Alaska Aging and Disability Resource Center (ADRC) Person Centered Intake Training Guide

DEVELOPED BY ALASKA DIVISION OF SENIOR AND DISABILITIES SERVICES

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History & Purpose

This handbook is intended to help train staff working at the Aging and Disability Resource Centers (ADRCs) and Short-Term Assistance and Referral Programs (STARs) on how to conduct the Person-Centered Intake (PCI). ADRCs and STARS will use the PCI to help participants seeking Long Term Services and Supports (LTSS) identify services and supports they may be eligible for and options that may be best suited to meet their needs.

The PCI enhances the previous tool used by the ADRCs, the Prescreen, by expanding the range of services and support options to include all of Alaska's Medicaid-funded LTSS options. This enhancement will allow the ADRCs and the STARs to serve as the single-entry point for all of these programs.

The PCI process:

- Collects sufficient information to determine potential eligibility for service and support options, including Medicaid Home and Community Based (HCBS) waivers, Community First Choice (CFC), and Personal Care Services (PCS), community funded supports, private pay services, and other options.
- Includes options counseling to ensure that the participant understands all of his/her LTSS options and is able to make an informed choice.
- Allows the *participant* and his/her representative to decide which LTSS option to pursue.

Overview of Handbook Contents

The PCI Handbook includes the following sections:

- **Introduction to Person-Centered Thinking and Goals-** The PCI is intended to be the first step in a person-centered process in which program participants' goals drive services. The PCI lays the groundwork for this by educating the participant about the process and helping her or him start to think about goals. To play this role, ADRC and STAR staff need to understand person-centeredness. This handbook introduces this topic. ADRC and STAR staff will receive additional training from SDS and their agencies.
- **Overview of the Person-Centered Intake Sections-** This chapter describes the major sections in the PCI, general guidance for completing the PCI, and how to understand the outcome and next steps. A step-by-step walk through of the entire PCI is included in the last section of the handbook.
- **Overview of the Assessment and Support Planning Process-** Staff conducting the PCI will be expected to explain the next steps, which include receiving an assessment and developing a Support Plan. This section provides a high-level description of the assessment and Support Planning processes.
- **Overview of Service Options-** Staff conducting the PCI will need to understand all of the Medicaid LTSS options so they can help participants select their best

option. This section describes all of the options, including the waivers, Community First Choice (CFC) option, and personal care services (PCS).

- **Participant Rights-** The section describes the rights of the participant in the PCI, assessment, and Support Planning process, such as the right to appeal an eligibility determination. Care coordinators have primary responsibility for making sure participants are informed about their rights, however, staff conducting the PCI should understand participant rights in case any questions arise. The primary staff conducting the PCI will need to inform participants they have a right to decide whether to apply for a program and request an assessment regardless of the outcomes of the PCI.
- **Reporting Mistreatment-** Staff conducting the PCI will need to understand the process for reporting mistreatment, such as abuse or neglect.
- **Detailed Review of the PCI-** This section provides a step-by-step walk through of each of the items in the PCI.

In this handbook, we identify the person requesting the receipt of LTSS as a "participant." Participant is used because it recognizes that, to the extent possible, the participant is actively selecting and overseeing services and supports. The handbook also refers to the "caller". The caller is the person placing the call to the ADRC or STAR. The caller may be the participant, a legally authorized representative for the participant, a family member or friend, an agency representative, or another individual.

Staff completing the PCI should make every effort to complete the PCI with the participant. If the participant is not able to accurately represent him/herself or the caller is a support from a provider agency or hospital discharge planner, staff should document the support's information in Section I.

Introduction to Person-Centered Thinking and Goals

Person centered thinking is often a paradigm shift. It requires a conscious commitment to listening to what is important to the participant, rather than focusing solely on service systems. Within a person-centered system, the participant should have the opportunity to lead the PCI, assessment, and Support Planning processes to the extent he/she would like and is capable of. A person-centered system should also empower participants to work towards goals that may not be met solely by services.

The PCI is the first step in this person-centered process. If a person is determined eligible, the Support Plan the care coordinator eventually writes needs to give an accurate picture of all supports the participant is using or wants to use, starting with supports that are not within the waiver system.

If the participant is not eligible for a Medicaid program, the person-centered approach will be applied after discussing an individual's options. Below we discuss the person-centered approach.

What Does It Mean to be Person-Centered?

Person centeredness is an approach in which the participant defines what is important to him or her. A participant who is accessing services is a whole person with resources and experiences that influence who he/she is today. Within this philosophy, participants have real choices for daily life and life direction rather than just from "the menu" of waiver services.

Consider the follow ideas/definitions:

- ***Self Determination*** is the right to define oneself and what is important to him/her. Services should support the opportunity to: make choices, share ordinary places, have relationships and grow them, know people, experience respect and have a valued social role, have the opportunity to share one's gifts, or a legacy.
- ***Community Membership*** means having real connections to a community; it means belonging. Being part of a community is one way that people define themselves. A person-centered approach uses partnerships and collaborative relationships with the community as a source of enduring supports.

A person-centered approach is not always "easy". It can shatter myths and assumptions about disability and aging. It can foster inclusive communities, and uncover what is already there: the extraordinary gifts and capacities of a participant. A person-centered approach assumes that the participants and those who are close to him/her are the primary authorities in the planning process.

Person-centered approaches differ significantly from traditional service planning. The table below provides a brief summary of how these two approaches compare.

Comparison of Traditional and Person-centered Planning		
	Traditional	Person-centered Approach
Who leads the development of plan?	Care coordinator leads a "team" in the development of a plan. The team is defined by the care coordinator and provider or may be specified in administrative regulation.	The participant leads/directs the planning. The role of the care coordinator is to assist and facilitate development of plan. The team includes people selected by the participant.
Where and when does planning meeting occur?	A meeting usually occurs in a location selected by the provider or care coordinator during regular "business" hours.	Planning meeting is at a location and time that is convenient to the participant.
What does the planning group discuss?	Team focuses attention on what is important for the participant based on	Planning focuses on the future desired by the participant. It will involve

	assessments of functional needs, behavior, social skills, and medical needs.	a balance of what is "important to" the participant for a happy life, as well as what is important for" the participant to remain healthy and safe. Information gathered from the participant about interests and preferences is balanced with information gathered from more formalized assessment(s).
What does the plan contain?	The participant's plan may look similar to the plans and ideas written for other people. Traditional plans frequently reflect what others think the participant should do. Service options and categories will define goals and goals may reflect what can occur within existing programs without changing anything.	Plans will reflect interests, qualities, and preferences that are unique to the participant and reflect his/her relationships and community. Some ideas may appear to be out of reach and can require major changes in how support is provided.
How is the plan evaluated for effectiveness?	The care coordinator and the team determine how effective the plan has been and whether outcomes have been achieved.	The participant evaluates how well the plan has worked and helps shape changes that improve outcomes and goals.

What Are Person-Centered Goals?

Person-centered goals, also called personal goals, are goals that are personally meaningful to the participant. Often, care coordinators are trained to recognize a health and/or safety issue and identify services that can help address it. Personal goals may be related to health and/or safety if the participant wants to address these concerns, however they may be something different all together.

Personal goals do not have to be tied to a service, nor do they have to be considered realistic or obtainable by the care coordinator, staff, family, or anyone else involved with

the participant. They are the participant's personal goals. During Support Planning, care coordinators will work with participants to develop a plan for meeting the goals. These plans may include publicly funded services, or they may simply include action steps that the participant needs to take to meet the goal.

Many elders and people with disabilities have accomplished a lot in their lives. They may say "I don't have goals" – however, it is important to listen carefully to identify potential goals. When developing or updating Support Plans listen for goals -- direct quotes from the participant are encouraged.

Some examples of common goal ideas expressed to care coordinators are listed below, then one possible example of an expanded statement goal statement.

- Goal: "I want to have my privacy respected" Respite services might be offered so that Sarah's primary unpaid provider, her daughter Brittany, will have some time away from her care giving duties to relax with her husband. Respite service caregivers will ask questions as needed to provide safe and appropriate care for Sarah and not ask personal questions unrelated to her care. Sarah will volunteer personal information if she is comfortable doing so.
- Goal: "I want to die at home where I live with my family and friends" Respite services might be offered so that her primary unpaid caregiver has relief from the time demands of care. The Alaska Comfort One Program and hospice services are available options that support her decision, and to assure that her wishes not to be moved to an institution are respected.
- Goal: "I just want to stay out of a nursing home and maintain my independence" John wishes to receive services in his home and live independently. He might be offered meals on wheels, chore and transportation services as well as Personal Care Services (PCS) services to help him remain in his home with reliable safe transportation to his medical appointments and support services.
- Goal: "I want to live in my the home that I built with my hands" While Tom continues to live in his home; Meals on Wheels might be offered to meet his need for a healthy diabetic meal each day and Chore services might be offered to help with tasks such as laundry, vacuuming, to maintain the his home.
- Goal: "I don't want a bunch of strangers in my home; I want my family to take care of me." Helen's granddaughter Beth could be her respite provider so that her primary caregiver, daughter Sophie will have time off from providing care.
- Goal: "I wish that my kids would quit worrying about me." Lifeline allows communication with emergency services when needed. Transportation services would provide safe and reliable travel to medical and support services. Chore services may be offered to help her with household chores such as vacuuming, snow shoveling, laundry, grocery shopping.
- Goal: "I'm afraid of falling" Sadie would like to be safe as she moves about, assistance and equipment might be offered to her to reduce the risk of falling. A

walker could be requested through Medicaid Durable Medical Equipment funding. The ALH staff will offer assistance with moving about the home and prompt or offer the walker if she forgets to bring it when leaving the home.

- Original wish statement from legal decision maker or concerned family member and planning team member: "I want my mother to have help with taking her medicine." Goal: ALH staff would offer prompting and assistance with self-administering her medications.

Overview of the Person-Centered Intake Sections

Potential applicants for HCBS services MUST have completed a Person-Centered Intake. The PCI includes the following ten sections:

I. **Participant, Decision Support, and Representative Information-** Gathers demographic information about the participant, information about others providing support during the Support Planning meeting, and if the participant has a representative who has legal authority for the participant, such as a guardian or power of attorney, information about the representative.

II. **CCMC Status-** Determine if the participant may meet eligibility for the Children with Complex Medical Conditions (CCMC) waiver. If the participant is over the age of 21, this section is skipped.

III. **DD Status-** Determine if the participant might benefit from supports offered through the Intellectual and Developmental Disabilities (IDD) waiver or the Individualized Supports Waiver (ISW). If the participant might benefit and meets the screening criteria, he/she will be directed to complete a DD Determination form.

IV. **Exploring Options and Level of Care (LOC) Screen-** Determines if the participant may meet nursing facility level of care (NFLOC).

V. **Eligibility-** This fully automated section provides information about the programs the participant is potentially eligible for based on responses to previous items.

VI. **Outcomes and Referrals-** Allows the *participant* to choose the services and supports he/she would like to pursue based on the PCI conversation; determine what the next steps should be; and allows the participant to request a copy of the PCI.

Conducting the PCI

The PCI is intended to be a conversation with the caller. All items do not need to be asked of the caller and the PCI does not need to be completed in a specific order, with the exceptions of Section I, which should be completed first, and Section VI, which should be completed last. Workers conducting the PCI should follow the flow of the conversation when selecting which items to ask. For example, if during the opening conversation the participant discusses the support he/she needs with activities of daily living (ADLs), such as bathing, dressing, eating, or getting around, the worker can skip to Section IV and complete the relevant items.

Throughout the automated PCI there are items that include a red asterisk (*). These items are mandatory to complete, with the exception of mandatory items that are indicated to be skipped because of a previous answer. For example, in Section III, DD Status, if there is no concern about the participant having a developmental disability, the automated system will disable subsequent items, including mandatory items that are not applicable. These skipped mandatory items do not need to be answered to consider the PCI complete.

Collecting Information- Demographics and Functional Screen

Sections I-IV gather information about the participant, representative (if applicable), and decision supports, including the potential support needs of the participant. As we discussed, these may be completed in any order based on the flow of the conversation, however it will likely be most efficient to first search within SAMS to identify if the participant already has a record within the system. If he/she does, staff should verify the information.

Sections II-IV gather information to determine which Medicaid waiver(s) and State Plan service(s) the participant is potentially eligible for. Prior to beginning these conversations, it will likely be helpful to explain that:

- The items ask about areas that the participant potentially needs additional support
- The conversation will result in determining what programs the participant potentially qualifies for, however the State will need more information before making a determination about program eligibility
- Staff completing the PCI will explain all of the participant's options to the caller after this discussion

If the caller is confused about how to respond to these items, the worker should provide examples and, if necessary, rephrase the item in a way that the participant can understand. If the worker chooses to do this, he/she should make sure the explanation is consistent with the intent of the item, as described in the detailed explanation of the PCI.

Analyzing the Results- Knowing the Resources

Section V uses algorithms to identify the waivers and programs that the participant is potentially eligible for based on the responses captured in Sections I-IV. It is critical that workers understand **all** of these programs, including how to access them, so that the worker can provide the participant with accurate information.

The PCI only indicates whether the participant is **potentially** eligibility for Medicaid waivers and PCS. This does **not** mean that the participant is eligible for the waivers. The PCI indicates only that they have met the targeting criteria that were designed to be more liberal than the actual assessment to make sure that all potentially eligible participants are offered a full assessment. The assessment, which is conducted by SDS, establishes

functional eligibility. The participant will also have to meet the financial eligibility criteria for Medicaid.

The Overview of Service Options provides more information about these programs.

Identified Resources and Follow-up

The final step of the PCI is working with the participant to determine the services and supports he/she would like to pursue and the next steps for doing so.

During this discussion, the worker should not assume that the participant will select the option that the worker believes is best. As part of a person-centered process, the participant should have all the information about his/her options and be supported in making the decisions. For example, if the participant is eligible for both the Alaskans Living Independently (ALI) and the Adults with Physical and Developmental Disability (APDD) waivers, it is important to inform him/her about the services offered under each, how each may help meet the goals he/she has shared, and next steps for enrolling in each program. Also, just because a participant qualifies for a waiver does not mean they will want to enroll in a Medicaid service. Workers must discuss **all** options available to the participant.

After discussing the participant's options, the worker should also discuss the next steps that are required to pursue these options. For example, if the participant would like to apply for enrollment in a waiver, the worker should provide him/her with a list of care coordinators to choose from and the appropriate Medicaid application if financial eligibility is not yet determined. A care coordinator will provide support in completing the Medicaid application, however participants who are not working with a care coordinator may request a referral for assistance in completing the Medicaid application. The worker should also offer the caller a copy of the PCI or Section VI and document all referrals that were made.

Overview of the Assessment and Support Planning Process

Roles and Responsibilities

The following people play a role in helping Alaskans access LTSS:

- The **ADRC**/STAR intake staff person's role is to:
  - Conduct the PCI (as described in this manual).
  - Help connect the caller to the next steps in accessing services. If the participant is applying for a waiver and/or CFC, this will involve helping him/her select and make a connection to a care coordinator. If the participant only wants PCS, the worker will help the participant select and connect with a PCS agency.
  - Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.
- The **SDS assessor's** role is to:

    - Conduct an assessment to determine if the participant meets the functional criteria for HCBS.
    - Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.
- The **care coordinator's** role is to:
    - Work with the participant and people the participant selects to complete an application and develop a Support Plan.
    - Coordinate the participant's services.
    - Communicate with service providers regarding service delivery and concerns.
    - Review and revise services as necessary.
    - Notify the participant about any change in services.
    - Notify the participant when services are denied, suspended, terminated, or reduced.
    - Document, report, and resolve the participant's complaints and concerns.
    - Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.

The participant's role is to actively participate in the assessment, leading the development of the Support Plan, and the coordination of her or his services by doing the following:

- Giving accurate information to the SDS assessor during the assessment, including the amount of assistance the participant needs to complete activities of daily living, such as dressing, taking a bath or shower, or moving around the house.
- Assisting in promoting his or her own independence.
- Cooperating with providers and the care coordinator.
- Notifying the care coordinator of changes in the participant's support system, medical condition, and living situation, including any hospitalizations, emergency room admissions, nursing home placements or Intermediate Care Facility for Individual with Intellectual Disabilities (ICF-IID) placements.
- Notifying the care coordinator if the participant has not received HCBS for 30 days or 1 calendar month.
- Notifying the care coordinator of any changes in the participant's care needs and/or problems with services.
- Notifying the care coordinators of any changes that may affect Medicaid eligibility.

WellSky Automation

SDS uses two different information technology systems that are operated by WellSky:

- Aging & Disability (formerly SAMS) is used by the ADRCs, STARs, for grant programs. The PCI is automated in this system.
- SDS Harmony Live is used for Medicaid services, including waivers CFC and PCS.

Limited information, such as the names of participants, is ported across the two systems. SDS hopes to integrate the functions currently performed in SAMS into Harmony in the near future.

Eligibility Criteria

To qualify for waiver and State Plan services, participants need to meet certain income and asset criteria to be enrolled in Medicaid. This is called meeting the financial eligibility criteria.

To be eligible for Medicaid HCBS services, a separate process is necessary to determine if the participant's disability or chronic care needs qualify him or her for these services. This process determines whether the participant meets the functional eligibility criteria.

If a participant meets both the functional and financial eligibility criteria, she or he can then be enrolled in an HCBS program.

Financial Eligibility Determination

A participant's income and assets must be below certain levels to be eligible for Medicaid services. The exact levels of income and assets vary based upon several factors, such as marital status, household size, and the participant's employment status. Participants enrolled in a waiver can qualify for Medicaid with a higher income.

Children *may* be eligible for waivers based on the child's income and assets, thereby waiving the family financial status.

The PCI contains a screen for financial Medicaid eligibility, and more instructions about when the participant may meet financial eligibility criteria is included within the description of Section I of the PCI.

Federal Poverty Guidelines can be found on the ADRC Website.

Functional Eligibility Criteria

PCS Functional Eligibility Criteria

To be eligible for PCS, in addition to receiving Medicaid, the participant must need assistance (hands-on help) with at least one ADL or IADL to remain at home.

Waiver and CFC Functional Eligibility Criteria

To be eligible for a waiver or CFC, a participant must meet an institutional level of care (LOC) criteria. Alaska's waivers primarily use two LOCs:

- The Nursing Facility level of care (NFLOC) determines eligibility the Alaskans Living Independently (ALI), Adults with Physical and Developmental Disability (APDD), Children with Complex Medical Conditions (CCMC) waivers.
- The Intermediate Care Facility for Individuals with Intellectual Disability level of care (ICF/IID-LOC) helps determine eligibility for the Individualized Supports Waiver (ISW) and Intellectual and Developmental Disabilities (IDD) waiver.

Participants in these waivers also must complete the Developmental Disability Determination process and when necessary Developmental Disabilities Registration and Review (DDRR) form.

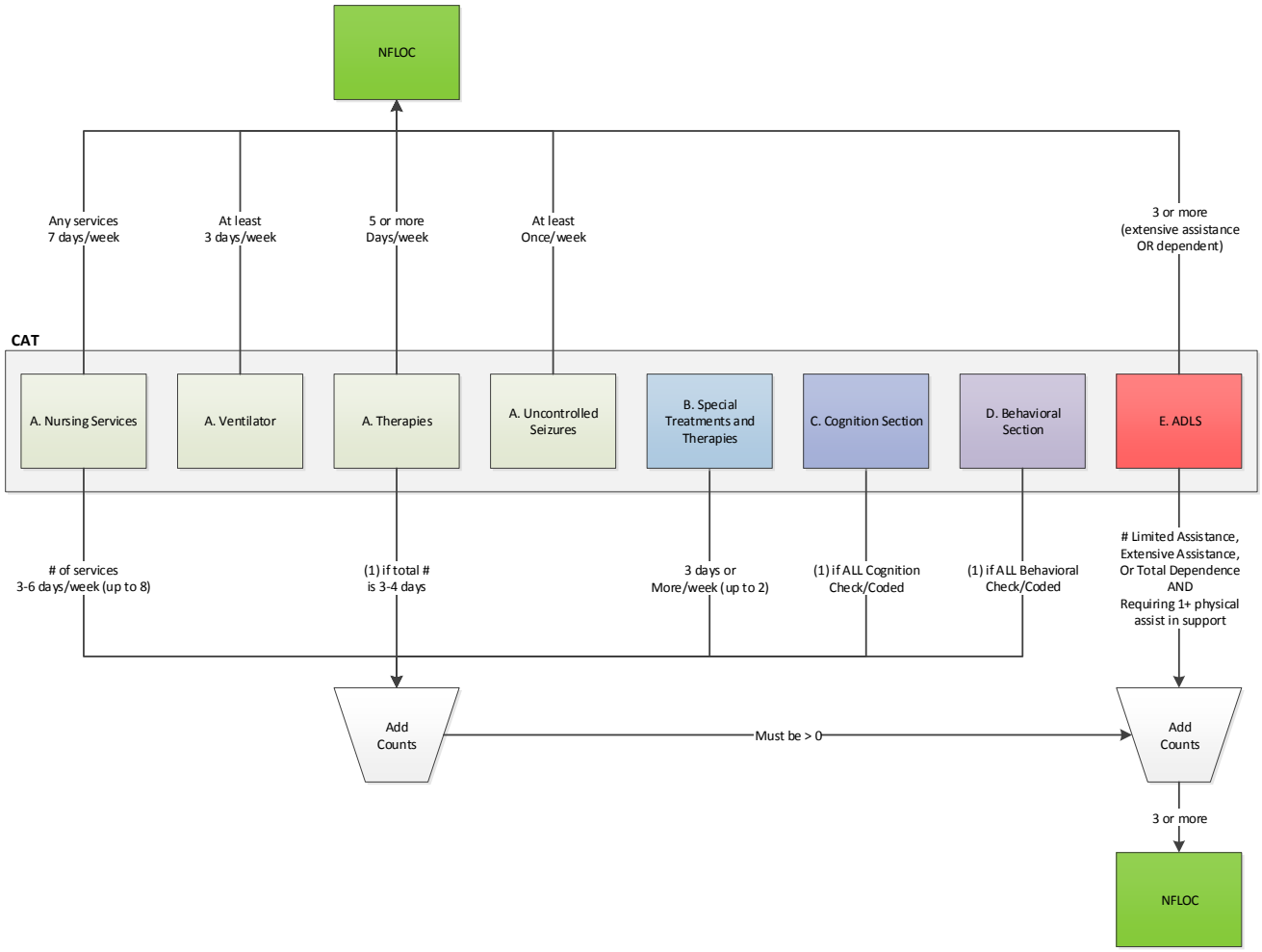
Participants who wish to enroll in Community First Choice (CFC) can meet either of these LOCs.

The following sections discuss these LOC in more detail.

NFLOC

To meet NFLOC, the participant must meet the criteria identified in the flowchart below. Participants can meet NFLOC by needing 1) substantial amounts of medical care or 2) extensive hands on assistance with three or more activities of daily living (ADL) (however needing assistance with bathing and dressing is not counted). Individuals can also meet NFLOC though different combinations of medical care, ADLs, behavior and/or cognition issues.

Nursing Facility Level of Care (NFLOC) Criteria



ICF/IID LOC

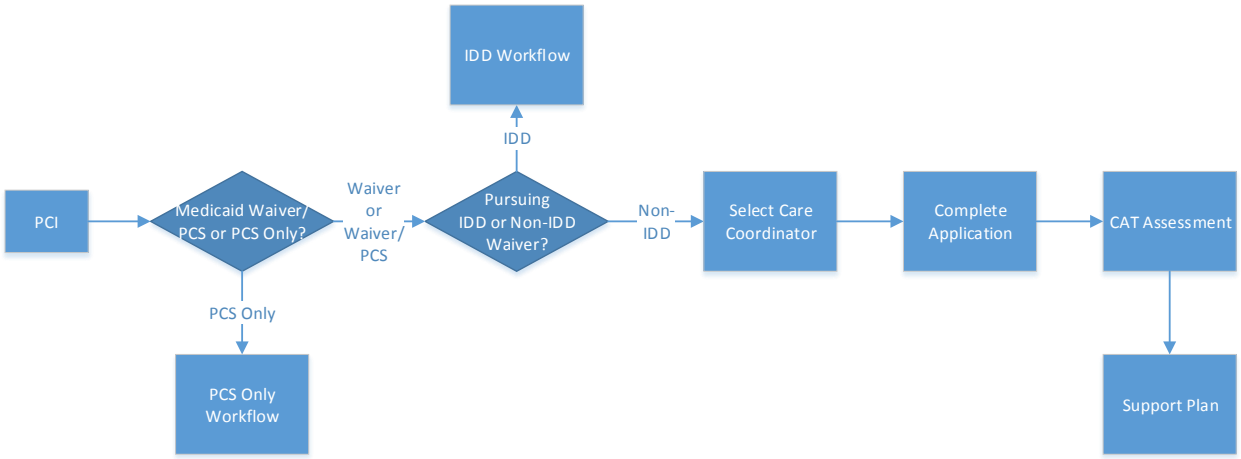
To meet ICF/IID LOC, the participant must require a combination and sequence of special, interdisciplinary, or generic assistance, supports or other services that are of lifelong or extended duration and are individually planned and coordinated. These services help the participant gain or maintain physical, sensory-motor, cognitive, affective, communicative and social skills. The participant must need significant coordinated supports to help him or her with mobility/motor skills, self-care/personal living, communication, learning, self-direction, social skills, life skills, community living and economic self-sufficiency and/or employment skills.

Waiver, CFC, and PCS Functional Eligibility Determination Process

Overview of the Processes

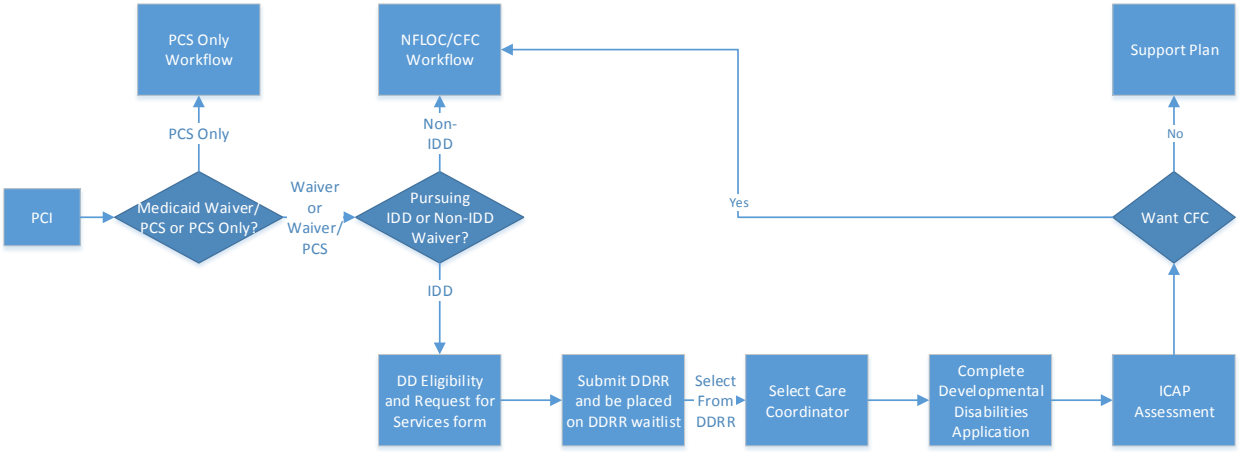
A flowchart and a brief description of the process for applying for PCS, the waivers, and CFC is provided below. More in-depth descriptions of each of the processes and tools after these workflows. Note that participant may apply to both a waiver and CFC.

Workflow for Enrolling in an NFLOC Waiver and/or CFC



After completing the PCI, if the participant is applying for a waiver that uses NFLOC and/or CFC, the ADRC/STAR worker should help the participant select a care coordinator. The care coordinator will help complete the waiver/CFC application. The care coordinator sends the application to SDS. SDS then conducts an assessment using the Consumer Assessment Tool (CAT) to determine if she or he meets NFLOC. This assessment will also assign CFC-PCS hours if the participant selects this option. The care coordinator receives the result of the CAT and develops the Person-Centered Support Plan (formerly known as the Plan of Care). The care coordinator submits the Support Plan to SDS for review and approval. Once SDS reviews the plan, it authorizes the hours.

Workflow for Enrolling in a DD Waiver

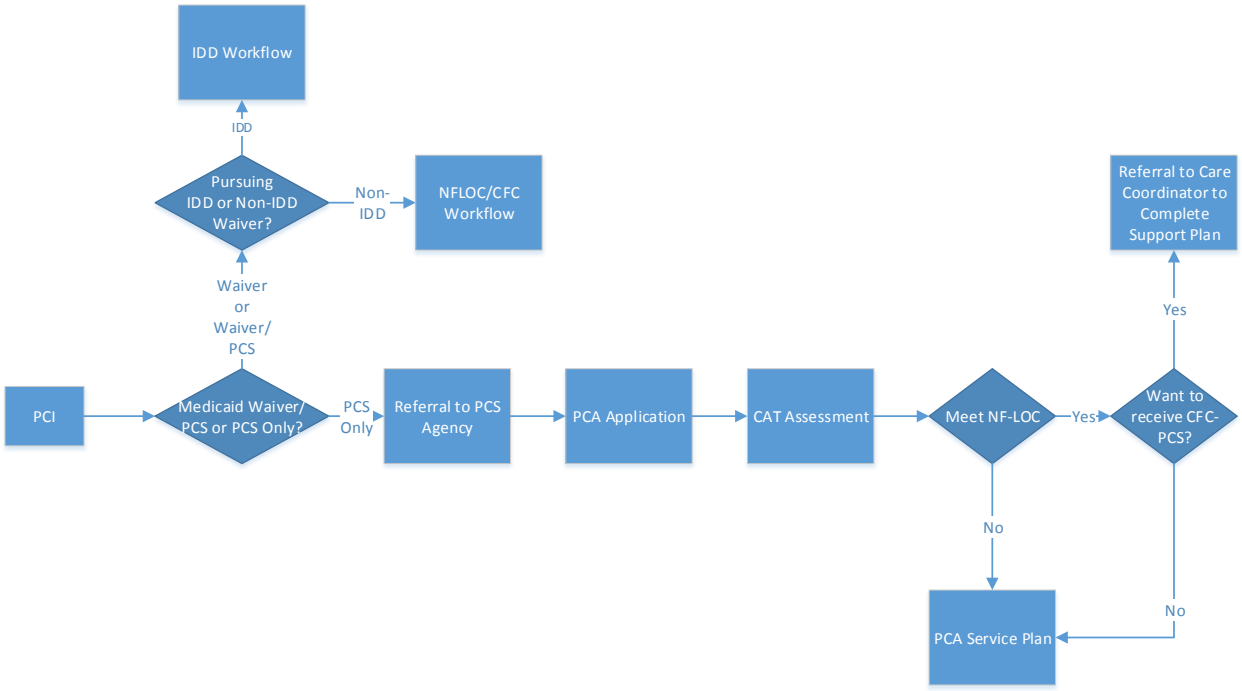


If a participant is applying for the ISW or IDD waiver, she or he will need to complete the Developmental Disability Determination (DDD) process. If they are determined to be DD eligible and want the IDD or IS waiver, they would complete the Developmental Disability Registration and Review (DDRR) form. If they are determined eligible and there is no waitlist for the ISW, they will be offered that Waiver. A worker at the STAR agency, which may be the staff conducting the PCI, can assist the participant in completing these

processes. Once a DDRR form is submitted, the participant is put on a waitlist that gives priority to those in the greatest need of services. Once a participant is selected from the waitlist, he or she selects a care coordinator, who completes the waiver application and submits it to SDS. SDS then conducts the Inventory for Client and Agency Planning (ICAP) tool. If the documentation verifies that the participant has a qualifying developmental disability and the results of the ICAP indicate that the participant meets the ICF/IID-LOC, the care coordinator works with the participant in developing a Support Plan, which is submitted to SDS. SDS reviews the plan and authorizes the hours. If a participant applying for one of these waivers also wants CFC-PCS hours, the care coordinator will notify SDS of this so that a CAT assessment can be conducted to assign CFC-PCS hours.

As of January 1, 2019 participants only interested in applying for CFC will need to start the application process through the PCI.

Workflow for Enrolling PCS Only



If the participant receiving the PCI only wishes to apply for PCS, he or she will be referred to a PCS agency. That agency will complete the PCS application. SDS will then conduct the CAT to determine if she or he meets the PCS requirements and determine the number of hours that can be assigned. If the CAT also determines that the participant meets NFLOC, the participant will be offered enrollment in CFC, which may provide additional hours. If the participant selects CFC-PCS, she or he will be connected to a care coordinator to develop a Support Plan.

Tools and Processes

Application

To initiate the process for eligibility determination and enrollment in waivers, participants must first complete an application. There are four types of applications:

- **Individualized Supports (IS) Waivers**- To apply for enrollment in an IS waiver, participants must first complete the Eligibility and Request for Services form. After this information is submitted, SDS will evaluate for eligibility for DD services. If eligible, the participant will then receive an approval letter of eligibility for ISW /DD services from SDS with instructions on how to apply.
- **IDD Waivers**- To apply for enrollment in an IDD waiver, participants must first complete the Eligibility and Request for Services form. After this information is submitted, SDS will evaluate for eligibility for DD services. If eligible, the participant will then receive an approval letter of eligibility for IDD/DD services from SDS with instructions on how to apply to be on the Alaska DD Registry.
- **Non-IDD Waivers**- To apply for enrollment in non-IDD waivers or to receive CFC while on an IDD waiver, participants must complete the Waiver Application, as well as several other pieces of information, including the Appointment for Care Coordination Services; Release of Information; Recipient Rights and Responsibilities; and Verification of Diagnosis. Participants applying for APDD must also provide proof of DD eligibility, which is the same process as for IDD waivers.
- **PCS**- If the participant is only applying for PCS, he or she will select a PCS provider agency, which will assist the participant with completing the PCS application. The PCS agency will then submit the application and request for assessment to SDS.

CAT Assessment

The CAT is the functional assessment that SDS uses to determine NFLOC eligibility and determine specific program criteria for resource allocation. The CAT involves a detailed functional assessment and observation of the participant, an interview with the participant, and consideration of supporting documentation. It is completed by an SDS Assessor. The Assessor uses the CAT to determine what the participant can do for him/herself and what kinds of hands on help has been needed within the last 7 days. Responses and observations are entered in each section of the CAT, which creates a numerical score for the different areas of functional skill.

The Assessor uses the CAT to determine LOC. Every CAT is reviewed by an SDS assessment supervisor prior to LOC determination. A care coordinator can attend the assessment appointment at the request of the applicant and/or legal representative.

DD Registry and ICAP

After the participant completes the DD Eligibility and Request for Services form and is determined to meet the DD criteria by SDS, he/she may apply for the IS waiver if there is not a waitlist. If there is a waitlist for the IS and IDD waivers the individual will complete the Developmental Disabilities Registration and Review (DDRR) form and be placed on

the DDRR registry for the IDD and IS waivers. SDS selects people from the registry based on their score for further assessment for enrollment into these waivers. After the participant is selected from the registry, he/she will select a care coordinator and complete/update their Developmental Disabilities Application and the ICAP assessment. These processes are further explained below.

Note: If a participant would like to enroll in both an IDD waiver and CFC, he/she will need to complete the CAT assessment in addition to the ICAP assessment.

DD Registry

After the participant has been determined to experience a developmental disability, the next step is to complete the DDRR form. This can be done with a STAR representative or the participant or his/her legal representative can submit the form on his/her own.

Once the participant has submitted his/her DDRR form, it will be scored and placed on the Developmental Disabilities Registry (also known as the "Wait List"). The DD Registry ranks applicants from the highest score (indicating greatest need for services) to lowest score (indicating lesser need) on the basis of the information provided on the DDRR. Highest scores are drawn from the Registry as funds become available. Participants drawn from the Registry will be notified with a certified letter (the "Notice to Proceed" letter) sent to the most current mailing address SDS has on file.

ICAP

The SDS assessment tool for determining ICF/IID-LOC is the ICAP. After SDS receives a complete application, they schedule an ICAP interview with each of the identified respondents.

The following are important points to note about the ICAP:

- The purpose is to identify adaptive and maladaptive behaviors, developmental strengths, the level of need for services, and other physical, health related or social concerns.
- An ICAP assessment is done once a year for children age two years eleven months to their seventh birthday.
- An ICAP is done every third year for applicants over age seven.
- Completed by an SDS QIDP (Qualified Intellectual Disability Professional).
- The actual assessment is an interview process with three respondents who know the applicant well.
- The care coordinator helps by identifying respondents to SDS using the form ***IDD-03 ICAP assessment information and consent.***
- Who is a good ICAP respondent?
  - An adult who knows the participant well. One of the respondents can be a parent or any adult living in the home, the others may be teachers, friends, staff, other family members, etc.
  - The SDS ICAP Assessor will use the information on the form to travel to the respondents, make appointments with them, and interview them.
  - The care coordinator should be ready to do more to help then just turn in the form:

- Helps the family and participant know what to expect
- Helps the family and participant identify alternate respondents for the ICAP if the individuals who are the first choice to respond not able to.
- Helps the participant identify good ICAP respondents. The SDS Assessor will visit each person and ask him or her a series of questions. This is the ICAP interview. The questions are about how the participant functions in daily life in different domains, such as physical abilities, social skills, and executive functioning.

After interviews are completed with all three respondents, SDS sends a letter of eligibility (or ineligibility) for DD waiver services. If the participant was found eligible for waiver services, the care coordinator will create the initial plan of care and submit it to SDS within 60 days.

Waiver/CFC Support Plan Development

All participants enrolling in a Medicaid waiver, including CFC, are required to complete a Support Plan. PCS only participants do not need to have a Support Plan. In the past, the Support Plan has been known as the Plan of Care.

The Support Plan is a person-centered process in which the participant, his/her legal representative, and others he/she chooses to include identify work with the care coordinator to identify the following:

- Personal goals
- Health and safety needs
- Habilitation goals
- Support preferences
- Availability of paid and unpaid supports
- How services can best meet goals and health and safety needs
- Selection of service providers
- Emergency back-up supports
- How to mitigate risks
- Whether a settings exception (e.g., restriction of access to food, the community, sharp objects, etc.) is appropriate
- Whether the participant would like to develop advance directives

Person-Centered Support Plan

The care coordinator will work with the participant and the participant's representatives to develop a Person-Centered Support Plan. The Support Plan will identify the participant's goal and be used to authorize services.

Individualized planning for each participant has now become the standard for all sorts of care plans, including the Support Plan. Because these are plans that reflect the participant's goals and service needs, no two plans should be the same.

The Centers for Medicaid & Medicare Services (CMS) requires Support Plans to be person-centered.

In 2014, CMS issued changes to the requirements regarding person-centered service plans for HCBS waivers under 1915(c) as follows:

- The person-centered Support Plan must be developed through a person-centered planning process
- The person-centered planning process is driven by the participant-
    - Includes people chosen by the participant
    - Provides necessary information and support to the participant to ensure that the participant directs the process to the maximum extent possible
    - Is timely and occurs at times/locations of convenience to the participant
    - Reflects cultural considerations/uses plain language
    - Includes strategies for solving disagreement
    - Offers choices to the participant regarding services and supports the participant receives and from whom
    - Provides a method to request updates
    - Conducted to reflect what is important to the participant to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
    - Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the participant
    - May include whether and what services are self-directed
    - Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others
    - Includes risk factors and plans to minimize them
    - Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the participant and his/her representative
- The Written Plan will reflect-
    - Opportunity to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS
    - Opportunities to seek employment and work in competitive integrated settings
    - The participant's strengths and preferences
    - Their clinical and support needs
    - Includes personal goals and desired outcomes
    - Providers of services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS
    - Settings chosen by the participant that are integrated in, and support full access to the greater community
    - Risk factors and measures in place to minimize risk
    - Individualized backup plans and strategies when needed

- Individuals important in supporting participant
- Individuals responsible for monitoring plan
- Plain language and be understandable to the participant and support providers
- Informed consent of the participant in writing
- Signatures of all individuals and providers responsible for services
- Distribution to the participant and others involved in plan
- Purchase/control of self-directed services
- The review and revision upon reassessment of functional need as required every 12 months, or when the participant's circumstances or needs change significantly, and at the request of the participant.

Waiver/CFC Support Plan Review

After the care coordinator submits the Support Plan to SDS, the SDS review team evaluates the Plan to determine whether it meets all the State and federal criteria and whether the services that are requested are appropriate for meeting personal goals and health and safety needs. SDS evaluates the following during this review:

- Recommended supports and services based on the assessment and whether these have been incorporated into the Plan
- Whether all necessary documentation has been included/completed
- Utilization and appropriateness of training and skills building, including habilitation goals
- Whether supports and services allow the participant to meet personal goals
- The schedule of supports and whether the requested supports are appropriate
- Adequacy of the risk mitigation plan

After the review is complete, SDS will either 1) approve the Support Plan, including authorizing services; and 2) request additional information, including documentation and justification of the recommended service hours, and send the Support Plan back to the care coordinator for amendments if all requests are not approved.

Overview of Service Options

Overview of Waiver, PCS, and CFC

The State offers five waivers for people with LTSS needs: ALI, APDD, CCMC, DD, and ISW. A participant may only enroll in one of these waivers at a time.

Personal care is provided through CFC if a participant meets an institutional LOC and State Plan PCS is available if a participant does not meet an institutional LOC. Participants cannot be enrolled in both CFC and PCS. However, a participant can be enrolled in one of the waivers and also receive CFC or PCS. It is unlikely that a participant will choose a waiver and PCS because CFC offers all of the benefits of PCS plus the potential for additional hours.

A participant who qualifies for both CFC and PCS may choose either program, however, CFC may provide additional hours and access to a care coordinator who will assist in developing a Person-Centered Support Plan. However, if a participant does not want or qualify for the additional hours and does not want to develop a Support Plan, the participant may choose PCS over CFC.

Alaskans Living Independently (ALI) Waiver

The Alaskans Living Independently (ALI) Medicaid waiver is intended to assist seniors 65 years of age and older or adults 21 years of age to 64 years of age who are physically disabled, and meet the NFLOC. The waiver, which is available statewide, includes the following services:

- Adult Day Care - Also referred to as Adult Day Services
- Care Coordination
- Respite Care - May be in-home or out-of-home, such as a nursing home or assisted living facility
- Chore Services - Scrubbing floors/walls, moving furniture, snow removal, chopping firewood, etc.
- Environmental Modifications - Also referred to as home modifications – Wheelchair ramps, grab-bars, walk-in tubs, etc.
- Meals - home delivered or served in a group setting
- Residential Supported Living - 24 hour care access in a setting that is not an institution, such as an assisted living facility
- Specialized Medical Equipment and Supplies
- Personal Emergency Response System
- In-home Specialized Private Duty Nursing
- Transportation - Medical and Non-Medical

ALI allows eligible participants to choose their own care providers, given the providers are qualified to provide such care. Care providers can be family members, including an adult child and in some cases, a sibling. Spouses are not able to provide care. However, there are some restrictions to this self-directed care.

It is not a requirement of the program that the participant live at home. They can reside in an assisted living community (more formally referred to as "residential supportive living"), but this may limit the range of services for which they are eligible. They cannot reside in a nursing home.

Adults with Physical and Developmental Disability (APDD) Waiver

Alaska Adults with Physical and Developmental Disabilities (APDD) is a Medicaid waiver intended for those 21 years of age or older with autism, an intellectual disability, or a developmental disability, which results in physical impairments. To qualify for this waiver, participants must meet the NFLOC and have a DDD (see above).

Examples of conditions that might qualify a participant for this waiver include cerebral palsy, spastic hemiplegia, intracranial injury, paraplegia, and quadriplegia. Participants of any age who have qualifying diagnoses that manifested before the age of 21 may qualify for this program.

The waiver includes the following services:

- Care Coordination
- Respite
- Chore
- Environmental Modifications
- Intensive Active Treatment
- Specialized Medical Equipment
- Meals (home-delivered)
- Specialized Private Duty Nursing
- Residential Habilitation
- Residential Supported Living
- Day Habilitation

Children with Complex Medical Conditions (CCMC) Waiver

The CCMC waiver is intended for children ages 0-21 who are medically fragile and/or technology dependent and meet NFLOC. CCMC Provides:

- Care Coordination
- Day Habilitation
- Residential Habilitation
- Respite
- Supported Employment
- Chore
- Environmental Mods
- Intensive Active Treatment
- Meals
- Nursing Oversight and Care Management
- Specialized Medical Equipment
- Transportation

Intellectual & Developmental Disabilities (IDD) Waiver and the Individualized Supports Waiver (ISW)

The IDD and ISW waivers are intended for participants with intellectual and developmental disabilities who 1) are determined through the Developmental Disability Determination Application to experience a developmental disability; 2) meet ICF/IID LOC criteria; and 3) are enrolled in Medicaid.

The Individualized Supports Waiver (ISW) was developed to replace the Community Developmental Disabilities Grant (CDDG) program. The ISW will also extend supports to participants who had not been covered by the grant program.

The primary differences between the ISW and the IDD waiver are 1) the ISW does not offer extensive out of home supports, such as a group home and 2) the ISW has an annual cost limit of up to $17,500. This means participants are able to have "buying power" up to $17,500 each year. This cost limit does not include the cost of care coordination. Participants can also receive services above the cost limit if they have a temporary emergency, such as a loss of a caregiver or a medical event. These emergency benefits must not exceed $5,000 over a three-year period.

ISW participants can access other services and supports from other sources that, in combination with waiver services, are sufficient to assure the participant's health and welfare, and inclusion in the community.

The table below compares the services offered on the IDD waiver and the ISW.

Comparison of IDD and ISW Waiver Services

Service	IDD Waiver	ISW
Care Coordination*	X	X
Residential Habilitation (4 services)		
• Family Habilitation	X	
• Group Home	X	
• In-Home Supports < 18	X	X (limited)
• Supported Living >18	X	X (limited)
Day Habilitation	X	X
Respite	X	X
Supported Employment	X	X
Chore	X	X
Environmental Modifications	X	
Meals	X	
Nursing Oversight and Care Management	X	
Specialized Medical Equipment	X	
Specialized Private Duty Nursing	X	
Transportation	X	X

*Care Coordination on the ISW is in addition to the participant's cost limit.

State Plan Personal Care Services (PCS)

State Plan PCS is available to all participants who are eligible for Medicaid. Participants do not have to meet NFLOC or enroll in a waiver. PCS provide support related to a

participant's ADLs (i.e. bathing, dressing, eating) as well as IADLs (i.e. shopping, laundry, light housework). PCS is provided statewide in Alaska through private agencies.

There are two models for PCS:

- **Agency-Based PCS Program (ABPCA)**- Participants may receive services through an agency that oversees, manages and supervises their care.
- **Consumer-Directed PCS Program (CDPCA)**- Each participant may manage his or her own care by selecting, hiring, firing and supervising their own personal care assistant. The agency provides administrative support to the consumer and the personal care assistant.

Community First Choice (CFC)

CFC is a new program that is part of the Medicaid reform initiative also known as 1915(k). CFC provides personal care services and other supports in the recipient's home as an alternative to institutional care. All recipients who currently meet an institutional level of care and receive both home and community based waiver services and PCS have predetermined eligibility. Participants may be enrolled in both a Medicaid waiver and CFC at the same time.

New participants will need to meet all three of the following criteria to be eligible for CFC:

- They will need to be enrolled in Medicaid. Unlike a 1915(c) waiver, CFC cannot be used to establish eligibility for Medicaid.
- They will need to have income that is less than or equal to 150% of the federal poverty level (FPL) unless they are enrolled in a 1915(c) waiver. In these cases, the income and asset limits for the waiver apply.
- They need to meet Alaska's level of care (LOC) criteria for at least one of the following institutions:
    - Nursing Facility (NFLOC)
    - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID-LOC)

CFC includes the following services:

- **Community First Choice Personal Care Service (CFC/PCS)**- The benefit of PCS under CFC is the same as State Plan PCS except that participants will receive a limited number of hours if they only need supervision or cueing on a particular ADL or IADL and meet the CFC eligibility criteria. Participants requiring supervision or cueing only with 2-3 ADLs/IADLs will receive 3 hours of support per week. Participants requiring supervision or cueing only with 4 or more ADLs/IADLs will receive 6 hours of support per week. The need for supervision or cueing must be related to a cognitive impairment which causes behavior issues.
- **Maintenance and Acquisition of Skills training**- To foster greater independence among the participants enrolled in CFC, the program supports the

acquisition, maintenance, and enhancement of skills that allow participants to be more independent in completing ADLs, IADLs, and health related tasks. This service may be utilized if the participant or the participant's representative chooses supporting maintenance and acquisition of skills as a person-centered goal. The service includes:
    - Training for PCS workers about how to foster independence
    - An increase in the number of hours provided for PCS for up to three months to allow these workers to spend more time fostering independence
- **Training for participants to select and manage CFC/PCS attendants-** CFC participants are offered voluntary training on how to select, manage, and dismiss attendants.
- **Emergency Response Systems-** All waiver Emergency Response Systems services have been folded into CFC. Participants wishing to enroll in the service must access the service through CFC.

Participant Directed Services

If the participant has a functional impairment with an ADL or IADL, he/she may be eligible to direct his/her own supports through the participant-directed services program. Participant directed services are provided through PCS and CFC-PCS. The participant or participant's authorized representative must demonstrate the ability to direct the participant's PCS.

Participants who meet the criteria for participant-directed PCS may choose the staff who provide PCS and are in charge of hiring, training, managing, and firing staff. Participants may choose to designate an authorized representative to manage these responsibilities.

Support staff need to be age 18 or older, able to pass the state and national fingerprint and background check, have current 1st Aid and CPR training, and be physically able to do the work. Support staff also need to be able to document the care that they have provided and fill out basic forms, like a timesheet.

Grant and Other Local Services

SDS makes grants to nonprofit organizational partners across Alaska. These partners use the funds to provide vital community based supportive services to families and participants experiencing Alzheimer's Disease and Related Disorders (ADRD), family caregivers of seniors aged 60 and over, grandparents raising grandchildren aged 55 or over, seniors aged 60 and over, individuals who have experienced a traumatic brain injury, and/or frail or disable seniors who need assistance in the home.

These services are available to participants who are waiting or do not qualify for HCBS under the Medicaid waiver program, or who only require minimal supports that can be provided by the grant services. These grants are awarded to agencies every three or four years through a competitive process. Funding for these programs comes from the U.S.

Administration on Aging, the Alaska Mental Health Trust Authority, and state general funds.

More information about grant services can be found at
http://dhss.alaska.gov/dsds/Pages/grantservices/default.aspx

Available Resources to Find Out More About Programs

https://akaccesspoint.com/SitePages/Home.aspx

Participant Rights

Participants have the following rights when the assessment is conducted and their Support Plan is developed:

- The right to file a complaint or to appeal the contents or results of the assessment and Support Plan.
- The right to choose any programs and service that the participant is eligible for. However, he/she may only be enrolled in one HCBS waiver at a time, with the exception of CFC.
- The right to choose and change to any willing and qualified Medicaid service provider in the service area where the participant lives. However, the service provider may choose not to serve the participant.
- The right for the participant to choose and change his/her Care Coordinator.
- The right for the participant to choose where he/she lives, including receiving supports in his/her own home, a residential setting, or an institution. However, the participant is responsible for paying for his/her own room and board. This will limit where he/she can live in most cases.
- The right to decline services that they do not wish to receive.

Reporting Mistreatment

What must be reported to Adult Protective Services?

Any incident in which a vulnerable adult suffers harm from abandonment, abuse, exploitation, neglect or self-neglect.

ABANDONMENT is the desertion of a vulnerable adult by a caregiver.

ABUSE is the intentional, knowing, or reckless non-accidental, non-therapeutic infliction of pain, injury, mental or emotional distress, or fear, including coercion and intimidation, and sexual assault.

EXPLOITATION is the unjust or improper use of another person or another person's resources for one's own profit or advantage, with or without the person's consent and includes acts by a person who stands in a position of trust or confidence with a vulnerable adult or who knows or should know that the vulnerable adult lacks the capacity to consent

that involve obtaining profit or advantage through undue influence, deception, fraud, intimidation, or breach of fiduciary duty.

NEGLECT is the intentional knowing or reckless failure by a caregiver to provide essential care or services or access to essential care or services to carry out a prescribed treatment plan necessary to maintain the physical and mental health of the vulnerable adult when the vulnerable adult is unable to provide or obtain the essential care or services or to carry out the prescribed treatment plan on the vulnerable adult's own behalf; in this paragraph, "essential care or services" includes food, clothing, shelter, medical care, and supervision.

SELF-NEGLECT is the act or omission by a vulnerable adult that results, or could result, in the deprivation of essential services necessary to maintain minimal mental, emotional, or physical health and safety.

UNDUE INFLUENCE means the use by a person who stands in a position of trust or confidence of the person's role, relationship, or authority to wrongfully exploit the trust, dependency, or fear of a vulnerable adult to gain control over the decision making of the vulnerable adult, including decision making related to finances, property, residence, and health care.

To Whom Should Reports be Made?

Reports should be made to Adult Protective Services within 24 hours. Reports of suspected abuse of a vulnerable adult may also be made to 1-800-478-9996.

Detailed Review of the PCI

This section provides a detailed review of each of the sections and items within the PCI. Within the tables below, the PCI item can be found in the left column and guidance for the item is contained within the right column. In the SAMS system, items marked with a red asterisk (*) are mandatory items.

Section I: Participant, Representative, and Decision Support Information

Section I collects demographic information about the participant, information about others providing support during the Support Planning meeting, and if the participant has a representative who has legal authority for the participant, such as a guardian or power of attorney, information about the representative. Prior to completing this section, the worker should search for the participant in the SAMS system to determine if a record has already been established. If the participant already has a record, verify that the information is correct.

Assessment Item	Guidance
Section I: Participant, Representative, and Decision Support Information	
I.A. Participant Information	
1. Participant's Name:_____ **2. Participant's Medicaid Number:_____** **3. Participant's date of birth:_____** **4. Participant's age:_____**	Items 1-4 capture identifying information about the participant.
5. Participant's primary phone number:_____ **6. Participant's secondary phone number:_____** **7. Participant's email address:_____**	Document contact information for the participant.
8. Gender ❍Male ❍Female	Identify the gender that the participant identifies as. This may be different than the sex that was identified at birth.
9. Current health care coverage: ☐ Medicaid ☐ Medicare ☐ VA ☐ Private Insurance ☐ IHS ☐ Other:_____ ☐ None	Identify the types of health care coverage the participant currently has. Check all that apply.
10. Participant household size:_____	Identify the number of individuals who live in the same household as the participant. Include the following individuals: • Spouse if legally married • Someone who is a tax dependent
11. Approximate total monthly income:_____	Enter the approximate monthly income across all income sources. These may include: • Employment • Social Security • Supplemental Security Income (SSI) • Pension/retirement income • Veteran's military benefits • Rental property income • Temporary disability insurance • Worker's compensation

Assessment Item	Guidance
Section I: Participant, Representative, and Decision Support Information	
I.A. Participant Information	
	• Unemployment
12. Approximate total assets:_____	Enter the approximate value of the participant's assets, including: • Checking accounts • Savings accounts • Cash • Stocks, bonds, money markets, IRAs • Real estate beyond the participant's home
13. Participant is likely eligible for Medicaid based on income and assets. ❍ No ❍ Yes	Identify whether the participant potentially meets the income and asset requirements for Medicaid and/or LTC Medicaid eligibility. The breakdown of household size and income, for potential Medicaid eligibility, can be found on the ADRC website at: http://dhss.alaska.gov/dsds/Pages/adrc/default.aspx If "Yes" and participant is not already enrolled in Medicaid, provide a referral to complete a Medicaid application or provide in-person support.
14. Participant is likely eligible for Long Term Care (LTC) Medicaid based on income and assets. ❍ No ❍ Yes	
15. Is the participant homeless? ❍ No ❍ Yes (Skip to 28)	Use item 15 to document whether the participant is homeless. If participant is homeless, discuss whether he/she would like more information about housing and homelessness services. If so, provide the information and document the I&R provided in section VI. If the participant is homeless, skip to item 28.
16. Home address:_____ **17. City:_____** **18. State:_____** **19. Zip code:_____** **20. Is participant's current residence a facility or assisted living home?** ❍ No (Skip to 22) ❍ Yes	Document the participant's home address and, if different from the home address, the mailing address. The term "home" refers to where the participant permanently lives.

Assessment Item	Guidance
Section I: Participant, Representative, and Decision Support Information	
I.A. Participant Information	
21. Name of facility:_____ **22. Mailing address (if different than home address):**_____ **23. City:**_____ **24. State:**_____ **25. Zip code:**_____	If the participant is living in a facility, identify the name of the facility in item 21. If he/she will live in a facility for the foreseeable future, provide the address as the home address. Use items 22-25 to document the participant's mailing address only if it is different than his/her home address.
26. Living arrangement: ❍ Alone ❍ With spouse/partner only ❍ With spouse/partner and other(s) ❍ With child (not spouse/partner) ❍ With parent(s) or guardian(s) ❍ With sibling(s) ❍ With other relative(s) ❍ With nonrelative(s)	Identify whether the participant lives alone or with other individuals. If the participant lives with other individuals, identify their relationship to him/her.
27. Are there any safety concerns about the current living arrangement? ❍ No (Skip to item 28) ❍ Yes **27a. Describe the safety concerns:**_____	Identify whether the participant, caller, and/or decision support have concerns about the participant's safety in the current living arrangement. Safety may be related to the participant's ability to function in the residence independently, such as ability to safely get around the home; unsafe home or apartment, including concerns about stability of the physical structure of the house, heating/cooling, or cleanliness; or related to an unsafe neighborhood or roommates. If there are safety concerns, document the concerns in item 27a.
28. Marital status: ❍ Single ❍ Married ❍ Divorced ❍Domestic partner	Document the participant's marital status.
29. Participant is a resident of Alaska. ❍ No ❍ Yes	Identify if the participant currently lives in Alaska and is an Alaska resident.

Assessment Item	Guidance
Section I: Participant, Representative, and Decision Support Information	
I.A. Participant Information	
30. Ethnicity- Hispanic or Latino ❍ No ❍ Yes	Indicate whether the participant identifies his/her ethnicity as Hispanic or Latino
31. Participant's race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other	Identify the race the participant identifies as. Check all that apply.
31a. If participant is AK Native or American Indian: Name of primary care provider:_	If the participant selected "Alaska Native" or "American Indian" in item 31, document the name of his/her primary care provider if known.
31b. If participant is AK Native or American Indian: Name of THO:_____	Identify the name of the Tribal Health Organization (THO) that the participant's primary care provider works for. If the provider does not work for a THO, enter "None".
32. Participant's primary language: ❍ English ❍French ❍ American sign language ❍ Hmong ❍ Korean ❍ Russian ❍ Spanish ❍ Tagalog ❍ Yupik ❍ Other **33. Does the participant need an interpreter?** ❍ No ❍ Yes	Identify the participant's primary language and whether she/he needs an interpreter to actively participate in the intake and any subsequent processes, such as assessment and Support Planning. An interpreter can be either a sign language interpreter or a translator. A participant may request an interpreter even if he or she speaks English as a secondary language if the participant is not comfortable discussing complex issues in English.
34. Participant is a Trust Beneficiary. ❍ No (Skip to 36) ❍ Yes **35. Identify Trust Beneficiary type:** ☐ Alzheimer's Disease & Related Dementias (ADRD) ☐ Mental illness	Identify whether the participant is a beneficiary of Alaska Trust funds/programs. If yes, identify the type of beneficiary in Item 35.

Assessment Item	Guidance
Section I: Participant, Representative, and Decision Support Information	
I.A. Participant Information	
☐ Developmental disability ☐ Chronic alcoholism and other substance abuse disorders ☐ Traumatic brain injury (TBI)	
36. Participant is a US Veteran. ❍ No [Skip to item 38] ❍ Yes **37. Caller/participant is interested in learning more about Veteran funded services.** ❍ No ❍ Yes	Identify if the participant is a US veteran. If "Yes", identify if he/she would like to learn more about services funded by the VA, such as the Veteran-Directed Home and Community Based Services (VD-HCBS) program.
38. Participant has a guardian or other legally authorized representative. ❍ No (Skip to Item 49) ❍ Yes	Identify if the participant has a person who acts as a legal decision maker for. A full list of representative types is included in item 47.
39. Name of Authorized Representative:_____ **40. Primary phone number:_____** **41. Secondary phone number:_____** **42. Email address:_____**	Items 39-46 gather the name and contact information about the legally authorized representative.
43. Mailing address:_____ **44. City:_____** **45. State:_____** **46. Zip code:_____**	Provide the mailing address of the participant's legal representative.
47. Representative type (Attach documentation showing representative's authority to act for the recipient): ❍ Parent ❍ Power of Attorney ❍ Guardian ❍ Delegated Parental Authority ❍ Representative Payee ❍ Conservator ❍ Unknown ❍ Other **48. Caller informed that representative needs to provide documentation as part of the application.** ❍ No ❍ Yes	Identify the type of legal decision-making capacity that the representative has in Item 43. If available, upload documentation of this capacity into the participant's record. If not, ensure that the representative is aware that this information needs to be verified prior to completing an application for a Medicaid waiver (if that is the route he/she chooses) using Item 44. Types of decision making authority are defined below: • **Power of Attorney**- a legal document that allows the principal to give authority to another person, the agent, to act on their behalf in

Assessment Item	Guidance
Section I: Participant, Representative, and Decision Support Information	
I.A. Participant Information	
	a legal capacity. • **Guardian -** an individual at least twenty-one years (21) of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated participant pursuant to appointment by a court. Guardianship may include limited, emergency or temporary substitute court appointed guardian but not a guardian ad litem. • **Delegated Parental Authority (DPA) -** An individual legally authorized to make decisions for another individual's child. The parent of the child is also still able to make decisions for their child. • **Representative payee** - a person or agency chosen by the Social Security Administration to receive and manage the recipient's social security or supplemental security income (SSI) benefits for the recipient who cannot manage his or her own money. • **Conservator** - a person at least 21 years of age who has been appointed by a court to manage the financial affairs of another person.
49. Participant has a decision support who is assisting with completing the PCI. ❍ No ❍ Yes, decision support is not a legally authorized representative (e.g., guardian, POA) (Skip to Item 51) ❍ Yes, decision support is a legally authorized representative (e.g., guardian, POA) (Skip to Section II)	Identify whether the participant has someone helping him/her complete the PCI. This includes staff or other individuals working with the participant to complete the PCI during the call or in-person appointment. If there is a decision support, identify whether he/she is the legally authorized representative. If so, this support information has been previously documented and the remainder of this

Assessment Item	Guidance
Section I: Participant, Representative, and Decision Support Information	
I.A. Participant Information	
	section can be skipped. If the support is not a legally authorized representative, skip to item 51 to briefly capture information about this individual. If the participant is completing the PCI independently, select "No" and proceed to item 50.
50. Would the participant like assistance in making decisions about their health and safety during the Assessment and Support Planning process? ❍ No ❍ Yes **50a. Describe the assistance requested:_____** Skip to Section II	Discuss with the participant the responsibilities and tasks that must be completed during the Assessment and Support Planning process and determine whether he/she would like other support throughout this process, such as the involvement of a family member, friend, or advocacy agency. If he/she would like this support, document who should be involved, how they should help, and whether a referral is necessary. After completing item 50, skip to Section II.
51. Decision support name:_____ **52. Relationship to participant:** ❍ Spouse ❍ Parent/Non-guardian ❍ Partner/Significant Other ❍ Friend ❍ Neighbor ❍ Independent Advocate ❍ Other relative ❍ Other informal helper ❍ Service/provider agency	Identify the name and relationship of the individual who is providing the participant with support in completing the PCI.

Section II: CCMC Status

This section identifies participants who potentially qualify for the Children with Complex Medical Conditions (CCMC) waiver. Participants enrolling in CCMC must be age 21 or younger, and Item 1 allows the entire section to be skipped if the participant does not meet this criterion.

Items within this section are complex and may be challenging for the worker to interpret and communicate to the participant. This handbook provides examples and definitions. All the items in this section must be marked "Yes" for the participant to potentially meet the CCMC eligibility criteria. If the worker is unsure about whether the criteria in the item have been met, the worker should select "Yes" so that further review and assessment can occur, rather than selecting "No" and screening the participant out of the waiver. The section is automated so that once a "No" response is selected, the remaining items in the section are skipped. All items are indicated as mandatory, however items that the system shows should be skipped are not mandatory.

With the exception of Item 1, each item is followed by a text field to capture a description of the information that the caller shared. This information will help inform the application and determination of eligibility for the CCMC waiver.

Assessment Item	Guidance
Section II: CCMC Status	
1. Is the participant age 21 years of age or younger? ❍ No [Skip to Section III] ❍ Yes	The CCMC waiver is only available to participants age 21 and younger. If the participant is older than 21, mark "No" and skip the remainder of the section.
2. Physician or other medical provider has suggested applying for CCMC and/or the participant may have complex medical needs. ❍ No [Skip to Section III] ❍ Yes	For this item, focus on whether a medical provider has suggested CCMC as an option for the participant and/or if the participant has complex medical needs, such as multiple diagnoses that impact functioning, health, and/or safety; medical dependency on equipment and technology; and medical issues that require regular daily monitoring.
3. Does the participant have a severe chronic physical condition that would result in long-term care in a facility for more than 30 days per year? ❍ No [Skip to Section III] ❍ Yes	A severe chronic physical condition is a physical disease that is persistent or long lasting in its effects, and when it occurs can result in admission to a hospital or nursing home.

4. Does the participant have a severe and chronic physical condition, which results in a prolonged dependency on medical care to maintain health and welfare OR Does the participant have a severe and chronic physical condition, which results in prolonged dependency on technology (device or instrument to replace or support a normal bodily function) to maintain health and welfare? ❍ No [Skip to Section III] ❍ Yes	A severe chronic physical condition is a physical disease that is persistent or long lasting in its effects. Identify if the condition requires frequent appointments or visits to the hospital, doctor's office, and/or medical provider to maintain health AND/OR if the participant's chronic physical condition creates a continued dependence on a machine or device to maintain health and safety. Examples of these include feeding tube for nutrition and ventilator for breathing.
5. Does the participant experience acute exacerbations or life-threatening conditions? ❍ No [Skip to Section III] ❍ Yes	Identify whether a flare-up or aggravation of the participant's chronic physical condition could be life threating and/or result in a hospitalization.
6. Does the participant need extraordinary supervision and observation beyond what is considered appropriate for age and/or stage of development? ❍ No [Skip to Section III] ❍ Yes	Compared to a participant of a similar age and/or stage of development who does not have a chronic physical condition or other disability, identify whether the participant needs additional monitoring and supervision because of a medical issue.
7. Does the participant need frequent or life-saving administration of specialized treatments, or dependency on mechanical support devices? ❍ No [Skip to Section III] ❍ Yes	Identify whether the participant needs continued use of medications, devices, or specialized treatments to support normal bodily functions AND not having measures would be life threatening.

Section III: DD Status

Section III identifies whether the participant potentially has a developmental disability (DD) and potentially meets the criteria to apply for one of the State's DD waivers.

Assessment Item	Guidance
Section III: DD Status	
1. Participant potentially experiences DD. ❍ No [Skip to Section IV]	If the caller has already said something that indicates that the participant has a developmental disability, select "Yes".

Assessment Item	Guidance
Section III: DD Status	
❍ Yes	If this a developmental disability was not clearly ruled out earlier in the conversation, ask questions to determine how to respond to this item. It is important to not to assume that some participants do not qualify as having a developmental disability. For example, an adult who had a major accident as a teenager might qualify according to the State's definition. Alaska State Law defines DD as *"a person who is experiencing a severe, chronic disability that:* *A) is attributable to a mental or physical impairment or combination of mental and physical impairments;* *B) is manifested before the person attains age 22;* *C) is likely to continue indefinitely;* *D) results in substantial functional limitations in three or more of the following areas of major life activity:* *• self-care* *• receptive and expressive language* *• learning, mobility* *• self-direction* *• capacity for independent living* *• economic self-sufficiency; and* *E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated"*
2. Participant has established DD eligibility. ❍ No, participant has not applied or has applied but not received a response [Skip to 7]	To have established DD eligibility the participant must 1) meet the DD criteria identified in Item 1; 2) Submit a current Developmental Disabilities Registration and Review (DDRR) form that has been scored and placed on the Registry; 3) Meet Alaska's level

Assessment Item	Guidance
Section III: DD Status	
❍ No, participant has previously been denied but would like to reapply [Skip to 7] ❍ No, participant has previously been denied and should be referred for non-DD services [Skip to Section IV] ❍Yes	of care (LOC) criteria for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID LOC); 4) and be enrolled in Medicaid. If the participant is unsure whether he/she has established DD eligibility with the State, the worker should search and confirm his/her status in the Harmony system. If the participant has not applied for DD eligibility or has not received a determination, select the first option. If the participant has applied for DD eligibility and been denied, however would like to reapply and explore DD service options, select the second option. If the participant has applied for DD eligibility and been denied, and would like to learn more about non-DD options, such as the ALI waiver or State Plan personal care services, select the third option.
3. Harmony case number:_____ **4. Eligibility approval date:_____** **5. Eligibility expiration date:_____** **6. Participant has a current DDRR.** ❍ Yes ❍ No	This information can be found in the Harmony system. To access the information, screeners must submit an inquiry. After completing items 3-6, skip to Section IV.
7. Is the participant receiving or has the participant received special education to address learning needs through an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) prior to the age of 22? ❍ No ❍ Yes	Note that this item should ONLY be marked "Yes" if the IFSP and IEP was intended to address learning needs, including adaptive needs. IFSPs and IEPs can be used to address many other issues, including behaviors, and this item should only indicate "Yes" if the Plan included support with addressing learning needs.

Assessment Item	Guidance
Section III: DD Status	
	If the participant is currently in school, ask if he/she currently or has received an IFSP or IEP. If the participant is not in school, ask if he/she received either of these plans prior to the age of 22.
8. Has the participant received therapy or special instruction to help with speech/language skills or to help them communicate with others? ❍ No ❍ Yes	This includes the utilization of a speech language therapist or other qualified professional to be able to communicate with others and understand what is communicated to him/her.
9. Has the participant received therapy or special instruction to help them move better? ❍ No ❍ Yes	Mobility is the physical ability of an individual to ambulate themselves. Mobility support professionals include physical and occupational therapists. This response should include considerations for physical mobility issues, such as not being able to walk up/down stairs, as well as cognitive mobility issues, such as not being able to navigate a bus route or use street signs to cross a road.
10. Has the participant received therapy or special instruction to help them learn to do things like dress or feed themselves, or complete personal hygiene? ❍ No ❍ Yes	Identify if the participant received support from a physical or occupational therapist or other qualified professional to help him/her complete ADL tasks.
11. Is the participant currently enrolled in an education program? ❍ No ❍ Yes (Skip to Item 13)	Education programs include pre-school, kindergarten, elementary, middle, and high school as well as college and technical training.
12. Has the participant ever received help from a job coach or received services to help find or keep a job? ❍ No ❍ Yes	Identify if the participant has ever needed support from a job coach (a person who provides in-person or remote support to learn and manage employment tasks) or receive supportive services, such as supported employment or disability-specific job services, to find or keep a job.
13. Is the participant age 15 or younger?	This item is used to inform the algorithm around potential DD eligibility.

Assessment Item	Guidance
Section III: DD Status	
❍ No ❍ Yes (Skip to Section IV)	
14. Does the participant have someone who helps them make decisions about their money or where they want to live like a guardian or conservator? ❍ No ❍ Yes	Identify if the participant has someone legally authorized to help them make decisions, such as a guardian, power of attorney (POA), or conservator.

Section IV: Exploring Options & Level of Care (LOC) Screen

Section IV identifies if the participant is interested in pursuing Medicaid funded HCBS. If the participant is interested, a screen is completed to determine if the participant potentially meets NFLOC. All items in this section are mandatory unless they are skipped.

Before completing the items within this section, the worker should have a conversation with the participant about all of his/her service and support options, including Medicaid waiver and State Plan services, grant funded services, private pay options, and supports paid for by other sources, such as a local mill levy or local agency. For example:

Ted, it sounds like you would like some help with dressing, making meals, and keeping your house clean. There are several options for receiving this help. One option is services and supports funded by Medicaid. You will need to be enrolled in Medicaid to receive these services, and I can ask you a few questions today to see if you might be eligible for them. Another option is supports that you or your family can pay for. This might include hiring an agency to deliver or make you meals and clean your house. Another option is to connect you directly with agencies that can provide support that you or your family can pay yourselves. We can also try to identify other options that do not require you to apply for Medicaid, such as getting more help from other family members or your church. What would you like more information about?

Assessment Item	Guidance
Section IV: Exploring Options & Level of Care (LOC) Screen	
1. Participant is interested in Medicaid funded HCBS and/or PCS. ❍ No (Skip to Section V) ❍ Yes, already enrolled in Medicaid ❍ Yes, need to enroll in Medicaid	Based on the conversation about service and support options, identify if the participant is interested in receiving services and supports through Medicaid waivers and/or PCS. If he/she is, identify if he/she is currently enrolled in Medicaid. If not, in Section V, document the need to apply for Medicaid.

Assessment Item	Guidance
Section IV: Exploring Options & Level of Care (LOC) Screen	
2. Participant receives nursing services (e.g., wound care, tube feeding, uncontrolled diabetes) at least one day a week. ❍ No ❍ Yes	Other examples of nursing services include tracheostomy care, ventilator care, and intravenous medications. Help which the participant or a family member can provide should not be counted (e.g., taking pills, changing a catheter bag).
3. Participant receives skilled therapies, including physical, occupational, speech, or respiratory, a total of three or more times per week. ❍ No ❍ Yes	These therapies must be provided by a licensed professional.
4. Challenges with participant's thinking: ☐ **None** ☐ **Orientation-** Difficulty knowing time, where he/she is, and why he/she is there ☐ **Short Term-** Problems remembering new information ☐ **Confusion-** Often confused ☐ **Conversation-** Difficulty conversing with others ☐ **Making needs known-** Difficulty making personal needs known	Check all that apply. The response should be checked if a family member or guardian indicates that there is a potential issue or if the worker is unsure about whether an issue exists.

Items 5 and 6 capture information specific to the support needs of the individual around Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Within the PCI, ADLs include:

- Bed Mobility- Moving around bed, adjusting position
- Transferring- Moving between different surfaces, bed, chair, etc.
- Locomotion- Moving around residence
- Eating/Drinking
- Toileting- Using, transferring, changing
- Personal Hygiene- Personal hygiene care
- Bathing
- Dressing- Getting dressed/undressed

IADLs include:

- Light meal preparation
- Main meal preparation
- Light housework
- Routine housework
- Laundry
- Shopping

There are three response options for each ADL/IADL:

- **Independent-** Able to accomplish ADL/IADL without intervention from staff or family
- **Minimum or Stand-by Assist-** Participant can complete ADL/IADL with verbal reminders or stand-by assistance. Participant may require set-up or clean-up assistance with activities such as bathing, personal hygiene, or meal preparation.
- **Hands-on or Total Assist-** Participant usually or always needs hands on assistance from at least one individual to complete ADL/IADL. For example participant requires one or two person hands-on assist for most transfers, participant usually needs others to feed him/her, participant needs others to complete all housework and laundry.

Staff should use the participant's self-report, feedback from PCI supports, and other documentation to inform this coding. Because this is a screen, the most critical determination is whether or not the participant usually requires hands-on assistance to complete the ADL/IADL. These areas will be further explored through the assessment process.

Section V: PCI Indicators

This section uses algorithms to identify which Medicaid waiver and PCS service options the participant is potentially eligible for. This information informs the options counseling that is described in the next section.

The algorithms for the indicators are populated using the following logic:

- **Participant may potentially meet NFLOC**
  - "Yes" to item IV.2, participant receives Skilled Nursing Services
  - "Yes" to item IV.3, Skilled Therapies three or more times per week, AND two or more of the following ADL tasks in VIII.5 are indicated as "Hands-on or Total Assist": bed mobility, transferring, locomotion, eating/drinking, toileting
  - Three or more cognition impairments in item IV.4 are checked
  - One or more cognition impairments in item IV.4 are checked AND one or more of the following ADL tasks in IV.5 are indicated as "Hands-on or Total Assist": bed mobility, transferring, locomotion, eating/drinking, toileting
  - Three or more of the following ADL tasks in IV.5 are indicated as "Hands-on or Total Assist": bed mobility, transferring, locomotion, eating/drinking, toileting

- **Participant may be eligible for DD services-** Participants would score as appropriate for referral for IDD services if they respond "Yes" to 3 or more of items 7-10, 12, 14.

  If items 12 and 14 are skipped due to responses to 11 and 13, these items should not count towards the indicator scoring.
- **Children with Complex Medical Conditions (CCMC) waiver-** "Yes" to all items in Section II
- **Community First Choice (CFC) waiver-** Meet NFLOC as identified in the first bullet
- **Personal Care Services (PCS) program-** Participants who meet the following criteria within Section IV, Level of Care Screen, may potentially meet PCS eligibility:
  - One or more of the following ADLs in item IV.5 are indicated as "Hands-on or Total Assist": Transferring, Locomotion, Eating/Drinking, Toileting, Bathing, Dressing **AND/OR**
  - One or more of the IADLs in IV.6 (Light Meal Prep, Main Meal Prep, Light Housework, Routine Housework, Laundry, Shopping) is indicated as "Hands-on or Total Assist"
- **Alaskans Living Independently (ALI) waiver-** Meet NFLOC as identified in the first bullet and are age 21 or older
- **Adults with Physical and Developmental Disability (APDD) waiver-** Meet NFLOC as identified in the first bullet AND respond "Yes" to item III.1
- **DD Determination to potentially access ISW/DD waiver-** Meet criteria in the second bullet, "Participant may be eligible for DD services"
- **Veterans Services-** Indicates as a US Veteran in I.36

Section VI: PCI Outcomes and Referrals

Section VI identifies the next steps for the participant and documents the outcomes and referrals from the call. This section replaces the PCI Summary Letter, and a copy of the section should be offered to participants once completed.

Assessment Item	Guidance
Section VI: PCI Outcomes and Referrals	
1. Recommended Services: ☐ PCS ☐ CFC ☐ ALI ☐ APDD ☐ DD Determination to potentially access ISW/DD ☐ CCMC	Indicate all the wavier and PCS options that the participant indicated as potentially eligible for in Section V.
2. Participant's Medicaid status.	This item informs the next steps for the participant. For example, applying for

Assessment Item	Guidance
Section VI: PCI Outcomes and Referrals	
❍ Enrolled ❍ Has already submitted application ❍ Will apply ❍ Chose not to apply	Medicaid will be a next step for people who want a waiver or PCS and are not already enrolled.
3. Programs participant would like to pursue: ☐ PCS ☐ CFC ☐ ALI ☐ APDD ☐ ISW ☐ DD ☐ CCMC ☐ Non-Medicaid Services	Select the waiver(s) and other services that the **participant/caller** would like to pursue based on the conversation during the PCI.
4. Rationale for participant's decision:	Briefly describe why the participant chose the option selected in Item 3. This may include the participant's perception of pros/cons between options and rationale for selecting/not selecting a Medicaid funded option.
5. Action steps for pursuing programs: ☐ Select care coordinator ☐ Select PCS Agency ☐ Refer to STAR for DD Eligibility ☐ Apply for Medicaid	Indicate all action steps that apply: • **Select care coordinator-** Select if the participant wishes to pursue a Medicaid waiver (select if pursuing both a waiver and PCS). Provide a list of care coordinators in the participant's area. • **Select PCS Agency-** Select this option if the participant chooses to pursue ONLY PCS. Provide a list of PCS agencies in the participant's area. • **Refer to STAR for DD Eligibility-** If the ADRC is completing the PCI and the participant would like to enroll in DD services and does not have established DD eligibility, provide a referral to the regional STAR agency. • **Apply for Medicaid-** Select if the participant would like to apply for PCS or a Medicaid waiver and is not currently enrolled in Medicaid. Provide a referral as necessary for support

Assessment Item	Guidance
Section VI: PCI Outcomes and Referrals	
	with completing the Medicaid application.
6. Outcome(s) of contact: ☐ I&R only ☐ Referred for Medicaid program ☐ Received Options Counseling ☐ Other:_____	Select all the outcomes of the contact. The "other" option will be periodically evaluated to determine if additional response options need to be included.
7. Benefits options provided: **8. Resource options provided:** **9. Service options provided:**	Document all areas that were discussed during the PCI, including entities that the participant should receive a referral to and options that were discussed but the participant chose not to pursue.
10. Caller/participant want staff to follow-up about the outcomes and referrals from the PCI. ☐ No [Skip to Item 12] ☐ Yes, follow up with caller (if not participant) ☐ Yes, follow up with participant **11. Staff should follow-up on:_____(Date)**	Ask the caller/participant whether he/she would like the worker or someone else from the worker's agency to follow-up with her or him after the PCI to ensure that he or she was able to address the next steps identified in the PCI. For example, checking to see if the participant was able to contact the agency to which the referral was made. If yes, identify who should be the follow-up point of contact and the date the caller/participant would like staff to follow-up. Inform the participant that the agency may not be able to follow-up on the exact date requested, however will be in contact around that date.
12. Summary of contact:	Briefly summarize the discussion and outcomes of the contact so that the participant can reference this in his or her copy of the PCI.
13. By responding yes, participant/caller acknowledges that all of the information provided to staff during the PCI is true and accurate to the best of his/her knowledge.	Because the information provided is used to determine whether a participant is potentially eligible for services and should proceed with meeting with a care coordinator or PCS Agency, verify that all the information that the caller shared was accurate. Once this is verified, select "Yes". If the caller/participant needs to make

Assessment Item	Guidance
Section VI: PCI Outcomes and Referrals	
	updates to the information provided, update the applicable sections and have a discussion about changes to the options and outcomes, if any.
14. Participant signature:_____	The participant may sign the PCI if requested. Obtaining the participant's signature is not mandatory. The ADRC can share this document with care coordinators or other providers only if they receive and ROI.
15. Participant received a copy of the PCI/PCI Outcomes and Referrals. ❍ No, did not request ❍ Yes, mailed ❍ Yes, faxed ❍ Yes, in-person	After completing this section, staff should off to provide a copy of the PCI or Section VI. PCI Outcomes. Indicate whether the participant received this copy and, if so, how the copy was provided.
16. Name of staff conducting the PCI: _____ **17. Name of staff agency:_____** **18. Staff telephone number:_____** **19. Staff email address:_____**	Identify the name and contact information of the staff who completed the PCI.
20. Status of PCI: ❍ Complete ❍ Incomplete (Document actions to complete in notes)	Identify if any additional steps need to be taken before the PCI is considered complete.

Appendix 1- Acronym List

Long Term Services and Supports (LTSS)- LTSS describes a range of services and supports that are often referred to as long term care. The terms services and supports are used instead of care to emphasize that participants are being supported in achieving their goals rather than passively being cared for. LTSS includes both support in the home and community and in institutions, such as a nursing facility.

Home and Community-based Supports (HCBS)- HCBS includes LTSS services that are not provided in an institution. This includes support in the home, such as services provided by a personal care attendant, or in the community, such as services provided by a group home.

Additional Acronyms:

- ABPCA- Agency-Based PCS
- ADL- Activity of Daily Living, such as bathing and dressing
- ADRC – Aging and Disability Resource Center
- ADRD- Alzheimer's Disease & Related Dementias
- ALI- Alaskans Living Independently
- APDD- Adults with Physical and Developmental Disabilities
- CAT- Consumer Assessment Tool
- CCMC- Children with Complex Medical Conditions
- CDDG- Community Developmental Disabilities Grant
- CDDG- Community Developmental Disabilities Grant
- CDPCA- Consumer-Directed PCS
- CFC- Community First Choice
- CFC-PCS – Community First Choice Personal Care Services
- CMS- Centers for Medicare & Medicaid Services
- DD- Developmental Disability
- DDRR- Developmental Disabilities Registration and Review
- DHSS- Department of Health and Social Services
- I&R- Information and Referral
- IADL- Instrumental Activity of Daily Living, such as shopping and housework
- IAT- Intensive Active Treatment
- ICAP- Inventory for Client and Agency Planning
- ICF-IID-LOC- Intermediate Care Facility for Individuals with Intellectual Disabilities
- IDD- Intellectual and Developmental Disabilities
- IMD LOC- Institution for Mental Disease Level of Care
- IPS LOC- Institutions providing Psychiatric Services Level of Care
- ISW- Individualized Supports Waiver
- LOC- Level of Care
- NFLOC- Nursing Facility Level of Care
- PCA- Personal Care Assistant
- PCI- Person-Centered Intake
- PCS- Personal Care Services
- QIDP- Qualified Intellectual Disability Professional
- SB-PCS- Skill Building Personal Care

Services
- SDS- Division of Senior and Disabilities Services
- STAR- Short Term Assistance Referral
- TBI- Traumatic Brain Injury
- TCM- Targeted Case Management
- THO- Tribal Health Organization
- VD-HCBS- Veteran-Directed Home and Community Based Services