:

(A) Meet all applicable federal, state and local requirements including zoning, licensing, sanitation, fire and safety requirements;

(B) provide, at a minimum, nursing consultation services, social work services, nutritionally balanced meals to meet specialized dietary needs as prescribed by health care personnel, personal care services, recreational therapy and transportation services for individuals to and from their homes;

(C) provide adequate personnel to operate the program, including:

(i) A full-time program administrator;

(ii) nursing consultation during the full operating day by a Registered Nurse (RN) licensed in the state of Connecticut; and

(iii) the direct care staff-to-participant ratio shall be a minimum of one to seven. Staffing shall be adequate to meet the needs of the client base. Volunteers shall be included in the ratio only when they conform to the same standards and requirements as paid staff.

(3) Adult Day Health Facility Requirements

(A) In order to be a provider of services to department clients, any facility located and operating within the State of Connecticut or located and operating outside the state of Connecticut, in a bordering state, shall be certified by the Connecticut Association of Adult Day Centers Incorporated, its successor agency or a department designee.

(B) A facility (center) located and operating outside the State of Connecticut in a bordering state shall be licensed or certified by its respective state and comply at all times with all pertinent licensure or certification requirements in addition to the approved standards for certification by the department.

(C) Certified facilities (centers) shall be in compliance with all applicable requirements in order to continue providing services to department clients. The failure to comply with any applicable requirements shall be grounds for the termination of its certification and participation as a department service provider.

(4) Services Covered and Limitations

(A) Payment for adult day services under the rate for a medical model is limited to providers which demonstrate to the department their ability to meet the following additional requirements:

(i) A program nurse shall be available on site for not less than fifty percent of each operating day;

(ii) the program nurse shall be a registered nurse, except that a program nurse may be a licensed practical nurse if the program is located in a hospital or long term care facility licensed by the Department of Public Health, with ready access to a registered nurse from such hospital or long term care facility or the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within one half hour of the request. The program nurse is responsible for administering medications as needed and assuring that the participant's nursing services are coordinated with other services provided in the adult day health center, health and social services currently received at home or provided by existing community health agencies and personal physicians;

(iii) additional personal care services shall be provided as specified in the individual plan of care, including but not limited to, bathing and transferring;

(iv) ongoing training shall be available to the staff on a regular basis including, but not limited to, orientation to key specialty areas such as physical therapy, occupational therapy, speech therapy and training in techniques for recognizing when to arrange or refer clients for such services; and

(v) individual therapeutic and rehabilitation services shall be coordinated by the center as specified in the individual plan of care including, but not limited to, physical therapy, occupational therapy and speech therapy. The center shall have the capacity to provide such services on site; this requirement shall not preclude the provider of adult day health services from also arranging to provide therapeutic and rehabilitation services at other locations in order to meet needs of individual clients.

(B) Payment for adult day services shall include the costs of transportation, meals and all other required services except for individual therapeutic and rehabilitation services.

(C) For participants in the assisted living service component, adult day services are included as part of the monthly rate. A separate reimbursement for this service is not authorized. The assisted living service agency may arrange for adult day health services and reimburse the adult day service provider from their all-inclusive rate.

(c) Assisted Living Services

(1) Description

Assisted living services are a special combination of housing, supportive services, core services, personalized assistance and health care designed to respond to the individual needs of those who require assistance with activities of daily living and instrumental activities of daily living. These services are necessary to enable the eligible clients to remain independent longer, thereby avoiding unnecessary or early transfer to a higher level-of-care facility.

(2) Provider participation

Assisted living services can be offered through an assisted living service package mechanism, provided by an ALSA licensed by the State of Connecticut Department of Public Health and enrolled as a performing provider with the department. Assisted living services shall be offered to eligible clients approved for participation in the following MRCs as defined in section 19-13-D105 of the Regulations of Connecticut State Agencies: State-funded congregates, housing and urban development facilities, private facilities and demonstration projects.

(3) Services covered and limitations

(A) Assisted living services are provided through a personal-assisted-living services package based on the needs of the eligible person. The negotiated per diem reimbursement represents the all-inclusive payment rate for the allowable personal care and core services.

(1) Personal care services include, but are not limited to, hands-on assistance with daily activities, including but not limited to, dressing, grooming, bathing, using the toilet, transferring, walking and eating. Personal care services may also include personal laundry and changing bed linens in conjunction with incontinence care or other needs which necessitate such assistance more than once per week. Some or all of the personal care services may be offered through an adult day center but, since the components of the adult day services are included in the payment to the ALSA, the adult day center shall be reimbursed by the ALSA through a sub-contract.

(2) "Core services" means the services described in section 19-13-D105 subsection (c)(3) of the Regulations of Connecticut State Agencies.

(3) The ALSA shall determine the assisted living services package appropriate for each client participating in the assisted living service component of the program from the following service levels:

(i) SP-1 Occasional personal care service-1 to 3.75 hours per week of personal services plus nursing visits as needed;

(ii) SP-2 Limited personal care service- 4 to 8.75 hours per week of personal care services plus nursing visits as needed;

(iii) SP-3 Moderate personal care service- 9 to 14.75 hours per week of personal care services plus nursing visits as needed; or

(iv) SP-4 Extensive personal care services- 15 to 25 hours per week of personal care services plus nursing visits as needed.

(B) Additional basic core services such as housekeeping, laundry and meal preparation beyond the level provided by the MRC under its core services package are allowed. The additional core services can be provided by the agency or the MRC facility. If the MRC is to perform the core services, the MRC must enter into a

contract with the ALSA for the purposes of performing the core services. The ALSA shall reimburse the MRC facility for the additional core services rendered by the MRC. The additional core services shall be only to those clients that are determined to need the services regardless of whether or not they are determined eligible to receive personal assistance services.

(C) The licensed assisted living services are a substitute for Medicaid and state-funded nursing and home health aide services for individuals with chronic, stable conditions. Assisted living services shall not be offered in conjunction with services provided under traditional fee-for-service.

(D) Skilled home health services are covered by Medicare for acute needs, often post hospitalization, and may be covered by Medicare in limited circumstances for individuals in MRC facilities. Such services shall be covered under Medicaid only for persons who are not eligible for Medicare benefits. Home health services, which do not meet the Medicare criteria for skilled services, are included in the payment for assisted living services under the program. Clients determined to need skilled nursing services which are not covered by Medicare and cannot be provided through the assisted living services package shall be transferred by the access agency into the fee-for-service component of the program, if allowed and feasible under the program.

The department may allow the ALSA to provide assisted living services for these clients in combination with Medicare and any of the assisted living service packages. The department shall not pay for duplicative services already covered under Medicare or another source of payment.

(E) The only additional services and charges authorized are personal emergency response system services and mental health counseling services. The department will not reimburse the ALSA for services provided under the waiver program or for home health or skilled nursing services that are provided under Medicaid. The Medicaid waiver client will continue to be eligible to receive the other traditional Medicaid benefits permitted under the department's medical assistance program policy.

(F) The nursing visits shall be provided on an as-needed basis to the client. The ALSA shall provide the nursing visits as indicated on the client's plan of care and in the assigned assisted living service package level.

(G) The ALSA may change a client's service level package at any time, provided proper justification and documentation is recorded in the client's record.

(H) The ALSA shall have their reimbursement by the department adjusted if the department determines that the client has to pay a client's mandatory contribution of service. The ALSA is responsible for the collection of the client's contribution towards their care.

(I) The ALSA shall act in good faith regarding the determination of the service needs of the client and shall document justification of the needs accordingly to assure non-duplication of services and proper billing to the department.

(J) When Medicare coverage is determined appropriate for a client due to the need for skilled care, the ALSA shall not seek approval or payment for these additional services from the department. Medicare is to be the payer source for these services. If there is no Medicare coverage, then the ALSA shall determine what type of nursing needs the client requires. If the personal care needs involve maintenance, such as ambulatory needs, then these are services that are to be incorporated in the duties of the ALSA home health aide. The ALSA shall not seek additional approval or payment for these services since these types of services are included in the service level package rate.

(K) Physical therapy is not a covered service under the Medicaid waiver or state-funded components of the assisted living services program.

(L) If the client is no longer eligible for program participation, then the MRC facility determines if the individual can remain a resident at the facility.

(d) Chore Services

(1) Description

Chore services include the performance of heavy indoor work, outdoor work or household tasks for elders who are unable to do these tasks for themselves because of frailty or other conditions. These services are necessary to maintain and promote a healthy and safe environment for elders in their own homes.

(2) Provider Participation

Chore service providers are not licensed or regulated and shall be provided by a person who is not a relative of the service recipient. Chore service providers shall demonstrate the ability to meet the needs of the individual seeking services. The department or the access agency shall ensure that the services provided qualify as chore services and are not services which should be provided by a licensed provider of home health services.

(3) Services Covered and Limitations

When an individual requires one-time only unique or specialized services in order to maintain a healthy and safe home environment, the Connecticut Home Care Program shall pay for highly skilled chore services which include, but are not limited to:

(A) Extraordinarily heavy cleaning where the work required is beyond the heavy cleaning normally performed by chore services;

(B) electrical repairs or installation;

(C) plumbing repairs;

(D) minor home repairs; and

(E) extermination.

(e) Companion Services

(1) Description

Companion services are home-based supervision and monitoring activities which assist or instruct an individual in maintaining a safe environment, when the person is unable to maintain a safe environment or when the person primarily responsible for monitoring and supervising is absent or unable to perform such activities.

(2) Provider Participation

(A) In order to provide companion services and receive reimbursement from the Connecticut Home Care Program, a companion shall be at least eighteen (18) years of age, be of good health, have the ability to read, write and follow instructions, be able to report changes in a person's condition or needs to the department, the access agency, or the agency or organization that contracted the persons to perform such functions and shall maintain confidentiality and complete required record-keeping of the employer or contractor of services.

(B) Companion services are not licensed or regulated and shall be provided by a person hired by an agency or organization. Certain relatives, as defined in section 17b-342-1(b)(29) of the Regulations of Connecticut State Agencies, cannot be providers of services. Providers shall demonstrate the ability to meet the needs of the service recipient. The access agency or a department designee shall also ensure that the services provided are appropriate for companion services and are not services which should be provided by a licensed provider of home health services.

(C) Companion service agencies or organizations shall abide by the standards and requirements as described in the performing provider agreement and sub-contract with the department or any authorized entity.

(D) Any homemaker-companion agency must register with the Department of Consumer Protection pursuant to sections 20-671 to 20-680, inclusive, of the Connecticut General Statutes.

(3) Services Covered and Limitations

Companion services may include, but are not limited to, the following activities:

(A) Escorting an individual to recreational activities or the necessary medical, dental or business appointments;

(B) reading to or for an individual;

(C) supervising or monitoring an individual during the self-performance of activities of daily living such as meal preparation and consumption, dressing, personal hygiene, laundry and simple household chores;

(D) reminding an individual to take self-administered medications;

(E) providing monitoring to ensure the safety of an individual;

(F) assisting with telephone calls and written communications; and

(G) reporting changes in an individual's needs or condition to the supervisor or care manager.

(f) **Adult Family Living**

(1) Description

Adult family living services provide an individual with continuous monitoring, supervision, coordination of daily living and management of overall health and welfare. These services are provided on a 24-hour basis in a private non-related family residence, when necessary to prevent or delay institutionalization.

(2) Provider Participation

For purposes of obtaining reimbursement under the Connecticut Home Care Program, the adult family living provider shall meet the following conditions:

(A) There shall be an individual designated to meet the specific needs of an adult family living client and that individual shall:

(i) Be at least eighteen (18) years of age, be of good health, have the ability to read, write and follow instructions, be able to report changes in a person's condition or needs to the sponsor of the foster care program or access agency or department designee, maintain confidentiality and complete required record-keeping of the employer or contractor of services;

(ii) not be the service recipient's relative, as defined in section 17b-342-1(b)(29) of the Regulations of the Connecticut State Agencies; and

(iii) be able to provide the individual with necessary supervision and assistance with management of overall health and activities of daily living.

(B) The family shall document that its income is adequate to meet the needs of the family;

(C) An adult family living provider shall not provide services to more than three (3) elderly persons at the same time; and

(D) Adult family living shall be provided in a living arrangement which conforms to applicable local and state building, health and safety codes and ordinances and meets the individual's needs for privacy.

(3) Services Covered and Limitations

The services provided to the individual shall include, but not be limited to, the following activities:

(A) Escorting an individual to recreational activities and to medical, dental or business appointments;

(B) reading to or for an individual;

(C) supervising or performing household tasks such as meal preparation, laundry and simple chores;

(D) supervising or monitoring an individual during the performance of activities of daily living such as eating, dressing and personal hygiene;

(E) reminding an individual to take self-administered medications;

(F) providing evening monitoring to ensure the safety of an individual;

(G) assisting with telephone calls and written communications; and

(H) reporting changes in an individual's needs or condition to a sponsor of the adult family living program or the care manager.

(4) Non-Reimbursable Services

Separate room and board charges are non-reimbursable services through the program. The client may be required to make payments directly to the adult family provider for room and board and meals.

(5) Meals

(A) Meals in the adult family living setting shall:

(i) Be nutritionally balanced and at least three (3) times daily;

(ii) include snacks and fluids as appropriate to meet the participant's needs; and
(iii) be adapted to modified diets if prescribed by a physician.

(6) Meals on wheels, homemaker services, companion services and chores services are not allowed.

(7) Additional allowable services

Attendance at an adult day center, personal emergency response system, mental health counseling and other benefits, if such services are deemed appropriate and are allowed within the program policy.

(g) **Home Delivered Meals**

(1) Description

Home delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own.

(2) Provider Participation

Reimbursement for home delivered meals shall be available under the Connecticut Home Care Program only to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council.

All "meals on wheels" providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Quality assurance and quality control shall be performed by the department's contracted providers to ensure that the "meals on wheels" service providers are in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older American's Act.

(3) Service Covered and Limitations

Payment under the Connecticut Home Care Program is not available for more than two meals a day.

(4) Meals must be delivered at the client's place of residence and must be provided directly to the client or to an authorized person. If the client is attending an adult

day center, the meal may be left at the center but the meal cannot be counted as part of the meals that the center is to provide to the client. The adult day center shall ensure that the client ordered meals are stored at an adequate temperature and the client takes the meal home.

(h) Home Health Services

(1) Description

Home health services include the same medical procedures that are included in the definition of home health services under the Medicaid program.

(2) Provider Participation

In order to receive payment from the Connecticut Home Care Program, providers of home health services shall be enrolled as home health providers under the Medicaid program and be licensed with the state Department of Public Health.

(3) Services Covered and Limitations

Home health services provided under the Connecticut Home Care Program shall be covered to the same extent as they are under the Medicaid program.

(i) Homemaker Services

(1) Description

Homemaker services are general household management activities provided in the home to assist or instruct an individual in managing a household when the elder is unable to manage the home or when the individual primarily responsible is absent or unable to perform such management activities. These services are provided on a part-time or intermittent basis.

(2) Provider Participation

(A) Homemaker services shall be provided by an individual that is at least eighteen (18) years of age, in good health, has the ability to read, write and follow instructions, is able to report changes in a persons' condition or needs to the department, access agency and the agency or organization that hired the service providers. Service providers shall demonstrate the ability to meet the needs of the individual service recipient and, when money management is involved, to protect the individual's financial interests. The homemaker service agency, the department or the access agency shall ensure that the services provided are appropriate for homemaker services and are not services which should be provided by a licensed provider of home health services or a professional financial advisor.

(B) Certain relatives, as defined in section 17b-342-1(b)(29) of the Regulations of the Connecticut State Agencies, are not allowed to provide homemaker services to program clients.

(C) Homemaker services shall only be provided through a homemaker service provider agency enrolled with the department and subcontracted with a department-contracted access agency or department designee.

(D) The homemaker service provider agency shall ensure that the individuals hired to perform the task of homemaker services meet all requirements set forth in subdivision (2)(A) of this subsection.

(E) The homemaker services shall be performed only for the benefit of the client and not for other members of the household.

(3) Services Covered and Limitations

Homemaker services include, but are not limited to:

(A) Changing linens;

(B) communication of health or other problems (neglect or abuse) to supervisor;

(C) correspondence, including written communications of a business or social nature;

(D) dishwashing;

(E) light housecleaning;

(F) laundry;

(G) meal planning and preparation;

(H) mending limited to repair of an individual's clothing;

(I) money management by bonded personnel, limited to check writing and balancing, bank deposits, paying bills and budgeting for the purpose of daily household expenses and personal needs, not including long term financial planning or investment advice;

(J) shopping; and

(K) transportation.

(j) Laundry Services

(1) Description

Laundry Service is designed to serve frail elders who have no other means of having laundry cleaned and shall be arranged by the contracted access agency or department designee.

(2) Provider Participation

Laundry Service is ordinarily to be provided by a commercial laundry company or by a provider of adult day health services.

(3) Services Covered and Limitations

The service is limited to one bag of laundry (up to 10 lbs.) every two weeks per client, except in cases where the case manager determines that a higher amount is necessary, such as when a client is incontinent. Two times in a 12-month period, an additional amount of laundry service may be provided per client. This additional service is limited to blankets, bedspreads and small rugs weighing no more than 20 pounds. Dry cleaning is not included in laundry services.

(4) Laundry services shall not be available to clients that are receiving homemaker services, to clients whose family caregivers are providing the service, to participants in the assisted living service component of the program or residing in any managed residential communities.

(k) Mental Health Counseling Services

(1) Description

Mental health counseling services are professional counseling services provided to help resolve or enable the eligible individual to cope with individual, family or environmentally related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation within the community, dealing with long term disability, substance abuse and family relationships.

(2) Provider Participation

For purposes of receiving reimbursement under the Connecticut Home Care Program, a mental health counseling provider shall be a licensed clinical social worker as defined in section 20-195m of the Connecticut General Statutes, and shall have experience and training in providing mental health services to the elderly, or a social worker who holds a masters degree from an accredited school of social work, or an individual who has a masters degree in counseling, psychology or psychiatric nursing and has experience in providing mental health services to the elderly.

Service providers are not allowed to provide mental health counseling to relatives, as defined in section 17-342-1(b)(29) of the Regulations of Connecticut State Agencies.

(3) Services Covered and Limitations

The department shall pay for mental health services conforming to accepted methods of diagnosis and treatment, including:

(A) Mental health evaluation and assessment;

(B) individual counseling;

(C) group counseling; and

(D) family counseling.

(I) Minor Home Modification Services

(1) Description

Minor home modifications, also known as environmental accessible adaptations to the home or place of residence of the client, are services available, if required by the individual's plan of care, that are necessary to ensure the health, welfare and safety of the individual and to enhance independence in their home without which, the individual would require institutionalization.

(2) Provider participation

The vendor or contractor shall be registered with the state Department of Consumer Protection to do business in the state of Connecticut. The vendor or contractor shall show evidence of a valid home improvement registration and evidence of worker's compensation, if applicable, and liability insurance, at the time they provide an estimate for the job to the access agency.

The vendor or contractor shall meet any additional requirements as established by the department.

(3) Services covered and limitations

(A) Services may include, but are not limited to, the installation of handrails and grab bars in the tub area, widening of doorways and installation of ramps and stair-glides, if deemed feasible and appropriate.

(B) The vendor or contractor shall provide all services, materials and labor that are necessary to complete the project/minor home modifications as indicated in the agreement with the department-contracted access agency.

(C) All services shall be provided in accordance with applicable state and local building codes.

(D) Excluded services are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual including, but not limited to, carpeting, roof repair and central air conditioning. Adaptations, which add to the total square footage of the home, are excluded from this service.

(E) Availability of services is contingent on appropriations of funds for services for both the Medicaid waiver and state-funded components under the program. No waiting list shall be maintained for services. Once the appropriated funds are exhausted, the access agency and department staff will be notified and no further requests for services will be taken. However, the access agencies and the department staff shall maintain a listing of those clients that can benefit from services if funds are made available.

(F) Review and approval of the service from the access agency shall include clients who are active and residing in a community setting that may include rental property, such as an apartment, or a private home. Clients must provide justification and documentation for the need and the cost related to the project. The department will provide a written decision to the request.

The access agency shall ensure that the client or client representative obtains written permission from the owner of the property, if the client is not the legal owner. This written permission must be obtained even if the property owner is a relative or friend of the client.

(G) The contractor or vendor and access agency shall ensure that the funding approved is used for the project approved. If the work is not completed, the contractor or vendor shall not be paid. Before payment is issued, the access agency shall verify that the work was completed as described in the work or project specifications.

If, after approval of a request for work on the property and prior to the commencement of the work, the client dies, enters a nursing facility, is hospitalized or institu-

tionalized, moves out of state, moves in with a relative or friend or moves into another type of community setting, then the work shall not be done. In the event that the client is living with a family member or friend, is hospitalized or institutionalized, or in a nursing facility on a temporary basis, approval for the work shall be placed on hold until the client returns home.

(m) **Personal Emergency Response System Services**

(1) Description

A Personal Emergency Response System (PERS) service is an in-home, 24-hour electronic alarm system activated by a signal to a central switchboard.

(2) Provider Participation

For purposes of receiving reimbursement from the Connecticut Home Care Program, providers of a PERS shall adhere to the following requirements:

- (A) Provide trained emergency response staff on a 24-hour basis;
- (B) have quality control of equipment;
- (C) provide service recipient instruction and training;
- (D) assure emergency power failure backup and other safety features;
- (E) conduct a monthly test of each system to assure proper operation;
- (F) recruit and train community based responders in service provision; and
- (G) provide an electronic means of activating a response system to emergency medical and psychiatric services, police or social support systems.

(3) Services Covered and Limitations

(A) PERS enables a high risk individual to secure immediate help in the event of a medical, physical, emotional or environmental emergency. These services are provided on a 24-hour basis when necessary to prevent or delay institutionalization of an individual.

(B) PERS services are provided through local hospitals or emergency response centers that provide 24-hour coverage.

(C) PERS is not allowed in those managed residential care facilities that offer PERS as part of the service package.

(D) PERS is not allowed for clients who enter a nursing facility as permanent placement, move out of state or are temporarily out of state.

(E) PERS providers shall be a legitimate vendor or contractor and be registered with the state Department of Consumer Protection.

(F) PERS providers shall meet all applicable requirements as described in subsections (m)(2) and (m)(3) of this section in order to be a provider of service to department clients.

(n) **Respite Care Services**

(1) Description

Respite care services provide short-term relief from the continuous care of an elderly individual for the individual's family or other primary caregiver.

(2) Provider Participation

Providers of respite care services shall meet one of the following qualifications to receive reimbursement from the Connecticut Home Care Program:

(A) In-Home Respite Care Provider

An in-home respite care provider is an individual who has received training as well as has experience in providing home care for elderly persons. In-home providers of respite care shall include, but not be limited to, companions, homemakers, home health aides and other home health care personnel; or

(B) Out-of-Home Respite Care Provider

An out-of-home respite care provider is an organized facility licensed, certified or otherwise operating under the guidelines of other State agencies to provide respite care appropriately as defined in sections 17b-342-1 to 17b-342-5, inclusive of the Regulations of Connecticut State Agencies. Out-of-home providers may include,

but are not limited to, rest homes with nursing supervision, chronic and convalescent nursing facilities, adult day care centers, homes for the aged or elderly foster care providers. Respite services provided in a licensed facility are limited to thirty (30) days per year per recipient.

(3) **Services Covered and Limitations**

The primary purposes of respite care services are to reduce the stress on the family members or other primary caregivers in order to assure that the client can continue to receive such necessary support; to allow the caregiver to meet other family needs; or to provide care during temporary absence of the primary caregiver.

(o) **Transportation Services**

(1) **Description**

Transportation services provide access to medical services, social services, community services and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization by enabling these individuals to retain their role as community members.

(2) **Provider Participation**

(A) In order to receive payment from the Connecticut Home Care Program, all commercial transportation providers shall be regulated carriers and meet all applicable state and federal permit and licensure requirements and vehicle registration requirements. Commercial transportation providers shall also meet all applicable Medicaid program enrollment requirements.

(B) There are no enrollment requirements for private transportation. Private transportation is defined as transportation by a vehicle owned by a volunteer organization, or a private individual, provided the vehicle is not used for commercial carriage.

(3) **Services Covered and Limitations**

(A) These services are provided when transportation is required to promote and enhance independent living and self-support; and

(B) Transportation services may be provided by taxi, livery, bus, invalid coach, volunteer organization or individuals. They shall be reimbursed when they are necessary to provide access to needed community based services or community activities as specified in the approved plan of care.

(C) Transportation services are not allowed for the purpose of attending an adult day health center or for program clients that are participants in the assisted living component of the program and who reside in certain managed care residential facilities.

(Effective July 8, 1998; amended September 3, 2010)

Sec. 17b-342-3. Service limitations, payment limitations, cost limits, waiting list and fee setting

(a) **Service Limitations**

(1) All home care services provided to individuals under the Connecticut Home Care Program shall be authorized in accordance with procedures established by the department prior to the delivery of the service;

(2) Reimbursement is not available from the department for personnel or agencies providing a home care service when such person or agency is required to be licensed, certified or otherwise regulated and does not fulfill the relevant regulatory requirements including the requirements under sections 17b-342-1 to 17b-342-5 of the Regulations of Connecticut State Agencies;

(3) When two or more providers of community based or home health services offer essentially the same service, the least costly service provider shall be used, provided that the quality of the service is similar;

(4) Providers of services, including subcontractors of the access agency and assisted living service agencies, shall maintain records to support claims made for

payment, which shall be subject to audit by the department or its designee for at least seven years;

(5) Reimbursement is not available from the department for services canceled in advance either by phone or in writing;

(6) Reimbursement is not available from the department when an individual does not utilize or refuses to utilize an arranged service;

(7) Reimbursement is not available from the department for any services provided prior to the assessment or the determination of program eligibility or not documented in an approved plan of care;

(8) Reimbursement is not available from the department including, but not limited to, when an individual dies, is hospitalized, enters a nursing facility, moves temporarily or permanently out of state, requests services to be terminated or is determined ineligible;

(9) Reimbursement is not available from the department if the access agency or assisted living service agency is determined not to have followed the requirements and process established by the department for uncollectible mandatory client contribution towards their care;

(10) Reimbursement is not available for home and community based services determined not to have been performed;

(11) Reimbursement is not available for services arranged by program clients or representatives, access agencies, assisted living service agencies or service providers without prior approval by the department or department designee;

(12) Reimbursement is not available for duplication of services or payment; and

(13) Reimbursement is not available from more than one department or state agency program.

(b) Payment Limitations

(1) All home care service providers shall bill the usual and customary charge and the department shall pay the lowest of:

(A) The usual and customary charge;

(B) the lowest Medicaid rate;

(C) the amount in the applicable fee schedule as published by the department;

(D) the fee or rate negotiated with the access agency and the assisted living service agency; or

(E) the amount billed by the provider of the community based service to the department.

(2) The access agency shall not use department funds to purchase home care services other than assessment, status reviews and care management from itself or any related parties.

(3) The assisted living service agencies shall not use department funds to purchase home care services other than assisted living services, which include all personal care assistance services and core services, or other allowable charges incurred by the agency.

(c) Cost Limits on Individual Plans of Care

(1) In order to receive home care services under the Connecticut Home Care Program, the elderly person's plan of care shall be within the cost limits related to the person's category of service for both the fee-for-service and the assisted living service components. All state-administered costs of home care services shall be included.

The following are the cost limits which define the categories of services for fee-for-service (to be used only for care managed and self-directed clients):

(A) Category 1 Services:

Home care services may be authorized for up to 25% of the weighted average nursing facility cost for individuals who are at risk of institutional placement but

who might not immediately enter a hospital or nursing facility in the absence of the program provided they also meet the financial eligibility criteria for the state-funded portion of the program.

Services for Medicaid recipients who are not functionally eligible for the Medicaid waiver portion of the program will be covered by the state-funded portion of the program.

(B) Category 2 Services:

Home care services may be authorized for up to 50% of the weighted average nursing facility cost for individuals who would otherwise require admission to a nursing facility and who meet the financial eligibility criteria for the state-funded portion of the program.

(C) Category 3 Services:

Home care services may be authorized for up to 100% of the average nursing facility cost for individuals who would otherwise require long term admission to a nursing facility and who also meet the financial eligibility criteria for Medicaid under the federal waiver. The cost of community-based services provided to individuals in category 3 shall not exceed 60% of the weighted average Medicaid rate in a nursing facility.

(2) Under the assisted living service component of the program there are four different levels of service that the assisted living service agency is to use when assigning the appropriate level of service to a client.

(A) The assisted living levels of service 1,2,3 and 4 are based on the client's nursing or personal care needs. Each level of service is reimbursed at a per diem rate established by the department. There may be different per diem rates for each of the assisted living services components depending on the negotiated rate by the assisted living service agency with the department. Refer to subsection (c)(1)(A) to (c)(1)(C), inclusive, of this section for specifics relating to the description of assisted living cost limits for categories of service.

(B) Additional cost for core services is allowed if the program client needs these supplemental services.

(C) The program client's cost for assisted living services cannot exceed the assigned service package and additional cost for core services which shall be specified on the client's plan of care and cost worksheet.

(3) Elders enrolled in the program have the ability to move from one service category to another within fee-for-service if care managed or self-directed, and from one level of service to another under the assisted living component. When the elderly person's functional or financial eligibility changes, the information shall be reviewed by department staff and a determination shall be made regarding the appropriateness of the change in service category and funding source for the services under the program.

(4) The agency that oversees an elder's plan of care shall be responsible for applying and monitoring the Connecticut Home Care Program cost limits in accordance with the following regulations:

(A) The agency shall first determine if the state-administered public funds to be expended for home care services in accordance with the elderly person's plan of care exceed the cost limits related to the individual's category of services or service package level cost. If the costs do not exceed the limit on a monthly basis, the person may receive services under the Connecticut Home Care Program, provided the program is accepting new applicants at the level for which the person is applying.

(B) If the monthly cost of state-administered public funds for home care services required to be provided under an individual's plan of care exceeds the cost limits related to the individual's category of services (fee-for-service only under the program), the agency shall project the cost of those services for the individual over a

12-month period. If the projected annualized cost of those services falls within the cost limits, the individual may receive services under this program provided that the program is accepting new applicants at the category of service for which the individual is applying.

(C) Clients participating in the assisted living services component whose needs cannot be met within the assisted living service package levels, may be referred to the access agency to determine if their needs can be met and the necessary services are available within the cost limits of the category of services provided under the fee-for-services delivery system. Once the client is care-managed, the client may be referred to the access agency as described under this subparagraph.

(D) If the agency does not have information on the actual cost of services being provided to the elder through other state administered programs, the agency shall estimate the cost based upon payments made for similar services. Information on all services provided under the requirements of an individual's approved plan of care shall be reported to the department.

(E) The agency shall be responsible for determining that the amount of state-administered public funds expended to provide services required under the person's plan of care continues to meet the cost limits set forth in this subsection and as described in subsection (c)(1)(A) to (C), inclusive, of this section.

(F) When the rates for home care services (including care management and assisted living services, such as personal care assistance and core services), covered by the Connecticut Home Care Program are increased, the access agency, assisted living service agency or department designee shall update the plans of care to reflect those increases upon receipt of the new rates. The access agency, assisted living service agency and other providers shall be liable for charges in excess of the cost limit following that transition period unless the case is under appeal or an exception to the cost limits is granted in accordance with subparagraph (G) or (H) of this subdivision or by the department Commissioner or his or her designee.

(G) Clients who were above the cost limits prior to July 1, 1992, shall continue to receive services to the extent that they qualify in accordance with section 17b-342(i) of the Connecticut General Statutes.

(H) Any person who requires a care plan that shall place the client above the cost limits may request an exception to the cost limits from the Commissioner or his or her designee. Approvals shall be based on extreme hardship, shall be time-limited (not to exceed three months), shall in no case exceed 100% of the average nursing facility cost and shall be home health service related.

(I) Requests for exceptions to the cost limits are not allowed when a client is pending Medicaid, when the client loses his or her Medicaid eligibility because of changes to their income or assets, loses Medicare coverage or is an assisted living service participant.

(d) **Waiting List**

(1) The state funded portion of the program is subject to availability of funds. The portion of the program funded under the federal waiver is subject to continued approval of the Medicaid waiver and to any limits on expenditures or the number of persons who can be served under the federal waiver application.

(2) In the event that the state appropriation or the upper limits under the federal waiver are insufficient to provide services to all eligible persons, the number of persons admitted to the program may be limited. When these limits are reached, the department may establish a waiting list. If a waiting list is established, the department shall serve applicants from the waiting list who meet all program requirements in order of their application except as otherwise provided in subdivision (d)(4) of this section.

(i) If there is a waiting list for either portion of the program and the applicant's name is reached, but the applicant is not eligible for benefits at the time the opening becomes available, the applicant's name may be placed in a "hold" position, unless the applicant is removed from the waiting list. The "hold" status enables the applicant to retain the position on the waiting list until such time as the applicant meets the requirements of the program. The applicant shall inform the department when the applicant meets the program requirements.

(ii) If the department learns that an applicant is deceased, or becomes enrolled in the Medicaid waiver portion of the program, the applicant shall be removed from the waiting list.

(iii) If the department learns that an applicant has entered a nursing facility or has moved out of state, or if the applicant requests removal from the waiting list, the department may remove the applicant's name from the waiting list.

(aa) The department shall notify the applicant that it intends to remove the applicant's name from the waiting list and the reason it intends to remove the applicant's name.

(bb) The applicant shall be provided with the opportunity to request that the name not be removed from the waiting list. It is the responsibility of the applicant to inform the department of the applicant's current address. If the applicant does not respond to the department, the applicant's name shall be removed from the waiting list.

(iv) If an applicant is removed from the waiting list in error, the applicant may be restored to the waiting list in the original place.

(3) Available openings within the program shall be allocated based on the proportion of the region's elder population adjusted to take into consideration the ratio of elders who are poor, minority, impaired or living in rural areas.

(4) If funds are available under the state-funded portion of the program, the department may from time to time establish priorities which ensure that persons with the greatest medical, social and economic need receive timely assistance. The department will only establish priorities under extreme circumstances.

(e) Rate Setting

(1) General Provisions

(A) The department shall, in accordance with section 17b-343 of the Connecticut General Statutes, establish a fee schedule for assessment, care management and other home and community based services as they are defined in section 17b-342-1(b)(7) of the Regulations of Connecticut State Agencies. The Commissioner may annually increase any rate in the rate schedule based on an increase in the cost of services. The department shall specify the rates for these services in the Request for Proposals (RFP).

(B) All financial and clinical records of providers shall be accessible at the request of the department and are fully subject to fiscal and programmatic audit by the department or its designees.

(2) Rates for Assessment and Care Management

(A) All access agencies wishing to provide assessment and care management services, and receive reimbursement for the same under contract with the department, shall submit bids to the department in response to the RFP. These bids shall be filed with the department on a date set by the department for the initial year of the contract.

(B) The rates for assessment and care management services shall be established by the department based on the responses to the RFP. In no event may a payment exceed the usual and customary charges of the access agency. In addition, the department shall not contract for any fees determined unreasonable or in excess of the fees set by the department.

(3) Rates for Status Reviews

The department shall establish a rate for status reviews.

(4) Rates for Other Community Based Services

(A) For the Connecticut Home Care Program, rates for other home and community based services (excluding assessment and care management) shall be set by the department in accordance with section 17b-343 of the Connecticut General Statutes. The rates to be charged for other home and community based services shall be set by a contract between the access agency and the service provider even when the services are provided without care management by the access agency. In no event may a contracted rate exceed the usual and customary charge of the provider or the rate set by the department.

(B) For the Connecticut Home Care Program, under no circumstances shall an access agency or assisted living service agency select a provider whose services do not meet the standards of quality established in section 17b-342-2(h) of the Regulations of Connecticut State Agencies.

(C) For the Connecticut Home Care Program, under no circumstances shall an assisted living service agency charge the department at a rate not approved by the department. The approved and enrolled assisted living service agency shall charge the approved rate established by the department and only for those allowable services.

(5) Rates for State-Funded Home Health Services

The rates for home health services provided to eligible persons, as defined in section 17b-342-2(h) of the Regulations of Connecticut State Agencies shall be the same as those paid under the Medicaid program. Home health services shall be paid only under fee-for-service for care managed or self-directed care program clients. For ALSA clients, these services are included in the rate.

(Effective July 8, 1998; amended September 3, 2010)

Sec. 17b-342-4. Nursing facility and hospital requirements**(a) Nursing Facility Admission Requirements**

Nursing Facilities shall comply with the following Connecticut Home Care Program requirements:

(1) Information and Forms Distributions

When a nursing facility identifies an elderly applicant for admission to the facility, the nursing facility shall inform the person about the program by providing a copy of the Home Care Request Form and program information.

(A) Medicaid Recipients and Applicants

Prior to admission to a nursing facility, recipients and individuals who have applied for Medicaid who are aged 65 years or older shall:

(i) Complete and submit to the department a Home Care Request form to confirm that they are Medicaid recipients or applicants;

(ii) be screened by the department through its health screen form to determine the need for nursing home care and the feasibility of home care pursuant to section 17b-342-1(b)(15) of the Regulations of Connecticut State Agencies; and

(iii) receive department authorization for admission and Medicaid payment for nursing facility care or home care. The effective date for Medicaid reimbursement on behalf of such person shall be no earlier than the date admission is authorized by the department.

(B) Other Requirements

(i) At the time of the admission of all other elderly persons, the nursing facility shall obtain a statement signed by the person verifying that he or she received the Connecticut Home Care Program materials and understands his or her rights and responsibilities under the Connecticut Home Care Program. The statement shall be maintained in the individual's file. If the person indicates that the program materials

were not received or requests Connecticut Home Care Program materials, the facility shall provide the person with a set of materials. The nursing facility shall complete a compliance form for this purpose.

(2) Emergency Admissions for Medicaid Recipients and Applicants

(A) In the case of emergency admissions as defined in section 17b-342-1(b)(15) of the Regulations of Connecticut State Agencies, elderly persons may be admitted to a nursing facility prior to completion of the health screen form. However, the facility shall notify the department within one (1) working day of the admission. Such an emergency shall be documented in writing on the department emergency admission documentation form prior to admission by a health care professional in the facility. The health care professional's name, business address and phone number shall be noted in the patient's record. A copy of the emergency admission form that specifies compliance with these regulations shall be provided to the department and maintained in the individual's records.

(3) Exemptions

The following are elderly persons who are exempt from the Connecticut Home Care Program screening process although they may request to be screened for participation in the program:

(A) Patients transferring from one nursing facility to another and intra-facility transfers;

(B) nursing facility patients who are admitted to a hospital and discharged back to a nursing facility;

(C) individuals who are out-of-state residents at the time they are seeking admission to a nursing facility;

(D) individuals seeking short term respite care in a nursing facility as defined in section 17b-342-2(n) of the Regulations of Connecticut State Agencies; and

(E) terminally ill individuals seeking nursing facility admission. For purposes of this subsection "terminally ill" means that a physician has signed a statement in a form specified by the department for this purpose only, identifying the patient's medical diagnosis and verifying that the individual's life expectancy is six (6) months or less. A copy of the physician's statement shall be submitted to the department and also be filed in the patient's nursing facility record.

(4) Coordination with screening process for Mental Illness and Mental Retardation under OBRA 1987.

(A) The preadmission screening procedures administered under the Connecticut Home Care Program shall be coordinated with the federally mandated screening for nursing home applicants with mental illness or mental retardation. Exemptions C, D and E above do not apply to the mandatory nursing home preadmission screening for mental illness and mental retardation related to the federal Omnibus Budget Reconciliation Act of 1987 (OBRA).

(B) Except when exemptions apply or the emergency admission procedures have been followed, the department shall not reimburse a nursing facility for any days that an elderly person spends in the facility prior to completion of the preadmission screening process for the Connecticut Home Care Program and the federally mandated screening for nursing home applicants with mental illness or mental retardation.

(b) **Hospital Responsibilities**

Hospitals shall comply with the following Connecticut Home Care Program requirements:

(1) Information and Forms Distribution

(A) If it can be determined by the hospital within three (3) days of admission that an elderly person, as defined in section 17b-342-1(b)(14) of the Regulations of Connecticut State Agencies, would be expected, based upon the professional judgement of hospital personnel, to be an applicant for admission to a nursing

facility without the services available through the Connecticut Home Care Program, the hospital shall distribute the Connecticut Home Care Program forms packet to such elderly person and provide information about the program. Hospital staff are encouraged to provide program information to all elders or their representatives.

(B) If the patient's condition is too unstable to make the above determination by day three, the Connecticut Home Care Program forms and information shall be provided when the determination can be made. The hospital staff shall document in the patient's record the reason for the postponement (e.g. "patient's condition too unstable to make determination"). The hospital staff shall also document the date the materials are distributed.

(2) Completion and Submission of Forms

Personnel responsible for discharge planning shall complete and submit to the department any required forms for determining nursing facility level of care eligibility.

(Effective July 8, 1998; amended September 3, 2010)

Sec. 17b-342-5. Reporting

All nursing facilities, hospitals, access agencies, assisted living service agencies, lead service providers and home care service providers shall comply with any reporting, quality assurance review and audit requirements established by the department for purposes of administering, monitoring and evaluating the Connecticut Home Care Program.

(Effective July 8, 1998; amended September 3, 2010)