HCBS Forms

Number	Name	Revision Date
SCDHHS FORM 1718	South Carolina Long Term Care Assessment Form	**August 2018**
DHHS Form 122 DC	Community Long Term Care Adult Day Health Care Form	**July 1, 2024**
DHHS Form 122A	Adult Day Health Care – Nursing Prescriber's Orders	**July 1, 2024**
	Approved In-Service Training topics	**July 1, 2025**
	Attendant Care Daily Log	**July 1, 2024**
	Competency Evaluation Documentation Form	**November 1, 2022**
	CPCA Prescriber Information Letter	**July 1, 2024**
	Head and Spinal Cord Injured Level of Care Procedures	**September 20, 2018**
	Mode of Transportation	**July 1, 2022**
	Private Duty Nursing Monthly Summary Form	**March 29, 2011**
	Twelve Strike Policy	**March 2019**
	DHHS Private Duty Nurse Supervisory Form	**March 29. 2011**
	Community Choices Waiver Pre-screening for Telemonitoring Service	**November 1, 2022**
	Annual In-Service Documentation Form	**November 1, 2022**
	Children's In-Home Care Prescriber information Form	**July 1, 2025**
	Prescriber Statement for Participant Directed Attendant Care	**July 1, 2025**
	Children's Attendant Caregiver Qualification Documentation	**July 1, 2025**
	Compentency Evaluation Documention Form (for Children's Personal Care)	**July 1, 2025**

South Carolina Long Term Care Assessment Form

Applicant Name _____ Medicaid # _____

Medicare # _____ Nursing Home/Hospital Completing Form _____

Referring Person & Title _____ Telephone # _____

Primary Contact Name _____ Relationship _____

Telephone # _____ Address _____

Reason for **REFERRAL**: ☐PRE-ADMISSION SCREENING **ROOM #** _____ ☐CONVERSION **CONVERSION DATE** _____

***For the application to be processed you MUST include the following information within 10 business days of the referral to avoid application termination.** ☐Consent Form ☐ Admission/Discharge notes/H&P ☐Nurses /CNA Notes ☐ Physicians Orders/MAR ☐ Wound Care Notes ☐PASRR Level 1 (if applicable) ☐PASRR Level 2 (if applicable)

***Please provide any supportive documents to assist with Level of Care. (Example: blood glucose logs, wound care notes)**

Diagnoses/ Conditions

1.	2.	3.
4.	5.	6.

Overall Medical Condition: ☐ **Stable** ☐**Unstable** ☐ **Flare up of recurrent/chronic problem**

Height: _____**ft.** _____**in. Weight:** _____**lbs.**

Treatment/Therapies	Additional Information
Circle/fill in categories that apply to the applicant. Send admit note/H&P, and supportive documents.	
☐ **Treatments** *__ATTACH BLOOD GLUCOSE LOGS/ CRITICAL LABS__ (if applicable)	☐ **Bi-pap** ☐**C-pap** ☐**Chemotherapy** ☐**Colostomy** ☐**Daily Weight Check** ☐**Decubitus care** ☐**Defribulator** ☐ **Dialysis** ☐**Feeding Tube** ☐**Blood Glucose Monitoring** ☐ **Ileostomy** ☐**Lesion irrigation** ☐**Mental Health Treatment** ☐**Nasal suctioning** ☐ **Nasopharyngeal suctioning** ☐**Nebulizer Treatment** ☐**Oral suctioning** ☐ **Other ostomy** ☐**Oxygen** ☐**Pacemaker** ☐**Pain Management** ☐**Parenteral IV** ☐ **Porta Catheter** ☐**Radiation** ☐ **Respiratory Therapy** ☐**Trach care** ☐**Transfusions** ☐ **Urinary catheter care** ☐**Urostomy** ☐**Ventilator/Respirator**
☐ **Therapies** *__ATTACH PT/OT/ST TREATMENT PLAN/PROGRESS NOTES.__	☐ **PT/Frequency:** _____ ☐ **OT/Frequency:** _____ ☐ **ST/Frequency:** _____
☐ **Diet/ Nutrition**	**Diet Order:** ☐ **Diabetic** ☐**Dietary supplement between meals** ☐**Fluid restriction** ☐**Leaves 25% of food uneaten at meals** ☐**Mechanically altered diet** ☐**No concentrated sugars** ☐**No diet restriction** ☐**Non-compliant with diet** ☐**Renal diet** ☐**Salt-restricted Diet** ☐**Significant weight gain-problem** ☐**Significant weight-loss problem** ☐**Swallowing problem** ☐**Wasting of body mass** ☐**PEG/Enteral feedings**
☐ **Skin Conditions/Treatments & Frequency** ***ATTACH WOUND CARE NOTES**	☐ **Abrasions, bruises** ☐**Burns** ☐ **Decubitus Care** ☐**Diabetic ulcer** ☐ **Open lesions** ☐**Rashes** ☐ **Skin desensitized to pain or pressure** ☐**Skin tears or cuts(other than surgery)** ☐ **Stasis ulcer** ☐ **Surgical wounds** ☐ **Ostomy Care** **Decubitus Stage** _____ **Site** _____ **TX Frequency** _____

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
ADL CODING KEY

ADL SELF-PERFORMANCE-- (Code for client's PERFORMANCE during last 7 days--Not including setup)

0. INDEPENDENT - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days

1. SUPERVISION - Oversight encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days.

2. LIMITED ASSISTANCE - Client highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 50% or more of the time -OR- More assistance < 50% of the time during last 7 days

3. EXTENSIVE ASSISTANCE - While client performed part of activity, over last 7 day period, help of following type(s) provided 50% or more of the time:
--Weight-bearing support
--Full caregiver performance during part (but not all) of last 7 days

4. TOTAL DEPENDENCE - Full caregiver performance of activity during entire 7 days

DEFINITIONS

TRANSFER - How the client moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/ from bath/toilet)

LOCOMOTION - How the client moves between locations in his/her room and living area. If in a wheelchair, self-sufficiency once in chair.

DRESSING - How the client puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.

EATING - How the client eats and drinks (regardless of skill).

TOILET USE - How the client uses the toilet (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

BATHING--How client takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.)

0. Independent--No help provided
1. Supervision--Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence

CONTINENCE SELF-CONTROL CATEGORIES (Code for client performance over 14 days)

0. CONTINENT - Complete control

1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly

2. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week

3. FREQUENTLY INCONTINENT - BLADDER, tends to be incontinent daily, but some control present; BOWEL, 2-3 times a week

4. INCONTINENT - Has inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time; or an indwelling catheter/ostomy that controls bladder/bowel

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM

ADL SELF-PERFORMANCE-- (Code for client's PERFORMANCE during last 7 days--Not including setup)

	CODE HERE
TRANSFER ☐ **Bed rail used** ☐**Bedfast all or most of the time** ☐**Lifted manually** ☐**Lifted mechanically** ☐**Poor balance** ☐ **Requires chair lift** ☐**Rocks/scoots to edge** ☐**Transfer aide** ☐**Unsteady on feet** ☐**Weakness/SOB/Poor endurance** ☐**Weight bearing/holding to objects**	
LOCOMOTION ☐ **Cane** ☐**Crutch** ☐**Exit seeking** ☐**Frequent falls** ☐**Frequent rest breaks/poor endurance** ☐**Holds on to walls/furniture** ☐**Manual wheelchair** ☐**Motorized wheelchair** ☐**Other person wheels** ☐**Shortness of breath** ☐ **Shuffling gait** ☐**Slow gait** ☐**Unable to put on prosthesis or brace** ☐**Unsteady gait** ☐**Walker** ☐**Wandering** ☐ **Wheelchair primary mode of locomotion** ☐**Wheels self**	
BATHING	
DRESSING	
TOILETING	
EATING	
BOWEL CONTINENCE ***Control of bowel movement, with appliance or bowel continence programs, if employed***	
BLADDER CONTINENCE ***Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants)*** **With appliances (e.g., Foley) or programs, if employed**	

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM

Communication	Speech Clarity:	Making Self Understood	Ability to Understood Others
Hearing: ☐ Unable to rate ☐ Hears adequately ☐ Hears special situations ☐ Highly Impaired	☐ Clear Speech ☐ Unclear Speech ☐ No Speech	☐ Understand ☐ Usually Understands ☐ Sometimes Understands ☐ Rarely/Never Understood	☐ Understand ☐ Usually Understands ☐ Sometimes Understands ☐ Rarely/Never Understood

Communication Conditions	Vision	Vision Conditions
☐ American Sign Language or Braille ☐Aphasia ☐ Communication board ☐Left hearing aid ☐ Right hearing aid ☐Signs/gestures/sounds ☐ Speech ☐Trach or speaking valve ☐Writing messages to express or clarify needs	☐ Unable to rate ☐Adequate ☐Impaired ☐ Highly Impaired ☐Blind ☐Legally Blind	☐ Contact Lenses ☐Prescription glasses ☐ Reading glasses

Memory	Cognitive Skills	Mood/Behavior Patterns
Short-term Memory: ☐ Unable to rate ☐OK ☐ Problem Long-Term Memory: ☐ Unable to rate ☐OK ☐ Problem	☐ Independent ☐ Modified Independence ☐ Moderately Impaired ☐ Severely Impaired	☐ Physically Abusive ☐ Socially Inappropriate/Disruptive Behavior ☐ Verbally Abusive

Mood/Behavior Patterns	Mental Status Questionnaire
1. Behavior not exhibited in last 7 days 2. Behavior of this type occurred less than daily 3. Behavior of this type occurred daily or more frequently **Only Code for behaviors seen in the last 7 days. Demonstrated signs of mental distress_____ Failure to eat _____ Failure to medication _____ Homicidal thoughts/actions _____ Motor agitation (pacing, handwriting, picking)_____ Persistent concern with health _____ Recurrent thoughts of death _____ Socially Isolated _____ Suicidal thoughts/actions _____ Verbal expressions of distress _____ Withdrawal from leisure activities _____ Withdrawal from self-care activities_____	Able to complete ☐Yes ☐No What is the name of this place? ☐Correct ☐ Incorrect Where is it located? ☐Correct ☐ Incorrect What is today's date? ☐Correct ☐ Incorrect What month is it now? ☐Correct ☐ Incorrect What year is it now? ☐Correct ☐ Incorrect How old are you? ☐Correct ☐ Incorrect What month were you born in?☐Correct ☐ Incorrect What year were you born? ☐Correct ☐ Incorrect Who is the president of the U.S.?☐Correct ☐ Incorrect Who was the president before him? ☐ Correct ☐ Incorrect

Community Long Term Care
Adult Day Health Care Form

FROM: _____ ADHC

PARTICIPANT'S NAME: _____

SOCIAL SECURITY NUMBER -'-"XXX"""""----'XX=-------- MEDICAID NUMBER,_____ DOB: _____

DIAGNOSIS: PRIMARY

(CURRENT) SECONDARY

MEDICAL HISTORY: _____

PHYSICAL EXAMINATION: T[| PI | **R[** | BP [|

LABORATORY DATA:

EENT:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTINAL:

GENITOURINARY:

MUSCULOSKELET AL:

SKIN:

ENDOCRINE:

ALLERGIES: _____

DIET:

SPECIAL CARE REQUIREMENTS: (List any daily activity limitations, special therapies or special care requirements):

Is the individual capable of self-administering their own medication(s)? [ ] Yes [ ] No

MEDICATIONS	DOSE/FREQ/ROUTE	MEDICATIONS	DOSE/ FREQ/ ROUTE

I ATTEST TO THE MEDICAL NECESSITY OF THE FOLLOWING SERVICES FOR THIS CLTC PROGRAM PARTICIPANT:

ADULT DAY HEALTH CARE _____

ADULT DAY HEALTH CARE NURSING
(Must complete Form **122A.)**

SIGNATURE OF PRESCRIBER _____ DATE: _____

Signature of CLTC Staff **DATE:**

DATE SENT: INITIALS:

Medicaid Home and Community-Based Waiver

Adult Day Health Care – Nursing

Prescriber's Orders

To: From:

Phone: Fax:

The client identified below participates in a Medicaid home and community-based waiver and has requested Adult Day Health Care-Nursing services. Please evaluate your patient's appropriateness for this service by completing and signing this form, noting any restrictions or special instructions. Please mail or fax this form to the above address. Thank you for your assistance in providing this service.

Participant: Medicaid ID:

ADHC – Nursing is limited to the following 6 skilled procedures:

1. [ ] **Ostomy Care**

Orders:

2. [ ] **Catheter Care**

Orders:

3. [ ] **Decubitus/Wound Care**

Orders:

4. [ ]**Tracheostomy Care**

Orders:

5. [ ] **Tube Feedings**

Orders:

6. [ ] **Nebulizer Treatment**

Orders:

Prescriber Signature: Date:

ADHC Nurse Signature: Date:

Date mailed to Prescriber: Date:

Approved In-Service Training topics
(Please submit topics not on this list for approval)

Basic First Aid

Fire Prevention & Safety

Feeding Your Clients

with Behavioral Needs

Alzheimer's disease

Infection Control

Building Trust & Confidence with Clients

Understanding Dementia

Performing Safe Transfers

HIPAA

Ergonomics/ Body Mechanics

Non-Traumatic Emergencies

Customer Service in Health Care

Communication Skills

Personal Care Safety Issues

Bathing Tips

Professionalism & Work Ethics

Understanding Abuse & Neglect

Standard Precautions

Preventing Pressure Sores

Heart Failure

Heart Attacks & Strokes

Incontinence & Personal Hygiene

Understanding basic Human Needs

Normal Aging Process

Being Assertive

Assistive Devices Working with Individuals

Bed-bound Clients Understanding

Domestic Violence

Brain & Spinal Cord Injuries

Hand washing

Chemical Hazards

Common Diets

Confidentiality

Cultural Diversity

Dealing with Family Members

Dealing with Dizziness

Understanding Depression

Understanding Diabetes

Flu Season

Getting Off to a Good Start

Food Preparation

How to Prioritize Your Work

Working with individuals with hearing loss

Understanding Hypertension

How to Prioritize Your Work

Hospice

Falls & Home Safety

/Updated 7/1/25

Activity & the Elderly

Mouth Care

Nutrition & Hydration

Pain & the Elderly

Passive & Active Range of Motion

Documenting Participant Care

Overview of the Body

Women's Health Issues

Vital Signs Update

Maintaining a Professional Distance

All about Headaches

Maintaining Clients Dignity

Non-Compliant Clients

Parkinson's disease

Stress Management Reporting &

Toileting Tips Taking Care of Your Back

Men's Health Issues

Working with Infants

Safety in the Workplace

Working with Individuals with Intellectual Disability or Related Disabilities

Working with Individuals with Mental Health Diagnoses

/Updated 7/1/25

Attendant Care Daily Log

Participant Name: _____

CLTC #:_____

Attendant Name: _____

Attendant's Phone Number: (_____)_____

Case Manager: _____

Daily Log of attendant care services for week ending:

Daily Task	S	M	T	W	Th	F	ST
Dates							
Provide/Assist with ADL's							
Bathing							
Dressing							
Grooming							
Personal Hygiene							
Transferring and Mobility							
Assist with Commode/Urinal/Bedpan							
Prepare and serve meal/snack							
Housekeeping							
☐ Vacuum ☐ Mop ☐ Dust							
☐ Sweep ☐ Trash							
☐ Clean Kitchen ☐ Clean Oven/Stove							
☐ Defrost/Clean Refrigerator							
☐ Laundry ☐ Clean Bathroom							
Clean Participant's Immediate Living Area							
Shopping Assistance							
☐ Errands ☐ Escort							
Assistance with Communication							
Monitoring of Participant							
☐ Vital Signs ☐ Skin Condition							
☐ Fluid Intake ☐ Loss of Appetite							
Remind to take Medication							
Other:							
Other:							

Weekly Summary of Participant's Condition

Attendant Signature:	Participant Signature:

Attendant Care Daily Log

Participant Name: _____

CLTC #:_____

Attendant Name: _____

Attendant's Phone Number: (_____)_____

Case Manager: _____

Daily Log of attendant care services for week ending:

Daily Task	S	M	T	W	Th	F	ST
Dates							
Provide/Assist with ADL's							
Bathing							
Dressing							
Grooming							
Personal Hygiene							
Transferring and Mobility							
Assist with Commode/Urinal/Bedpan							
Prepare and serve meal/snack							
Housekeeping							
☐ Vacuum ☐ Mop ☐ Dust							
☐ Sweep ☐ Trash							
☐ Clean Kitchen ☐ Clean Oven/Stove							
☐ Defrost/Clean Refrigerator							
☐ Laundry ☐ Clean Bathroom							
Clean Participant's Immediate Living Area							
Shopping Assistance							
☐ Errands ☐ Escort							
Assistance with Communication							
Monitoring of Participant							
☐ Vital Signs ☐ Skin Condition							
☐ Fluid Intake ☐ Loss of Appetite							
Remind to take Medication							
Other:							
Other:							

Weekly Summary of Participant's Condition

Attendant Signature:	Participant Signature:

Competency Evaluation Documentation Form

(for Personal Care Aides participating in CLTC programs)

Aide's Name_____ SSN # _____

Testing Agency_____

Test Administered By _____

Title and Nurse License Number _____

TEST RESULTS

AREA TESTED	PASSED/FAILED	DATE
Observation, Reporting and Documentation of patient status and the Care of Service provided		
Reading and Recording Temperature, Pulse and Respiration		
Confidentiality, accountability, and prevention of abuse and neglect		
Basic First Aid to include monitoring for side effects of medications and recognition of basic medical problems		
Basic Infection Control Procedures		
Fire safety/disaster preparedness		
Maintenance of a clean, safe and healthy environment		
Recognizing emergencies and knowledge of emergency procedures		
Appropriate and safe techniques in assisting in bathing, dressing, toileting, and any other activity of daily living		
Safe transfer techniques and ambulation		
Normal range of motion and positioning		
Ways to work with the physical, emotional, and developmental needs of the populations served by the agency, including the need for respect for the patient, his or her privacy, and his or her property		
Orientation to traumatic brain injury, spinal cord injury; and similar disabilities		
Adequate nutrition and fluid intake		
Meal Planning and Preparation		
Shopping		
Transportation and Escort Services		
Any other task that the agency may choose to have the PCA perform		

If retesting was required on any of the above components, document below the remedial instruction provided and the date(s) retested.

_____

_____

_____

_____

_____

CERTIFICATION STATEMENT

It is hereby certified that the competency evaluation documented by this form meets the requirements of the competency training and evaluation program as outlined in the Community Long Term Care Scope of Services for Personal Care Aide and was administered by an instructor/evaluator who meets the requirements of such regulations.

Instructor/Evaluator_____
(Signature) (Date)

RN Supervisor_____
(Signature) (Date)

CPCA Prescriber Information Letter

Date: _____

Dr. _____

_____

_____

RE:_____SSN: _XXX-XX_____DOB: _____

Application for Children's Personal Care

Dear Dr._____,

Our agency coordinates services for the above child who participates in the Children's Personal Care Program through SCDHHS, In order to determine if the child continues to meet the medical necessity criteria, we need specific information regarding the child's medical condition. Enclosed is a copy of the signed Consent Form authorizing the release of this information.

Please complete Sections I through III of the CHILDREN'S PERSONAL CARE PROGRAM PRESCRIBER'S INFORMATION FORM. Please return the form by fax as indicated below, within the next ten (10) business days. This information will be reviewed to determine if the child meets the medical eligibility criteria and to authorize services, if appropriate.

Please note, the form must be completed by a physician, nurse practitioner, or physician's assistant.

If you have any questions, please contact me at the number

below.

Sincerely,

_____

Care Coordinator

Phone: _____

Fax: _____

Enclosures: Copy of Consent Form, Children's Personal Care Program Prescriber Information Form

Head and Spinal Cord Injured Waiver Policy and Procedures

Referral for Level of Care

Community Long Term Care is responsible for initial (Pre-Admission Screening) nursing facility level of care (LOC) determinations for the Head and Spinal Cord Injured (HASCI) Waiver operated by The South Carolina Department of Disabilities and Special Needs (DDSN). A CLTC Nurse Consultant (HASCI Specialist) has been designated in each Area Office as the person that will facilitate level of care determinations. The HASCI Specialist is the liaison between the CLTC Central Office and the Area Office Staff, and will make recommendations, provide training and assist other office staff on policy and procedures regarding the HASCI Waiver

DDSN has established intake criteria for HASCI Waiver Applicants. Once the Applicant is determined by DDSN to meet the target population for the HASCI Waiver and has been assigned a waiver slot, the Applicant will be referred to CLTC for a level of care determination.

1. DDSN will make all requests for Nursing Facility level of care determinations for HASCI Waiver through Community Long Term Care Centralized Intake. These referrals must be made electronically using the following website:

   https://phoenix.scdhhs.gov/cltc_referrals/new

   Following electronic referral submission:
   • Information is entered into a secure website;
   • CLTC Centralized Intake Team will have immediate access to the referral;
   • The referral will be processed and transferred to the appropriate CLTC Area Office;
   • A referral confirmation number will be provided and may be utilized to monitor the status of the referral.

2. As part of the electronic referral, DDSN Case Managers must attach the supporting documents listed below:

   • South Carolina Long Term Care Consent Form (SCDHHS Form 121) signed by the applicant or primary contact;

• DDSN/CLTC Transmittal Form for Nursing Facility Level of Care (HASCI Form 7) with the top section completed;

3. CLTC will conduct a home visit, complete the assessment and render a level of care determination within fifteen (15) business days of receipt of the case assignment. The level of care must be team staffed with another CLTC Nurse Consultant.

4. If the HASCI applicant is hospitalized at the time of the level of care request, the level of care is tentative and must be finalized upon discharge. If the discharge is within 180 days of the tentative level of care, a telephone update may be completed. If it appears the applicant does not meet level of care, then a visit must be completed prior to the final level of care determination. If the discharge is greater than 180 days, another visit must be made for the final level of care determination.

5. CLTC will forward the level of care determination to DDSN via HASCI Waiver Transmittal Form, completing the bottom portion of the form indicating the level of care date and expiration date. A copy of the completed Form 1718 and any pertinent narrative notes should be attached. This information must be sent to DDSN within 5 business days of completion.

6. This level of care determination is valid for 30 calendar days. Note: Months that have 31 days should be monitored closely.

7. DDSN is responsible for notifying the applicant of the level of care decision.

8. CLTC will close the HASCI application in Phoenix as “entered HASCI Waiver”. If the applicant does not meet level of care, the case should be closed as “Medically Ineligible”.

9. If the Applicant has not entered HASCI within 30 days of the assessment, DDSN will request a level of care update via the HASCI Transmittal Form and a referral submitted electronically. CLTC will conduct an update via home visit or telephone assessment within fourteen (14) days of the receipt of the referral. The level of care must be team staffed with another CLTC Nurse Consultant within three (3) business days.

10. Note: The update may be completed by telephone if the request is within 180 calendar days of the original assessment. A face-to-face visit must be made if it appears that the applicant does not meet level of care, regardless of the time frame.

11. This re-determination of level of care must be team staffed with another CLTC Nurse Consultant. CLTC will inform DDSN of the level of care re-determination via the Transmittal Form.

12. If the applicant is transferring to HASCI from a CLTC Waiver, the CLTC Nurse Consultant may complete the assessment and level of care via a telephone assessment or face-to-face assessment.

CLTC Referrals to the HASCI Waiver

CLTC Participants may be referred to HASCI Waiver for HASCI services. Participant referrals to the HASCI Waiver should be made by calling the DDSN Eligibility Division at 1-800-289-7012.

CLTC Waiver Participants Transitioning to HASCI Waiver

CLTC Participants may choose to terminate CLTC waiver participation in order to enroll in the HASCI Waiver. See section 10.21.10 for transfer to/from another waiver.

HASCI Level of Care Process

1) Individual is referred to DDSN for possible enrollment in the HASCI Waiver

2) DDSN determines if the individual meets the target population criteria

3) If the individual meets the target population criteria, they are assigned to a case manager who then creates a referral in Phoenix for Long Term Living (LTL) to perform the level of care.

4) LTL Nurse performs the level of care. An individual can meet the HASCI-Int by having at least 2 intermediate services.

Nursing Facility Level of Care			
	Number of Functional Deficits	**Number of Intermediate Services**	**Number of Skilled Deficits**
Current Level of Care			
Intermediate	**2**		
Intermediate	**1**	**1**	
Skilled	**1**		**1**
Skilled	**1** **Totally dependent in all ADLs**		
Changed Level of Care			
Intermediate	**2**		
Intermediate	**1**	**1**	
Skilled	**1**		**1**
Skilled	**1** **Totally dependent in all ADLs**		
HASCI-Int		**2**	

MEDICAID HOME AND COMMUNITY- BASED WAIVER
ADULT DAY HEALTH CARE
MODE OF TRANSPORTATION

TO BE COMPLETED BY ADULT DAY HEALTH CARE AND MAINTAINED IN PARTICIPANT RECORD

PARTICIPANT NAME _____

MEDICAID NUMBER_____

TRANSPORTATION TO BE PROVIDED BY:

Participant's residence is _____ miles from the center.

_____Participant/Authorized Representative is responsible for transportation.

_____Center/Contractor will be responsible for providing transportation.

_____

_____

I certify that the information above reflects the current transportation arrangements for this participant.

_____ _____ _____
Signature Title Date

USE SECTION BELOW TO DOCUMENT ANY CHANGES IN TRANSPORTATION ARRANGEMENTS.

TRANSPORTATION TO BE PROVIDED BY:

Participant's residence is _____ miles from the center.

_____Participant/Authorized Representative is responsible for transportation.

_____Center/Contractor will be responsible for providing transportation.

_____

_____

I certify that the information above reflects the current transportation arrangements for this participant.

_____ _____ _____
Signature Title Date

Private Duty Nursing Monthly Summary Form

Monthly Summary Date:	**Provider Name:**

Client Name:	**CLTC number:** **DOB:**

SYSTEMS OVERVIEW: Please answer with yes or no, and explain as appropriate.

Neuro	Is the client currently having seizures? explain:	Date of last seizure: Treatment for seizure:	Spasticity issues, explain
Pulmonary	Does the client have a tracheostomy? Ventilator? When is oxygen used? Saturations WNL.	Are breath sounds clear? Can the client handle own secretions? Explain:	How often are bronchodilators used?
Cardiac	Does the client experience tachycardia? Bradycardia?	Murmurs? List circulation issues:	Last HR_____BP____/____
GI	Is the client experiencing vomiting? Treatment:	Diarrhea/Constipation: Treatment:	Explain diet: Route:
Endocrine	Is the nurse monitoring blood sugars? When? How?	Last blood sugar: Treatment needed?	Insulin ordered? Documentation appropriate?
GU	Has the client experienced urinary retention?	Color: Amt. adequate?	Odor of urine appropriate?
Integument	Is the client experiencing decubiti? Bruises?	Is there a stoma site? Location? Clean/dry?	Any treatment for stoma?
Pain	Is the client in pain? Location of pain: Explain:	List pain scale used:	PRN Tylenol or Motrin Other narcotics used? Irritability issues?

CARE COORDINATION

List other agencies involved:	List therapies:	Is the nurse incorporating treatment into shift?

CHANGES IN CONDITION

Please document any changes in condition such as: Secretions different from usual, toleration of feeds, symptoms of infections, worsening of contractures, wound condition, changes in ventilator support:

CHANGES IN POC (PLAN OF CARE/POT) Are the Prescriber's orders current as of today? Explain:

HOSPITALIZATIONS, ER & PHYSICIAN VISITS: List all visits attended including dietician, nurse practitioner.

Provider:		
Date:		
Reason:		

PROGRESS TOWARD GOALS listed in treatment plan:

PROBLEMS/CONCERNS:

Name	**Date**

Please Fax to DHHS/DDSN Case Manager

Twelve Strike Policy

Personal Care I and II, Children's Personal Care, Attendant, Companion and Nursing Services

One strike will be given to a worker for each incident where a resolution must be done and no valid reason is given. After the twelfth strike, resolutions will no longer be accepted if no valid and verified reason is given.

- The Electronic Visit Verification System includes Care Call and the mobile app. Workers who are new to the Electronic Visit Verification system (EVVS) will have a one-month grace period to learn the system before strikes begin to be issued. However, workers rehired or returning to work who will be using Care Call will not get this grace period since they should already know how to use Care Call.

- Workers will be given one strike per incident. For example, if worker is providing Personal Care I & II services for a participant and checks in for both services but fails to check out, only one strike will be given to correct both the PCI & PCII claims. If the worker checks in for multiple participants on the same call, only one strike will be given.

- After one year, each worker begins a new strike period. This means that the twelve-strike policy is an annual policy rather than a lifetime policy. For new workers, the annual date begins on the worker start date keyed in the worker registration section of Phoenix. The worker start date should always be the first day the worker will serve a participant to receive the full 30 day grace period.

- Each resolution not submitted timely will receive a strike. Providers must submit the resolution **within 10 days from the Sunday following the Date of Service** to be timely**.** Any resolutions submitted after that date will have strikes issued. These strikes will be assigned to the worker on the claim(s) although it is the responsibility of the provider agency to submit the resolutions timely.

- Division of Long Term Living's CLTC Area Offices will have **14 days to respond to the provider agency resolutions that were submitted timely**.

- Providers must use the participant's landline phone or the mobile app to document services in the Electronic Visit Verification System. Any problems using the participant's landline phone or the mobile app should be reported immediately (by the next business day). The best way to notify the case manager is by sending a conversation in Phoenix. **Attendants must notify the Case Manager by phone.** The Employer of Record will be able to provide the Case Managers contact information. If the landline phone is disconnected or not working when the provider arrives, a resolution may be done. The provider must be prepared to have a mobile app available to serve the participant by the third visit when the landline phone is out of service. If the provider cannot/ will not begin using the mobile app, the provider must notify the case manager by the third visit that they will no longer be able to provide services to the participant. The provider may continue to serve the participant, at the case manager's request, until a new provider can be set up. No strikes will be given if this arrangement is made and documented.

- If a participant has a landline phone but it is regularly out of service (2-3 times a month), the mobile app must be used for that participant.

- Providers may run the Infractions by Worker report on the Phoenix Provider Portal website to monitor the worker strikes.

Examples of when strikes will be given and will not be given

Strikes

- Worker forgets to check in but does check out
- Workers forgets to check out but does check in
- Worker forgets to check in and worker forgets to check out
- Resolutions submitted late

Non-Strikes

- Worker makes a mistake during the grace period
- Care Call or mobile app not working and central office has said not to issue strikes
- Local telephone provider problems that have been verified by the area office
- CM has been notified and verified participant's phone is not functioning
- CM was notified and verified participant's phone was not available
- Worker checks in with incorrect worker ID
- Worker checks in for the incorrect service
- Participant's phone not available and the provider DID NOT notify CM by the next business day
- Participant's phone not functioning, and the provider DID NOT notify CM by the next business day

DHHS Private Duty Nurse Supervisory Form

Fax to DHHS/DDSN Case Manager - Please Print

Provider:	Date of Visit:
Client Name:	DOB:
Client CLTC Number:	Nurse:
Is the client Medicaid eligible? How was it checked?	
Have Care Call claims been reviewed?	
Is the nurse caring for the client an RN or LPN? If the nurse is an LPN, please list the tasks that the LPN must be supervised on?	
Has the nurse completed the required minimum 6 hours training per calendar year in order to care for this client?	
Does the nurse arrive at the scheduled time?	
Has the nurse been trained to care for the needs of this particular client? i.e. ventilator care, tracheostomy care, catheter care.	
Was the nurse oriented to this client? How long has the nurse been caring for this client?	
During the visit did the supervisor meet with the Responsible Party (RP)?	
Does the RP have concerns regarding the client? Regarding the nursing care being provided? Is the nurse an appropriate match for the client?	
When the physician's orders were last updated? Is there a copy in the chart?	
Has the Plan of Care been reviewed? Has the MAR been reviewed?	
Has the Disaster Plan been reviewed?	
Does the client continue to have skilled needs?	
Has a Discharge Plan been created? What is a tentative discharge date?	
Is the client a candidate for weaning? Why?	
What goals are in place in order to actively plan for weaning?	
What is the weaning plan?	
Is the RP aware of the weaning plan? Is the RP in agreement?	
What concerns are there about weaning?	
Does the nurse have any other concerns about this client?	
Nurse Supervisor:	

Community Choices Waiver Pre-screening for Telemonitoring Service

Participant Name:_____ CLTC #_____ DOB _____

1. Participant has at least one of the required primary diagnoses (mark all that apply):
   - □ Insulin Dependent Diabetes Mellitus
   - □ Chronic Obstructive Pulmonary Disease
   - □ Hypertension
   - □ Congestive Heart Failure

2. Participant has had at least two hospital admissions and/or emergency room visits in the last 12 months. List approximate dates:_____ and _____ .

3. A. Participant is capable of utilizing the telemonitoring equipment and transmitting the necessary data. Mark all that apply :
   - □ can transfer safely and stand on scales independently (if applicable)
   - □ can apply appliance to arm (if applicable)
   - □ can apply appliance to finger (if applicable)
   - □ can use the telephone
   - □ can follow direction
   - □ can remember to utilize service
   - □ willing to commit to daily use

   OR

   B. If all of the above do not apply, is there an individual available to them that is willing and capable of utilizing the telemonitoring equipment and transmitting the necessary data to the telemonitoring provider daily? If no, the participant is not eligible for telemonitoring at this time. If yes, list the individual(s) name and contact information below.

   Name of individual who will assist daily: _____
   Contact telephone number: _____
   Address: _____

   Name of individual who will assist daily: _____
   Contact telephone number: _____
   Address: _____

   Named individual confirms willing and capable to case manager. If no, the participant is not eligible for telemonitoring at this time. If yes, continue.

4. Assessment Finding:
   - □ Eligible for Telemonitoring Service at this time
   - □ Not eligible for Telemonitoring Service at this time

5. If eligible
   - □ Name of the primary physician _____
   - □ Phone number of the primary physician _____
   - □ Is there a working phone in the home □ yes □ no
   - □ Is the phone a □ landline or □ wireless
   - □ What is the name of the phone carrier _____
   - □ Are there pets in the home □ yes □ no
     Is the home free of pest □ yes □ no. If no, specify: _____

Case Manager Signature Date

Annual In-Service Documentation Form

□ **(for Personal Care Aides participating in CLTC programs)**

Aide's Name_____

Testing Agency _____

TITLE OF TRAINING	DATE	HOURS EARNED	SIGNATURE AND TITLE OF TRAINER	SIGNATURE OF EMPLOYEE
Confidentiality, accountability and prevention of abuse and neglect				
Fire safety/disaster preparedness				
First aid to include monitoring for side effects of medications and recognition of medical problems				
Documentation and Record Keeping				
Ethics and Interpersonal relationships				
Orientation to traumatic brain injury, spinal cord injury, and similar disability				
Lifting and Transfers				

My signature below certifies that the above listed trainings have occurred under my supervision.

_____ _____

Nurse Supervisor Signature Date

TITLE OF TRAINING	DATE	HOURS EARNED	SIGNATURE AND TITLE OF TRAINER	SIGNATURE OF EMPLOYEE

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Eunice Medina DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

CHILDREN'S IN-HOME CARE PRESCRIBER INFORMATION FORM

DATE: _____

SECTION I - PERSONAL INFORMATION

Name:_____SSN:_____DOB:_____

SECTION II - MEDICAL INFORMATION

Date of Last Office Visit:___/_____/_____ Height:_____Weight_____

Diagnosis:

_____

_____

Prognosis:

_____

Rehabilitative Potential:

_____

Current Physical Conditions and Functional Limitations requiring hands on assistance:(Check all that apply)
To qualify for the services, the individual must have at least one functional deficit which is defined as requiring hands on assistance (which is not age appropriate) with either 1) transfer or 2) locomotion or 3) all four of the following: bathing, dressing, eating and toilet use or 4) daily bladder and/or bowel incontinence.

	Bathing		Mobility
	Dressing		Toileting
	Eating		Transferring
	Hygiene		Bladder/Bowel Incontinence

___Other (Please specify)

_____

Medications: *Include Medication dosage, frequency and administration route*

_____

_____

CHILDREN'S IN-HOME CARE PROGRAM PRESCRIBER INFORMATION FORM

SECTION III- MEDICAL NECESSITY – *SERVICE NEEDS REQUIREMENT:*

Yes_____No The individual must require daily monitoring and observation due to medical needs which could result in medical complications. The medical needs must be documented, and the services of a personal care aide must be required and intended to maintain optimum health status.

Personal care aides are prohibited from providing skilled care tasks identified on this form. Skilled care may be provided by an approved children's attendant caregiver.

Please provide additional information as indicated above:

	Daily monitoring/observation and assessment due to a medical condition ***Specify condition(s) and interventions***
	Medication Monitoring
	Catheter Care
	Skin impairment/ at risk for skin breakdown
	Speech, Physical, or Occupational therapy
	Tube feedings ***Specify:***
	Nasopharyngeal or tracheostomy suctioning or tracheostomy care
	Daily skilled monitoring for a combination of conditions which may result in special medical complications***. Specify possible complications, monitoring and interventions required***
	This individual is totally dependent in all activities of daily living
	Ventilator Dependent
	Vital sign monitoring ***Specify frequency:***
	Problem behavior ***Specify:***
	Cognitive Impairment
	Wandering/ Exit Seeking (not age appropriate)
	Lack of Safety Awareness (not age appropriate)/ Safety Precautions/ High Risk for Falls
	Special Diet. ***Specify:***
	Other ***Specify:***

How long would you expect personal care services to be needed?

[ ] 3 Months [ ] 6 Months [ ] 9 Months [ ] 12 months [ ] Indefinite

Note: ***If indefinite is checked, subsequent certification will not be required unless it appears the participant no longer meets the medical necessity criteria. If needs change a new certification form is required.***

Prescriber's Signature:_____Date:_____/_____/

S.C. MEDICAID HOME & COMMUNITYBASED WAIVERS PRESCRIBER STATEMENT FOR PARTICIPANT DIRECTED ATTENDANT CARE

I. PARTICIPANT INFORMATION SECTION: (To be completed by the participant and case manager.)

Participant's Name _____ Medicaid # _____ Date of Birth _____

Address _____ City _____ ZIP Code _____

Home Telephone Number _____ or Other Number(s) _____

Person Acting on Behalf of Participant/Representative _____ Telephone Number _____

List the "skilled service activities" I request the attendant to perform. Skilled service activities are those activities that are not routine activities of daily living and are activities the participant would be able to perform if the person was not disabled.

_____

_____

_____

_____ have been given information about the South Carolina Nurse Practice Act that provides for the performance of skilled services by unlicensed personnel. I and/or my designee understand that if at any time I want my attendant to perform additional "skilled service activities" not listed on this form, I will be required to complete this form with the additional services listed and have this self-direction form approved again.

Participant's/Representative Signature _____ Date _____

11. PRESCRIBER STATEMENT: (To be completed by the physician, physician assistant or nurse practitioner.)

☐ I agree that the participant or his/her designee can self-direct the "skilled service activities" listed above.

☐ I agree that the participant or his/her designee can self-direct the "skilled service activities" listed above with the following exceptions. Please list the exceptions to the participant or his/her designee self- directing the "skilled service activities" listed above.

_____

☐ I do not agree that the participant or his/her designee can self-direct the "skilled service activities" listed above.

Signature of Prescriber _____ Date _____

MEDICALLY COMPLEX CHILDREN (MCC) WAIVER PROGRAM
CHILDREN'S ATTENDANT CAREGIVER QUALIFICATION DOCUMENTATION

_____ XXX- XX-_____
Children's Attendant Caregiver Name **SSN**

_____ _____
MCC Waiver Participant Name **CLTC#**

DOCUMENTATION OF CHILDREN'S ATTENDANT CAREGIVER QUALIFICATIONS

TASK/SKILL/QUALIFICATION	USC NURSE	DATE	ATTENDANT CAREGIVER	DATE
CPR Training (Indicate initial or re-certification and training date) [ ] Initial [ ] Recertification Date Completed_____				
First Aid Training (Indicate initial or re-certification and training date) [ ] Initial [ ] Recertification Date Completed_____				
Tuberculosis Screening (Indicate initial or annual risk assessment – Annual RA) [ ] Initial [ ] Annual RA Date Completed_____				
Background Check* Date Completed_____ *Has no known conviction of abuse, neglect, or exploitation of adults or children, crime against another person, or felony				
Communicates effectively with participant [ ] Observed_____ [ ] **Did Not Observe/NA				
Communicates effectively with Employer of Record, if applicable [ ] Observed_____ [ ] **Did Not Observe/NA				
Adheres to basic infection control procedures while providing children's attendant care (If observed indicate date) [ ] Observed _____ [ ] **Did Not Observe/NA				
ADL Care – Bathing (If observed indicate date) [ ] Observed_____ [ ] **Did Not Observe/NA				
ADL Care – Dressing (If observed indicate date) [ ] Observed _____ [ ] **Did Not Observe/NA				
ADL Care – Eating (If observed indicate date) [ ] Observed _____ [ ] **Did Not Observe/NA				
ADL Care – Hygiene (If observed indicate date) [ ] Observed _____ [ ] **Did Not Observe/NA				
ADL Care – Mobility (If observed indicate date) [ ] Observed _____ [ ] **Did Not Observe/NA				
ADL Care – Toileting (If observed indicate date) [ ] Observed _____ [ ] **Did Not Observe/NA				
ADL Care – Transferring (If observed indicate date) [ ] Observed _____ [ ] **Did Not Observe/NA				

** Provide an explanation of any unobserved skill on page two

DOCUMENTATION OF SKILLED TASKS AND OTHER TASKS/QUALIFICATIONS

In the rows below indicate specific skilled tasks or other tasks from the waiver care plan observed during the match visit. Additional tasks or qualifications not represented above may also be included below.

TASK/SKILL/QUALIFICATION	USC NURSE	DATE	CAREGIVER	DATE

If additional observation or review was required on any components included on this form, document below the remedial instruction provided and the date(s)observed. If additional training is required, document the plan for instruction. Attach additional documents if necessary.

It is hereby certified that the tasks, skills, or qualifications documented on this form meet the minimum requirements for children's attendant caregivers as outlined in the Home and Community Based Services (HCBS) Scope of Services for Children's Attendant Care Self-Directed and was validated by a nurse employed by the vendor contracted to perform the task.

Children's Attendant Caregiver
(Signature) (Date)

USC Nurse
(Signature) (Date)

COMPETENCY EVALUATION DOCUMENTATION
(for Children's Personal Care)

Aide's Name_____ SSN # _____

Testing Agency _____

Test Administered By _____

Title and Nurse License Number _____

TEST RESULTS

AREA TESTED	PASSED/FAILED	DATE
Observation, Reporting and Documentation of patient status and the Care of Service provided		
Reading and Recording Temperature, Pulse and Respiration		
Confidentiality, accountability, and prevention of abuse and neglect		
Basic First Aid to include monitoring for side effects of medications and recognition of basic medical problems		
Basic Infection Control Procedures		
Fire safety/disaster preparedness		
Maintenance of a clean, safe and healthy environment		
Recognizing emergencies and knowledge of emergency procedures		
Appropriate and safe techniques in assisting in bathing, dressing, toileting, and any other activity of daily living		
Safe transfer techniques and ambulation		
Normal range of motion and positioning		
Ways to work with the physical, emotional, and developmental needs of the populations served by the agency, including the need for respect for the patient, his or her privacy, and his or her property		
Orientation to traumatic brain injury, spinal cord injury, intellectual disabilities, enteral and parenteral feeding, trach care, and technology-dependent conditions; crisis stabilization and de-escalation of behaviors		
Adequate nutrition and fluid intake		
Meal Planning and Preparation		
Shopping		
Transportation (optional for ages 18 – 21) and Escort Services (optional)		
Any other task that the agency may choose to have the PCA perform		

If retesting was required on any of the above components, document below the remedial instruction provided and the date(s) retested.

_____

_____

_____

_____

_____

CERTIFICATION STATEMENT

It is hereby certified that the competency evaluation documented by this form meets the requirements of the competency training and evaluation program as outlined in the Home and Community Based Scope of Services for Personal Care Aide and was administered by an instructor/evaluator who meets the requirements of such regulations.

RN Supervisor_____

(Signature) (Date)