Personal Care Assistant (PCA), Community First Services & Supports (CFSS), Homemaking, ICLS and Respite Care Client Handbook

Home at Heart Care, Inc.
221 3rd Ave SW
P.O. Box 183
Clearbrook MN 56634
(On the corner of 3rd Ave & Elm St)

218 776 3508 Phone
866 810 9441 (Toll Free)

218 776 3507 Fax
866 810 7008 (Toll Free Fax)
www.homeatheartcare.com Web
info@homeatheartcare.com Email

Effective January 30, 2025

This Client Handbook belongs to:

Name ______________________________

Phone ______________________________

Address ____________________________

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As indicated herein, most of the information within this Client Handbook & H@HC Policy Booklet is excerpted from the Minnesota Department of Human Services publication *Community First Services and Supports (CFSS) Policy Manual* found on the Minnesota Department of Human Services website at https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/cfss.jsp as of January 30, 2025; other Minnesota Department of Human Services websites which can be accessed from https://mn.gov/dhs/ ("MN-DHS Website") and the Minnesota Department of Health website, www.health.state.mn.us ("MDH Website) as of January 30, 2025. Changes in statutes, rules, regulations and policies of either the federal government or State of Minnesota after the dates the source material was published/may therefore not be reflected within the MDH Guidebook, the MN-DHS Website, the MDH Website and/or this Handbook.

If you have any questions regarding the information within this Client Handbook & H@HC Policy Booklet (including without limitation your potential eligibility for participation in Minnesota's Home at Community Services Program), please consult with an attorney or contact the Minnesota Department of Human Services Disability Services Division, https://mn.gov/dhs/.

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February 1, 2024

Dear Clients,

Thank you for selecting Home at Heart Care (H@HC) as your provider for your services. I realize that you had many provider choices and we are honored that you considered us. Each recipient of our services receives this Handbook or one like it. I believe it is important for you or someone you trust to read through this along with the H@HC Policy Booklet, because it will help you understand your responsibilities and ours as well as we serve you. Our Handbook and H@HC Policy Booklet include things that we are required by the State of Minnesota to provide to you such as the Minnesota Home Care Bill of Rights, Notice of Privacy Practices, Community Based Services Recipients Rights Packet (if applicable) and more.

As you can see below, I've included our Mission, Vision, and Value statements. These statements identify what we believe and what we want to be. This allows you the option up front to decide if we are a company that you would want to serve you. Simply said, the Mission statement is what I call our ultimate purpose for existing as a company. Our Vision statement is what we hope to accomplish as a company. And our Core Values is simply a list of common values that we hope everyone associated with Home at Heart Care would aspire too.

Please call us with any questions or concerns and please tell us how we can serve you better. Again thank you for giving us this opportunity.

Sincerely,
Troy McQuown
CEO,
Home at Heart Care, Inc.

Locally owned & operated in Clearbrook, MN
www.HomeAtHeartCare.com
(218) 776-3508

In-Home Personal Care & Homemaking

Mission Statement

Our name is an acronym for our Mission Statement.

Home is the word we use to describe the place where each person should be able to find rest, nourishment, comfort, healing and belonging regardless of ability.

Where it's **at** for us; connecting every person to a great caregiver.

The **Heart** of a great caregiver is one of trust, hospitality, compassion and responsibility.

We **Care** about people, because God cares about people.

Vision

To support In-Home Caregivers throughout the State of Minnesota who can make a Godly difference in someone's heart and home.

Core Values

Trust: We honor all relationships we have by serving with honesty and integrity.

Hospitality: We make the most of every opportunity we are given to help someone feel valued and loved.

Compassion: We serve with kindness and compassion, following Christ's example for us.

Responsibility: We work hard to meet the needs of the people with which we have been entrusted.

Community First Services and Supports (CFSS) is a Minnesota health care program that offers flexible options to meet the unique needs of people. CFSS allows people greater independence in their homes. CFSS with replace personal care assistance (PCA) and the Consumer Support Grant (CSG). DHS began implementing CFSS on October 1, 2024.

PROCESS for CFSS agency model[1]

Note: All assessment happening on or after Oct. 1, 2024, will follow the CFSS agency model or CFSS budget model process.

To access CFSS agency model services:

1. The person requests an assessment.
2. The lead agency conducts the assessment and determines the person's need for services.
3. The person selects CFSS services, if eligible.

   Note: A person eligible for a waiver or AC may choose to use the waiver or AC instead of or in addition to CFSS services.
4. The lead agency provides the person with a list of consultation services providers.
5. The person chooses a consultation services provider and notifies the lead agency of their choice.
6. The lead agency issues a service authorization for consultation services.

   Note: During the transition year, the lead agency also authorizes six months of PCA personal care services and six months of QP units to avoid a gap in the person's services.
7. The person selects the agency model, a CFSS provider agency and a financial management services (FMS) provider, if applicable.

   Note: An FMS provider is only required if the person will purchase goods and services.
8. The person writes the service delivery plan with help from the consultation services provider, if desired.
9. The consultation services provider reviews the service delivery plan.
10. The lead agency approves the service delivery plan.
11. The lead agency issues a service authorization to the CFSS provider agency, personal emergency response (PERS) provider and FMS provider, if applicable.

    Note: During the transition year, the lead agency takes the appropriate action based on the person's situation:

    - **Person not on waiver/AC:** End the current SA and enter a new SA that starts on the day after the end of the six-month SA and ends on the last day of the person's service plan year. For most people, this new SA lasts for six months.
    - **Person on a waiver/AC and not enrolled in a managed care organization (MCO):** Enter new lines on the existing SA for the person's approved CFSS services. The new lines start on the day after the end of the six-month lines and end on the last day of the person's service plan year. For most people, these new lines last for six months.
    - **People age 65 and older who receive PCA/CFSS through their MCO:** Follow the MCO's process for authorization.

[1] Information in this section derived from Overview of the PCA and CFSS processes (last visited January 24, 2025).

12. The person and CFSS provider agency fill in any details missing in the service delivery plan.
13. The person and CFSS provider agency train the workers.
14. All of the following happens:
    - The workers deliver care according to the service delivery plan.
    - The FMS provider facilitates the purchase of goods and services, if applicable.
    - The PERS provider delivers PERS equipment and ongoing services, if applicable.
15. The person and CFSS provider agency oversee and evaluate services.
16. The CFSS provider agency requests a reassessment 60 days before the end of the current authorization.

CFSS Provider Agency[2]

Differences: In CFSS, the two provider types that are not in PCA are consultation services provider and Financial Management Services (FMS)

What does a CFSS Provider Agency do?

- Have a manual that describes their policies and procedures.
- Give people information about their rights.
- Comply with provider marketing policies.
- Ensure staff members meet training requirements.
- Evaluate and supervise services.
- Comply with legal requirements for workers' wages.
- Ensure they are never the provider agency and the housing provider for the same person.
- Meet all requirements for Minnesota Health Care Programs (MHCP) providers.

PERSONAL CARE ASSISTANCE (PCA) & COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS) SERVICES

The eligibility requirements for CFSS will be the same as PCA. A person eligible for PCA will also be eligible for CFSS unless they have a change in their condition.

Who may receive PCA/CFSS services?[3]

To be eligible for a person must:

- Live in the community and not a facility, such as a skilled nursing home.
- Be able to direct care or have a representative who can direct care on their behalf.
- Be enrolled in one of Minnesota's health care programs: Medical Assistance (MA), an MA waiver, the Alternative Care Program and some people on MinnesotaCare.
- Have an assessment that determines they are eligible.
- Not be using the Family Support Grant

The person's county, tribal nation or managed care organization conducts the assessment.

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[2] Information derived from PCA/CFSS provider agency requirements overview (last visited January 24, 2025)
[3] Information derived from Community First Services and Supports / Minnesota Department of Human Services (last visited January 24, 2025)

What can PCA/CFSS Services do for me?[4]

Differences between PCA and CFSS: PCA covers services provided by a qualified professional (QP).

CFSS Covers

- Assistance with skill development, maintenance and enhancement.
- Consultation services.
- Worker training and development.
- Goods and services.
- Financial management services (FMS).

PCA/CFSS covers these four basic categories of services:

- Activities of daily living (ADLs): Activities a person needs to carry out on a daily basis to remain healthy and safe. The covered ADLs are dressing, grooming, bathing, eating, positioning, transfers, mobility and toileting.
- Instrumental activities of daily living (IADLs): Activities a person needs to carry out on a regular basis related to living independently in the community. Examples include shopping, paying bills, communication and meal preparation. IADLs are limited for a person younger than 18.
- Observation and redirection of behaviors: Monitoring a person's behaviors and redirecting them to more positive behaviors when needed.
- Health-related procedures and tasks that can be delegated or assigned by a health care professional: Tasks such as supporting a person with self-administered medications or help with range of motion exercises.
- Driving [**NOTE: DUE TO MULTIPLE CHALLENGES, HOME AT HEART HAS DECIDED NOT TO INCLUDE DRIVING IN THE SERVICES THAT THEIR WORKERS PROVIDE]**

CFSS also covers assistance with skill development, maintenance and enhancement, consultation services, worker training and development, goods and services, financial management services (FMS). These services are separate from Home at Heart and the personal care services provided.

ASSESSMENT[5]

There are no differences in the assessment process for PCA and CFSS.

What is a PCA/CFSS Assessment?

You must have an evaluation of your needs to see if CFSS services are right for you. An assessor visits your home and reviews your daily needs and health.

How do I schedule an assessment?

Depending on what health care program you are with, different people do the assessment. Your assessment should happen within 20 days of contacting one of the following:

- If you are over 64, and enrolled with a managed care organization, you must contact your MCO's member services department.
- Otherwise, you must contact your local county or tribal nation.

[4] Information derived from PCA/CFSS covered services (last visited January 24, 2025)
[5] Information derived from Assessment for PCA/CFSS services (last visited January 24, 2025)

Does my participant's representative have to be there?

If you are under 18 years old or need help directing your own care, you need a participant's representative. A participant's representative has to attend your assessments. If the assessor thinks you need a participant's representative, you need to reschedule your assessment for a time your participant's representative can attend.

What can I expect at the assessment?

An assessor visits your home and reviews your daily needs and health. During the evaluation, the assessor completes the CFSS Assessment and Service Plan form. The assessment:

- Documents your health status.
- Determines your need for a representative.
- Determines your need for services.
- Determines the amount of services to authorize.
- Identifies service options.
- Provides you with a list of CFSS consultation services providers.
- Refers you to other resources and programs, when appropriate.

If CFSS services are right for you, the assessor will authorize services based on the results of the assessment.

What happens after the assessment?

A copy of the CFSS eligibility results will be sent within 10 business days to:

- You.
- Representative (if applicable).
- PCA/CFSS provider agency (if known).
- Consultation services provider (if known).

How often do I need an assessment?

A new evaluation is needed yearly, or when your health changes significantly. Contact your assessor or your provider agency if you have a significant change in your health.

SERVICES FOR CHILDREN UNDER AGE 18[6]

There are no differences in this policy for PCA and CFSS.

You must schedule an assessment to determine if PCA/CFSS services are available for your child.

What extra rules apply to children?

- Children under 18 must have a participant's representative.
- Parents, stepparents or paid legal guardians cannot be a child's PCA/CFSS worker.
- PCA/CFSS workers cannot help children with most instrumental activities of daily living (IADLs).
- CFSS services depend on the age of the child and what parents do for a child that age.

[6] Information derived from PCA/CFSS age-appropriate dependencies (last visited January 24, 2025)

What are age appropriate dependencies?

There are activities that all children of a particular age are unable to do on their own. For example, no infants can bathe themselves. The assessor looks at what activities of daily living children without disabilities can do independently.

What can PCA/CFSS workers do for my child?

PCA/CFSS worker can:

- Provide hands-on assistance with an activity of daily living (ADL)
- Remind or standing by and direct the completion of an ADL.
- Identify and de-escalate episodes of behavior.
- Perform delegated health-related procedures and tasks.

PCA/CFSS workers may help children with some instrumental activities of daily living (IADLs) such as light housekeeping and laundry for health and hygiene reasons integral to CFSS services for the sole benefit of the child. These IADLs must be listed on the Assessment and Service Delivery Plan.

What are PCA/CFSS workers not allowed to do for my child?

- Assist with most IADLs.
- Assist other family members unless under the shared service option.
- Child care or babysitting.

What kinds of tasks must family do?

Parents and family members are responsible for:

- Basic care, nurturing and supervision.
- Giving medication.
- Most IADLs, like shopping, cooking, laundry, cleaning and transportation.

Can my child's PCA/CFSS worker help at school?

A child who needs CFSS services during the school day will have an individualized education plan (IEP/IFSP) written. Parents have a choice of how PCA/CFSS services are delivered at school.
To learn more, talk with the school special education director. The PCA/CFSS worker should not duplicate or replace services already provided by the school.

See Minnesota Health Care Programs Individualized Education Programs Services at the following website Individualized Education Program (IEP) Services - Personal Care Assistance (PCA) Services.

PARTICIPANT'S REPRESENTATIVE (RP)[7]

In both PCA and CFSS, the person directs their own care unless they are unable to do so. If necessary, another individual can direct care on the person's behalf. The requirements, limitations and responsibilities of this individual are the same in both PCA and CFSS. The only

[7] Information derived from Responsible party (PCA) and participant's representative (CFSS) (last visited January 24, 2025).

difference is in PCA this individual is called the Responsible Party (RP) and in CFSS the individual is called the Participant's Representative (representative).

Do I need a representative?

Representatives are required if:

- A minor
- An incapacitated adult who has a court-appointed guardian
- Determined through the assessment process to need a representative.

Who can be my representative?

An individual who is age 18 or older and capable of directing care on behalf of a person receiving PCA/CFSS services when the person is assessed as unable to direct their own care.

Representative could include, but is not limited to:

- Parent
- Licensed family foster parent
- Neighbor
- Friend
- Two people (such as divided households and court-ordered custodies)

Representative must be:

- Listed on the person's service agreement and service delivery plan.
- Identified before the lead agency authorizes PCA/CFSS services.

Who cannot be my Representative?

- PCA/CFSS worker, including a parent serving as a worker for their minor child or a spouse serving as a worker for their spouse.
- Provider agency owner or manager.
- Provider agency staff member, unless related by blood, marriage or adoption.
- Lead agency staff member or contractor acting as an employee.
- Qualified Professional (QP) (PCA only).
- Financial management services (FMS) provider owner or manager.
- FMS provider agency staff member, unless related by blood, marriage or adoption.
- Consultation services provider owner or manager.
- Consultation services provider staff member, unless related by blood, marriage or adoption.
- Worker training and development provider.

The Representative must:

- Actively participate in planning and directing the person's PCA/CFSS services.
- Help the person make choices about PCA/CFSS services.
- Request changes to the person's service delivery plan, as needed.
- Sign required forms, including all worker time and activity sheets.
- Sign the Representative agreement.

Note: The Representative is the only individual who may request that the person change models or providers. DHS will confirm all requests for changes are from the Representative listed in MMIS.

Monitoring

The Representative must:

- Be available when the person receives services via an agreed upon communication method (e.g., phone call) that is documented in the service delivery plan and on the Representative agreement.
- Monitor PCA/CFSS services to ensure workers follow the person's service delivery plan.
- Communicate with all providers and/or workers, as needed.
- Monitor the delivery of services to ensure they are provided (e.g., ensure documentation is accurate).
- Review and approve the worker's documentation of time worked (refer to note below.)

Note:

- If there are two RPs/Representatives of a minor, only one must sign the documentation.
- The Representative must be the person approving the worker's documentation of time worked, with one exception: When there are two biological or adoptive parents living with a minor, either parent can sign and approve documentation (except in cases when one or more parents are serving as the worker.)

Health and Safety

The Representative must:

- Develop the service delivery plan with the QP (PCA) or consultation services provider (CFSS).
- Determine if current PCA/CFSS services meet the person's health and safety needs or if the person needs a change to their services.

Representative Agreement

Before the person receives PCA/CFSS services, the Representative must sign an agreement to indicate understanding of the responsibilities associated with the role. The Representative must complete and sign a new agreement annually. When there are two individuals identified as the person's Representative, each individual must sign the agreement.

Delegation

During a temporary absence of at least 24 hours (but not more than six months), the Representative may delegate their role to another individual who meets the requirements for an Representative.

The Representative must communicate to the provider agency or FMS provider about the need for a delegated Representative, including the following information:

- Name of the delegated Representative.
- Contact information for the delegated Representative.

Delegated RPs/Representatives must:

- Be identified at the time of the assessment, if possible.
- Be listed in the service delivery plan.
- Meet all criteria and perform the functions of the Representative.
- Complete and sign CFSS Representative Agreement DHS-6893F (coming soon).

RIGHTS AND RESPONSIBILITIES[8]

What are my responsibilities?

PCA/CFSS services are designed to be flexible and driven by you. You are responsible to request an assessment, provide honest and accurate information to the assessor's questions, and to enter into an agreement with Home at Heart that describes the services you will receive.

- Do not ask your PCA/CFSS worker to complete tasks not allowed by state law.
- Do not ask your PCA/CFSS worker to help or take care of others in your home.
- Keep track of the hours of PCA/CFSS services you have used.
- Review and sign accurate time tracking information for your worker.
- Work with Home at Heart to train and determine the competency of your worker.
- Orient your workers to your needs and preferences.
- Direct your workers as they deliver services.
- Report any problems with the quality of the services delivered by your worker to Home at Heart, your case manager or care coordinator (as applicable).
- Notify Home at Heart of changes that affect your service delivery plan, such as hospitalization or a change in your place of residence.
- Participate in the evaluation of services and support workers.

What are my rights?

Similarities: People using PCA and CFSS have rights that their workers, providers, lead agency staff and DHS must respect and protect.
Differences:

- In PCA, people's rights are described in the Home Care Bill of Rights. PCA provider agencies are required to provide each person with the Home Care Bill of Rights at the start of services.
- In CFSS, people's rights are listed in this handbook and in CFSS Statute (Minn. Stat. §256B.85, subd. 20b and 20c).

People using CFSS have the right to:

- Choose or change service options (with some exceptions; refer to CFSS Manual – PCA service options and CFSS service models and CFSS Manual – CFSS budget model requirements).
- Choose their providers.
- Participate in person-centered planning.
- Participate in developing their service delivery plan.
- Participate in choosing their workers.

People using CFSS have a right to information about:

- Their rights and responsibilities.
- Service options.
- Available providers.
- The services their provider does and does not provide before the start of services.

[8]Information derived from Person's rights and responsibilities in CFSS (last visited January 24, 2025)

- How much the services cost and under what circumstances they might be responsible for costs.
- Their staffing, including the proposed frequency and schedule (CFSS agency model only).
- The process to change services and/or providers.
- How to file complaints with their providers without fear of retaliation.
- How to contact the Ombudsman Office for Long-Term Care.

People using CFSS agency model have the right to:

- Receive services from a worker trained and determined competent by a supervising professional with the appropriate background for their needs.
- Have their support worker preferences documented by the provider agency and met whenever possible (if the person expressed a preference).

People using CFSS have the right to:

- Refuse or terminate services.
- Change their services and/or providers, including a coordinated transfer between providers.

People using CFSS have a right to received timely notices of:

- Reduction, termination or denial of services (minimum 10-day notice).
- Provider discontinuing services (minimum 30-day notice, with some exceptions).

People using CFSS have a right to appeal:

- Results of their assessment.
- Denial of their service delivery plan.
- Removal by DHS or the lead agency from the CFSS budget model.

People using CFSS have the right to continue accessing their CFSS services until they receive the outcome of their appeal of a reduction or termination of services.

People using CFSS have a right to:

- Privacy (refer to Information Access and Privacy, DHS-2667 [PDF]).
- Freedom from maltreatment.

CONSULTATION SERVICES[9]

People receiving PCA will need to meet with a Consultation Services Provider upon their reassessment beginning Oct 1, 2024.

What does a Consultation Services Provider do?

- Ensure the person knows and understand their rights by taking the following actions within five working days of the start of services and annually:
    - Provide the person with CFSS Rights and Responsibilities, DHS-6893R (PDF) or an alternative when the person needs it to understand their rights.
- Provide the person with:
    - Consultation services provider's policies and procedures.

[9] Information derived from CFSS consultation services overview (last visited January 24, 2025)

    - Information about how to file a complaint about the consultation services provider.
    - Contact information for the Ombudsman Office for Long-Term Care.
- Enter into a written agreement with the person that describes the roles and responsibilities of each party.
- Provide the person with the information they need to make service choices, including, but not limited to:
    - Person-centered planning information.
    - Differences between the agency and budget models.
    - Risks and responsibilities of the agency and budget models.
    - How to find a list of all provider agencies and/or FMS providers.
    - How to make changes to their service delivery plan.
- Not attempt to influence the person's choice of model or provider.
- Not limit the number of times the person changes or updates their service delivery plan.
- Protect the person's right to privacy and freedom from maltreatment.
- Provide education to help people make informed decisions about how to meet their needs using CFSS.
- Help people write their service delivery plans, if desired.
- Review people's service delivery plans.
- Provide people with ongoing support, as needed.

The consultation services provider:

- Educates the person about CFSS and its service options.
- Supports the person to write their service delivery plan, to the extent the person desires.
- Reviews the person's service delivery plan.
- Provides guidance about whether the person's service delivery plan is complete and only contains covered services.
- Submits the service delivery plan to the lead agency for approval.
- Responds to questions and concerns the person has throughout the service plan year.
- Supports the person to make changes, if needed.
- Semi-annually reviews the person if they do not have a case manager/care coordinator and their spouse or parent (if a minor) serves as their worker.

PCA/CFSS SERVICE DELIVERY PLAN (care plan)[10]

Differences: In PCA, the document is called the "care plan". In CFSS, the document is called the "service delivery plan."

There are differences in the covered and non-covered services in PCA and CFSS. There are also differences in the process to develop a service delivery plan. In CFSS, DHS encourages people and their consultation services provider to use the DHS service deliver plan template.

What is a service delivery plan?

A person-centered, written document that identifies the PCA/CFSS services a person will receive based on their assessed needs and how those services will be delivered. This plan must be

[10] Information derived from PCA/CFSS service delivery plan (last visited January 24, 2025)

created/updated before starting services, whenever there is a change, and annually at the time of reassessment. A copy must be kept in your home, with the provider agency and your consultation services provider.

Who writes the service delivery plan?

In PCA, you or your Representative (if applicable) are responsible to:

- Write the service delivery plan, with help from the qualified professional (QP) as desired.
- Implement the service delivery plan, with help from Home at Heart.

In CFSS, you or your Representative (if applicable), are responsible to:

- Write their service delivery plan, with help from the consultation services provider as desired.
- Submit the service delivery plan to their consultation services provider for review.
- Implement the service delivery plan, with help from Home at Heart.

Home at Heart will help you write the plan, work with you to fill in details not included in the plan approved by the lead agency, provide a copy for your home, provide the covered services included in the plan and supervise and document the competency of the workers to perform the tasks listed in the plan.

What is included in the service delivery plan?

- Total units available.
- Person's name, address and telephone numbers.
- Person's person master index (PMI) number.
- Person's date of birth.
- Representative's name, address and telephone numbers (if applicable).
- Start date and end date of the service delivery plan.
- Dated signature of the person or Representative.
- Covered services.
- Person's individualized needs and goals.
- Services provided by the worker.
- Special instructions or procedures.
- Emergency Plan.
- Worker training and development plan.
- Description and cost of goods and services (if applicable), including how they meet the criteria for covered goods and services.
- Personal emergency response system (PERS) provider and costs (if applicable).
- Skill maintenance and enhancement plan (if applicable).

PCA/CFSS Service Delivery Plan Changes[11]

Differences: In PCA, the QP and the person write the service delivery plan and make changes as needed. In CFSS, the consultation services provider and the person write the service delivery plan and make changes as needed.

The following changes require authorization from the lead agency or DHS:

- Change in provider.

[11] Information derived from PCA/CFSS service delivery plan changes (last visited January 24, 2025)

- Change in your Representative.
- Change in service model.

The following changes do not require authorization from the lead agency or DHS:

- Changes in your contact information (or your representative's contact information), minor changes in how your worker performs a task, or your backup plan.

Please communicate with Home at Heart to keep your records up to date on these types of changes.

SERVICE AUTHORIZATION AND APPEALS

What is the service authorization?

Document used to identify services, providers and payment information for a person receiving home care, Alternative Care (AC) or waiver services. It allows providers to bill for approved services and allows DHS to audit usage and payment data.

How many hours of PCA/CFSS help will I receive?

If you qualify, you could get from one hour and 15 minutes a day to 24 hours a day, depending on your needs.

What is a Service Agreement letter?

You will get a letter indicating how many 15-minute units of PCA services you may use. This letter is called the service agreement letter. It tells you about your service authorization amount. Instructions for understanding this letter are on page one of the PCA Assessment and Service Plan.

When can I begin getting PCA/CFSS services?

Your letter includes the effective date of service. You can begin receiving services on that date, if you have named a provider. You have 60 days to choose a provider agency.

What if I disagree with my assessment results, how can I appeal?

You may appeal a decision about your authorization for services or total units. Details about appeal procedures are included in the service agreement letter. A variety of appeals resources are available at the DHS Appeals and Regulations Division Website. https://mn.gov/dhs/general-public/about-dhs/administration-management/appeals.jsp#

PCA/CFSS WORKER CRITERIA, REQUIREMENTS & RESPONSIBILITIES[12]

Differences:

- In PCA, a person who receives PCA cannot serve as a worker for other people who receive PCA and a PCA worker cannot be younger than age 16.
- In CFSS, a person who receivies CFSS can serve as a worker for other people who receive CFSS, the person who receives CFSS has a budget for worker training and

[12] Information derived from PCA/CFSS worker criteria, requirements and responsibilities (last visited January 24, 2025)

development, and there are restrictions on the number of hours a spouse or parent of a minor can provide.

Who can be a PCA/CFSS worker?

Employment Requirements:

- Be 16 or older (Note: People ages 16-17 must meet additional requirements)
- Pass the standardized certification test.
- Pass a background study initiated by Home at Heart.
- Begin the enrollment process to become a PCA/CFSS worker.

Requirements specific to providing services

A person employed as a PCA/CFSS worker must:

- Complete training and orientation on the needs of the person receiving services.
- Communicate effectively with the person and Home at Heart.
- Provide covered services according to the person's individual service delivery plan and as directed by the person and/or their representative.
- Respond appropriately to the person's needs.
- Receive feedback from the person, representative and provider agency, if applicable.
- Document the services they provide and the times they provide those services.

A PCA/CFSS worker who is age 16-17 must meet these additional requirements:

- Be employed by only <u>one</u> PCA provider agency responsible for compliance with current labor laws
- Be monitored by a qualified professional every 60 days.
- Have all worker evaluations conducted in person and at the location the person receives CFSS services. (CFSS only)
- *High School students aged 16 and 17 may not work after 11 p.m. on an evening before a school day or before 5 a.m. on a school day.*

Limitations

A PCA/CFSS worker cannot provide services to a person if they have any of the following relationships with that person:

- RP (PCA only)
- Representative.
- Paid legal guardian.
- Licensed foster care provider, unless the person and the worker live in the same home.

Only the first 310 hours worked by a PCA/CFSS worker are eligible for Medical Assistance payments to a provider agency/FMS provider, regardless of:

- The number of people the PCA/CFSS worker supports
- The number of provider agencies/FMS providers with which the PCA/CFSS worker is affiliated.

<u>Note:</u> if the worker suppots people eligible in both PCA and CFSS during the transition, the 310-hour limit applies to the total hours worked in both PCA and CFSS.

PCA/CFSS WORKER TRAINING AND ORIENTATION[13]

Similarities:
In PCA and CFSS, the worker's employer must train, supervise and evaluate the worker.

Differences:
In PCA, an individual called the qualified professional (QP) is responsible to:

- Train the worker on the individual needs of the person.
- Ensure the worker is competent to support the person.
- Supervise the worker.
- Evaluate the worker.

The lead agency authorizes QP units to pay for the QP's time.

In CFSS, the entity responsible for these tasks depends on the person's model:

- In the agency model, the CFSS agency supervising professional(s) are responsible for these tasks.
- In the budget model, the person is responsible for these tasks.

In both CFSS models, the lead agency authorizes a CFSS worker training and development budget that the worker's employer (e.g., agency or person) can use flexibly to fulfill these responsibilities.

What is a CFSS worker training and development budget?

A separate budget available to employers of CFSS workers (e.g.,., CFSS agency or person/representative) to pay for training, observation, monitoring and coaching of CFSS workers. These activities help CFSS workers expand their skills to support the person's specific needs.

Overview of worker training and development

1. The person includes ideas and information about their worker's training needs when they write their service delivery plan.
2. The lead agency authorizes worker training and development for the person.
3. The CFSS provider agency and person write and refine the worker training and development plan.
4. The supervising professional trains the person's worker and ensures they are competent.
5. The worker attends classes, if applicable.
6. The CFSS provider agency bills DHS for time the supervising professional spends training the worker and for classes, if applicable.

What can a supervising Professional(s) use the training and development budget for?

- Explain and demonstrate needed tasks.
- Observe, monitor and coach the worker on performing tasks.
- Evaluate the worker's competency to perform tasks.
- Document that the worker is competent to perform a task.

[13] Information derived from CFSS worker training and supervision (last visited January 24, 2025)

What can a PCA/CFSS workers use the training and development budget for?
Home at Heart can use the CFSS worker training and development budget to pay the fees for a worker attending a class or workshop on topics related to the person's assessed needs.

A class can take place in a variety of setting and have varying amounts of learners (e.g., one-on-one training, traditional classroom course, online class).

What can the training and development budget NOT be used for?

- Training for anyone who is not the worker (e.g., provider agency staff, person receiving services, representative).
- Training provided by the person's consultation services provider.
- General provider agency training, worker orientation or training about CFSS self-directed models.
- The trainer's planning time.
- The worker's wages during the training (refer to the employer responsibilities section or FMS provider responsibilities section for a description of how the provider agency/FMS provider pays for the worker's time).
- Training or supervision provided by the person, their support worker or their informal supports, including their representative.
- Services that exceed the amount specified in Long-Term Services and Supports Service Rate Limits, DHS-3945 (PDF), unless approved by DHS.
- Training provided by an individual without the relevant background needed to provide training on that topic.

Worker training plan
All people using CFSS must have a worker training plan. Home at Heart must create a plan that describes:

- Training the person's workers need.
- The supervising professional(s).
- The license, education, training or work experience of the supervising professional(s).
- A plan to supervise and evaluate the workers.
- Classes the worker(s) will attend, if applicable.

When is my PCA/CFSS worker oriented and trained on my needs?
For each worker, Home at Heart must:

- Evaluate the worker's competency to support the person within 30 days of the worker starting PCA/CFSS services for that person.
- Complete the initial evaluation through direct observation of the worker performing tasks in a setting where the person is receiving PCA/CFSS services.
- Conduct periodic performance reviews at least once per year.

If the worker is a minor, Home at Heart must complete **ALL** worker competency evaluations in person and in a setting where the person is receiving CFSS services.

All education, training and experience relevant to the tasks the person needs must be documented, as well as any other training provided by the employer and all performance reviews conducted by Home at Heart. Worker training must be reviewed and updated at the start of service, after annual

reassessments, when there is a significant change in the service deliver plan and when a performance review indicates a need for additional training.

Updates to the worker training plan

Home at Heart must update the worker training plan in all of the following situations:

- At reassessment.
- When a new worker starts providing services to the person.
- When there are significant changes to the person's service delivery plan.
- When a performance review indicates a worker needs additional training.

How should I orient my PCA/CFSS worker?

There is more than one way to orient and train PCA/CFSS workers. Some people respond well to oral directions while others may prefer hands-on demonstrations. Some people may prefer written information.

You will work with your Home at Heart supervising professional in training your worker. You may consider writing down your expectations so they are clear and you and your workers can refer back to them.

What topics should I cover in orientation?

Tour

Give PCA/CFSS workers a tour of their new work site. Include:

- Emergency escape locations
- Fire detectors and alarms
- Fire extinguishers
- Location of care plan
- Location of supplies or equipment they will be using
- Place where they can put their coat, belongings
- Restrooms
- Spaces where they will be working

Boundaries

Different people have different boundaries. What one person is comfortable with or thinks is appropriate may not be what someone else considers appropriate. Some examples:

- Live-in PCA/CFSS workers. There will be additional issues to discuss with workers who live with you. Issues can include free time, common spaces used by everyone, cleaning schedules, use of personal items and payment of bills.
- Personal property. PCA/CFSS workers should respect your personal property and ask permission if they want to use it. For instance, you may or may not want to share food and beverages with your workers.
- Personal phone calls. PCA/CFSS workers should ask to make or answer a call (either on your phone or their cell phone). Placing a time limit on the calls may be beneficial. Also, be aware that long distance phone calls may happen. Talk to your PCA/CFSS worker about costs prior to the phone call.
- Smoking. You should discuss whether it is okay for a PCA/CFSS worker to smoke in your house, or in a designated area outside of your house. Let them know about how to dispose of butts.

- Use of vehicles. Home at Heart does not provide transportation services under CFSS. Please do not ask your PCA/CFSS worker to drive you to any location. They can accompany you to appointments and community events when you have another driver or transportation.

Your Needs

- As you go through your routine, explain why tasks need to be done. This will help PCA/CFSS workers realize the importance of these tasks.
- Ask for feedback about how you are explaining things. There may be a way to be clearer in your explanations.
- Be patient. Learning how to do new things takes a while. Do not become frustrated if your PCA/CFSS worker does not catch on right away.
- Conduct specific training on your cares, such as how to transfer from a bed to a chair or how to style your hair.
- Give a lot of examples and explain any technical terms you use.
- Provide training on how to operate any life support equipment (e.g.,. feeding tubes, ventilators, etc.) you have. Include how to properly handle and clean this equipment or any other medical supplies you use.
- Stress the importance of documentation of tasks and times.
- Talk about any symptoms or health concerns they need to be aware of. Include anything that may arise and how to handle the situation. For example, if you have epilepsy, what do you expect the PCA/CFSS worker to do if you are having a seizure?
- Talk about your disability and how it affects your life. The more your PCA/CFSS worker knows about your disability, the better they will be able to meet your needs.

Paying a spouse or parent of a minor for PCA/CFSS services[14]

Differences:

- In PCA, provider agencies must bill DHS for services provided by the person’s spouse or parent of a minor using the claims modifier U2.
- In CFSS: there restrictions on the number of hours of CFSS services a person’s spouse or the parent of a minor can provide per week however, provider agencies and FMS providers bill the same way they bill for other workers.

The term “parent” includes adoptive parent, biological parent, stepparent, legal guardian of a minor or a person legally responsible for a minor. A “spouse” includes anyone to whom a person is legally married.

The spouse or parent of a minor must meet all PCA/CFSS worker criteria and meet the qualifications and standards identified in the person’s service delivery plan.

A spouse or parent of a minor can be paid to help their spouse or child with tasks beyond what is considered ordinary responsibility (e.g., doing additional laundry for a 12-year-old child who is incontinent). The service provided must not be an activity the spouse or parent of a minor would typically perform or be responsible to perform, such as:

- Age-appropriate supervision or transportation of children.

[14] Information derived from CFSS - Paying a spouse or parent of a minor (last visited January 24, 2025)

- Ordinary household maintenance (e.g., house cleaning, meal preparation, laundry).

While providing PCA/CFSS services as identified in the service delivery plan, the spouse or parent of a minor must function as a paid worker, not as a spouse or parent. The spouse or parent of a minor must follow all policies that apply to all workers, including recording hours worked that correspond to the job description and general work schedule. The schedule can include variability for school schedules, extracurricular activities, illness, absent workers, etc.

Spouse or one parent of a minor providing services

Home at Heart cannot bill for more than 60 hours in a seven-day period for:

- A spouse providing services.
- A parent of a minor if they are the only parent providing services.
- A person providing services to both their spouse and their minor child.

More than one parent of a minor providing services

If more than one parent of a minor provides services to their minor child(ren):

- Home at Heart cannot bill for more than a total of 80 hours in a seven-day period.
- Home at Heart cannot bill for more than 40 hours for each parent in a seven-day period.

What can a PCA/CFSS worker do for me?[15]

PCA/CFSS workers can help you with covered services including:

- Dressing
- Grooming
- Bathing
- Eating
- Transfers
- Mobility
- Positioning
- Toileting
- Health related procedures and tasks
- Observing and redirecting behaviors

For adults, PCA/CFSS workers may also help with instrumental activities of daily living (IADL) such as:

- Go to medical appointments.
- Participate in the community.
- Pay bills.
- Communicate by telephone and other media.
- Complete household tasks necessary to support the person with an assessed need (e.g., planning and preparing meals or shopping for food, clothing and other essential items).

PCA/CFSS workers can assist children with instrumental activities of daily living (IADL) **ONLY** under the following conditions:

- The child needs immediate attention for health and hygiene reasons.
- The IADL is necessary to support the child with an assessed need.
- The assessor indicates the child has this need in their assessment results.

A PCA/CFSS worker may observe and provide redirection to the person for episodes of behavior that need redirection, as identified in the person's service delivery plan.

[15] Information derived from PCA/CFSS covered services (last visited January 24, 2025)

CFSS covers time spent by the worker to help the person acquire, maintain or enhance the skills necessary for them to complete ADLs, IDLs or health-related tasks.

Can a PCA/CFSS worker help with my medications?[16]

Under the direction of you or your Representative, your PCA/CFSS worker can:

- Open medications under the direction of you or your Representative, including medications given through a nebulizer.
- Organize medications (e.g., put them in a daily pill container) under the direction of the person or their Representative (if applicable).
- Remind you to take regularly scheduled medications, including medications given through a nebulizer.
- Bring you your medication
- Bring you food or liquid to take with medications.

PCA/CFSS workers cannot:

- Determine medication dose or time medication should be given.
- Determine the person's need for medication or evaluate the effectiveness of it.
- Set-up your medication independently.
- Perform sterile procedures.
- Inject fluids and medications into veins, muscles or skin.

The PCA/CFSS worker is responsible to:

- Follow the directions of you or your Representative.
- Follow Home at Heart policies.
- Complete documentation after finishing each task.

What is a PCA/CFSS worker unable to do for me[17]?

PCA/CFSS workers cannot:

- Provide services not listed on the assessment, service delivery plan, or authorization.
- Application of restraints.
- Attempts to control or discipline you by limiting their access to something they need or want.
- Home maintenance or chore services (e.g., lawn care, snow removal, packing belongings).
- Services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules
- Services that only provide child care.
- Services provided by a non-relative who owns or otherwise controls the living arrangement.

Where can a PCA/CFSS worker provide services to me?

You can receive PCA/CFSS services wherever normal life activities take you. This includes but is not limited to:

- Your home.

[16] Information derived from PCA/CFSS assistance with self-administered medications (last visited January 24, 2025)

[17] Information derived from PCA/CFSS covered services (last visited January 24, 2025)

- Home of a family member or friend.
- Location of community activities.
- Child care program licensed under Minnesota statutes or operated by a local school district or private school.

The PCA/CFSS worker cannot provide services in the PCA/CFSS worker's home, unless the PCA/CFSS worker lives with you. If the location of services includes a fee or other costs, discuss this with your PCA/CFSS worker prior to event. PCA/CFSS worker's are not required to pay for expenses related to providing services.

Can I use my PCA/CFSS worker at work?
PCA/CFSS worker may assist you at work. They may provide any assistance you need in your care plan. You have the following choices for getting personal care assistance at work:

- You may schedule a PCA/CFSS worker to come in to your workplace at the times you need help.
- You may find someone employed at your workplace who is willing to work as a PCA/CFSS worker for you.

Please check with your employer before hiring a co-worker to be a PCA/CFSS worker in the workplace.

Sometimes you may need help with things specific to your job, such as typing or filing. Talk with your employer about the options you have for getting this help. Perhaps someone else at the workplace can help arrange assistance or assist with tasks. These are often considered reasonable accommodations under the Americans with Disabilities Act (ADA).

COACHING YOUR CAREGIVER

Home at Heart Care is responsible for evaluating your Caregiver; however, we cannot accurately evaluate your Caregiver without your help. You will be asked to provide constructive feedback about your Caregiver for formal evaluations that are done by Home at Heart Care. It is important for Caregivers to know how they are performing and whether they are meeting your expectations before evaluations are conducted.

Here are some tips on giving feedback to your Caregiver:

- Give feedback often. Praise good performance and initiative. It will make your Caregiver feel good and encourage continued good performance. Praise will also balance the times when you need to correct them. If you do need to correct your Caregiver, do not attack the person: For Example; "Mike, you are really dumb! Haven't I told you many times how to transfer me?" It is better to say something like, "Mike, I know you tried, but that transfer didn't go very well. Maybe we should practice that again and I'll explain how to do it."

- Do not save praise or criticism for the evaluations. Constructive feedback can happen on a daily basis and should. Caregivers need to know how they are doing so they can continue to do things correctly or change what they are doing if it is not correct.

If you are having an ongoing problem with your Caregiver, contact your QP. It is important to not let any negative issues go unmentioned.

DISCHARGING A CAREGIVER

It is Home at Heart Care's goal to only place Caregivers in your home that you feel comfortable with. You can request that someone not work for you if you do not feel comfortable with them for any reason and Home at Heart Care will work with you to address your concerns. Home at Heart Care, is a traditional provider agency, which means Home at Heart Care is responsible for terminating all employees.

GOODS AND SERVICES THROUGH CFSS[18]

CFSS allows people to purchase goods and services and PCA does not.

What are goods and services?

Items or services purchased through CFSS that either increase the person's independence to complete tasks associated with their assessed needs or decrease the person's need for assistance with a covered CFSS personal care service from another person.

Goods and services purchased through CFSS must meet all of the following criteria:

- Related to an assessed need.
- For the direct benefit of the person.
- Increase the person's independence to complete tasks associated with their assessed needs or decrease their need for assistance with a covered CFSS personal care service from another person.
- Included in the person's service delivery plan.

Examples include grab bars, wheelchair ramps, assistive technology, fees for grocery delivery service, laundry service, or specialized devices for dressing or grooming to name a few.

What can a person NOT use CFSS funds to purchase?

1. A good or service that is:
    a. Not related to an assessed need.
    b. A replacement for human assistance that is not a covered CFSS service.
    c. Not for the direct benefit of the person.
    d. Not the most cost-effective option to meet the person's need(s).
    Note: If the person prefers a version of an item that is more expensive than the least costly alternative, they can purchase that item and pay for the difference in cost.
    e. Covered under any other state plan service.
    f. The responsibility of another entity (e.g., a person's school, Medicare or private insurance).
2. Medical supplies or equipment covered by Medical Assistance (MA).
3. Insurance premiums and copays.
4. Room and board costs.
5. Vacation expenses.
6. Vehicle maintenance, except for maintenance of disability-related modifications.
7. Tickets to recreational events.
8. Bus passes or tokens.
9. Camps and classes.

[18] Information derived from Goods and services through CFSS (last visited January 24, 2025)

10. Legal or advocacy-related fees.
11. Experimental treatments.
12. Monitoring technology.
13. Homemaking.
14. Membership fees or costs, except when the service is necessary for the person's health condition and monitored by a Minnesota Health Care Programs (MHCP)-enrolled physician, advanced practice registered nurse or physician's assistant.

What is the process for goods and services?

1. The person includes the following information in their service delivery plan:
    a. The goods and services.
    b. The cost of the goods and services.
    c. How the goods and services meet an assessed need and increase their independence to complete tasks associated with their assessed needs or decrease their need for assistance with a covered CFSS personal care service from another person.
2. The consultation services provider:
    a. Reviews the person's service delivery plan.
    b. Offers guidance on whether the goods and services meet the requirements in the covered items section on this page.
    c. Submits the service delivery plan to the lead agency for authorization.
3. The person selects a financial management services (FMS) provider to facilitate the purchase of the goods and services.
4. The lead agency:
    a. Reviews and approves the person's service delivery plan.
    b. Issues a service authorization that includes a line for goods and services that is separate from the line for units. The line for the good or service includes the cost of the good/service and the FMS provider fees.
    c. Notes: the goods/services line includes the FMS fee, and the line for the units is determined through this calculation – total number of units for which the person is eligible minus the cost of goods and services divided by the current CFSS rate.
5. The person purchases the goods or services, or the FMS provider purchases the goods or services for the person.
6. If the person purchased the goods or services, the person submits a receipt to the FMS provider.
7. The FMS provider bills DHS.
8. If the person purchased the goods or services, the FMS provider reimburses the person.

What must I do for goods and services?

1. Identify the goods and services to meet their needs.
2. Identify the cost of the goods and services.
3. Add the following information to the service delivery plan:
    a. Goods and/or services
    b. Cost of the goods and/or services
    c. How the goods and/or services meet an assessed need and increase their independence or decrease their need for assistance from another person.
    d. FMS provider the person selected
    e. FMS provider fee

4. Save receipts and submit them according to the FMS provider's policies if the person purchases the goods and services.

Home at Heart does not have any responsibilities related to authorizing or purchasing goods and services.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)[19]

Similarities: In both PCA and CFSS, people must have a back-up plan in case their worker is absent.
Differences: In CFSS, adults can use some of their units/dollars to purchase a personal emergency response system (PERS) as an electronic back-up system.

What is PERS?

PERS is the installation and monitoring of an electronic device typically worn as a pendant or bracelet that includes an alert or panic button the person can press in the event of a fall or other emergency.

Who is eligible for PERS?

A person is eligible if they are:

- An adult, 18 and older
- Not on a Waiver or AC
- Lives alone or is alone for significant parts of the day
- Does not have a regular caregiver for extended periods of time and requires support and supervision.
- Has not identified anyone as their back-up support.

The policy for CFSS PERS is separate from the policy for CFSS goods and services described above. PERS is not included in the CFSS goods and services policy.

CFSS covers the following services for PERS

- Purchase of the PERS equipment, including necessary training or instruction on use of the equipment ($1,500 maximum).
- Installation, setup and testing of the PERS equipment ($500 maximum).
- Monthly monitoring fees ($110 monthly maximum).

CFSS PERS does NOT cover:

- PERS for a person who does not meet at least one of the eligibility criteria listed above.
- PERS from a provider not enrolled as an MHCP PERS provider.
- Equipment used to deliver Medical Assistance (MA) or other MHCP services.
- Sensing and/or monitoring systems that do not require activation by the person.
- Supervision or monitoring of activities of daily living (ADLs) provided to meet the requirements of another service.
- Telehealth and biometric monitoring devices.
- Video equipment.

[19] Information derived from CFSS personal emergency response systems (PERS) (last visited January 29, 2025)

A person cannot use extended CFSS units/dollars to purchase PERS.

What is the process to purchase PERS?

1. The person includes the services they need and the provider they selected in their service delivery plan.
2. The consultation services provider reviews the person's service delivery plan.
3. The lead agency approves the person's service delivery plan.
4. The lead agency authorizes units/dollars to the selected provider.
5. The selected provider bills DHS or the managed care organization (MCO) for the services they provide.

What is my responsibility with PERS?

- Select a PERS provider
- Include the type of services they need (i.e., purchase, installation, monitoring) and the provider they select in the PERS section of their service delivery plan.
- Communicate with their consultation services provider if they need changes.

Consultation services provider will answer your questions and review the service delivery plan and provide guidance about whether it meets the eligibility criteria.

Home at Heart does not have any responsibilities related to a person's PERS purchase.

EMERGENCY PLANNING

What is an emergency plan?
Emergency plans address your immediate health needs when something unexpected happens. The Minnesota State Council on Disability has an emergency preparedness website available to help people with disabilities improve emergency preparedness.

What is a medical emergency plan?
It is good to have a plan in place for a medical emergency. You may want to carry a card or small piece of paper with you and also post this information in your home:

- Diagnosis
- Medications
- Allergies
- Health conditions and instructions
- Emergency contact information
- Doctor contact information
- Insurance information

What is an emergency evacuation plan?
Be sure to discuss evacuation plans with your friends, family and Caregiver.

Discuss the type of emergency and what action would be needed to evacuate safely.
Put together a disaster supply kit that includes what you would need to survive for three to ten days on your own.

Develop a checklist for evacuation including:

- contact numbers for helpers

- transportation options
- medications
- medical supplies

FLEXIBLE USE[20]

Differences: In PCA, people's units are divided into two 6-month spans, with some limitations. PCA time does not carry over into the next six-month period. In CFSS, people are able to use the units/dollars flexibly throughout the entire service plan year.

Flexible Use Restrictions

Consumers may use their PCA/CFSS hours/units in a flexible manner unless any of the following is true:

- Person is on the Minnesota Restricted Recipient Program (MRRP)
- Lead agency denies flexible use.
- DHS revokes or denies flexible use.

Consumers may use their PCA hours/units in a flexible manner to meet their needs within the following limits:

- Total authorized hours/units must be divided between two six-month date spans.
- No more than 75% of total authorized hours/units may be used in a six-month date span; health and safety must be assured.
- Units cannot be transferred from one six-month date span to another.
- Additional PCA hours/units cannot be added unless there is a change in condition.

Consumers cannot add additional hours/units unless you experience a change in condition.

Your consultation services provider must:

- Help the person determine how to use the total authorized amount of CFSS services to meet their needs and ensure their health and safety, if requested.
- Help the person develop a month-to-month plan to use CFSS units/dollars as part of the service delivery plan, if requested.
- Review the plan and ensure the planned monthly use of units/dollars can meet the person's needs.

Home at Heart will:

- Ensure you complete a month-to-month plan for the use of CFSS units and add it to your CFSS service delivery plan.
- Monitor your use of CFSS units.
- Notify you or your Representative if you use more CFSS hours than planned.

FINANCIAL MANAGEMENT SERVICES (FMS) FOR CFSS[21]

Differences: PCA does not include financial management services (FMS).

[20] Information derived from Flexible use of PCA/CFSS services (last visited January 24, 2025)
[21] Information derived from Financial management services (FMS) for CFSS (January 29, 2025)

FMS is a service that provides help with financial tasks, billing and employer-related responsibilities for people who self-direct their services as well as facilitate the purchase of goods/services for people in both the CFSS agency and budget models.

QUALIFIED PROFESSIONAL (QP)[22]

A qualified professional (QP) is a person who provides training, supervision and evaluation of an agency's PCA workers and the services they deliver.

Similarities: In both PCA and CFSS:

- Each person must have a service delivery plan that describes how their needs will be met.
- An individual with a background relevant to the tasks the person needs trains and supervises the worker.
- DHS provides units (PCA) or dollars (CFSS) to a worker's employer to train the worker on the person's needs.
- The worker's employer can request additional units (PCA) or sessions/dollars (CFSS) from DHS if needed.

Differences: In PCA, the QP is responsible to perform the functions listed above. In CFSS, the entity responsible for these functions varies.

If your PCA/CFSS worker is performing health-related tasks, your QP must be a registered nurse.

Service Delivery Plan Development

PCA: the QP supports the person in writing their service delivery plan.
CFSS: The person writes their service delivery plan with support from the consultation services provider, as desired. The agency and the person will develop the plan further, as needed.

Worker Training

PCA: the QP trains the worker and ensures they are competent to perform the tasks
CFSS: CFSS agency staff member with a background relevant to the tasks trains the worker and ensures they are competent.

Supervision

PCA: the QP supervises the worker through QP visits.
CFSS: the agency is responsible to supervise the workers.

Units/Budgets

PCA: The county authorizes QP units for covered QP services.
CFSS: the county authorizes

- consultation services sessions for support to write and review the service delivery plan
- a worker training and development budget for training and supervision of the worker and/or for classes for the worker.

How often does the QP visit?

[22] Information derived from Comparison of PCA qualified professional (QP) services and CFSS services (January 29, 2025)

At minimum, the QP must visit the service delivery location and meet with the person and RP (if applicable) to evaluate the PCA/CFSS worker(s) and/or oversee the delivery of PCA/CFSS services within the following timelines:

PCA[23]

- Within the first 14 days the PCA worker(s) begin to provide services to the person
- Every 60 days for PCA workers who are ages 16-17
- Every 90 days during the person's first year of service
- Every 120 days after the person's first year of service
- After the first 180 days of the person's service, QP visits may alternate between unscheduled phone or internet technology and in-person visits, unless the in-person visits are needed according to the care plan. (if the worker is 16-17, all QP visits must be in person).

CFSS[24]

- Within the first 30 days
- Every 90 days (first year in-person visits only, one in-person a year thereafter)
- Within 30 days of discovery/receipt of changes in the person's condition

Managed care organizations (MCOs) have the authority to require all QP visits to be conducted in person. PCA provider agencies must check with the person's MCO to see if it allows QP visits to be done remotely.

H@HC QP Expectations

Qualified Professionals approve the worker's schedule for employment with Home at Heart Care. Often times it may take working side by side with the PCA/CFSS worker to ensure the worker practices our values of Responsibility, Hospitality, Trust, and Compassion. At the QP's discretion, they may work entire shifts observing the PCA/CFSS worker to approve work hours for their client.

SPENDOWNS; BILLING

If you are required by Minnesota Medical Assistance, Medicaid or your Managed Care Organization to incur a spenddown for the services provided to you by Home at Heart Care, Home at Heart Care will bill you for the spenddown amount as shown in the Minnesota Health Care Programs statement provided to Home at Heart Care relative to the services provided to you.

DISCONTINUATION OF SERVICES FOR NONPAYMENT

It is Home at Heart Care's policy to discontinue providing services to clients who have unpaid debt owing to Home at Heart Care. If you are billed by Home at Heart Care for services (including spenddown amounts referenced above), Home at Heart Care (at its discretion) may discontinue providing the services to you if you do not pay the unpaid amounts billed to you in the manner set forth herein below.

[23] Information derived from Sec. 256B.0659 MN Statutes (last visited January 29, 2025)
[24] Information derived from Sec. 256B.85 MN Statutes (last visited January 29, 2025)

TEMPORARY SERVICE SUSPENSION AND TERMINATION

Home at Heart has established a Temporary Service Suspension and Termination Policy that is included in the H@HC Policy Booklet for your reference. Please make sure you review this policy and ask your QP if you have any questions.

CONSUMER SAFEGUARDS[25]

Abuse and Neglect

What is adult maltreatment?

There are three basic kinds of adult maltreatment:

- Abuse - physical, emotional or sexual
- Neglect - caregiver neglect or self-neglect
- Financial exploitation

Who are vulnerable adults[26]?

The Minnesota Vulnerable Adults Act lists the different types of people considered a vulnerable adult under the law. Every adult recipient of PCA or home care services is considered a vulnerable adult.

It is the policy of Home at Heart to protect the adults served by Home at Heart who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults. Suspected Maltreatment may include but not limited to financial exploitation, Caregiver neglect or self-neglect, or verbal, physical, sexual or emotional abuse. All employees must comply with the Home at Heart Care Maltreatment of Vulnerable Adults Mandated Reporting Policy included in the H@HC Policy Booklet and as the same may be amended at any time and from time to time. Failure to comply will result in disciplinary action, up to and including immediate termination.

What is considered abuse?

Physical abuse is conduct that produces or could reasonably be expected to produce physical pain, injury or emotional distress. This includes:

- Criminal assault
- Hitting, slapping, kicking, pinching, burning or biting
- Punishment.

Physical abuse could also include:

- Restraints
- Unreasonable confinement
- Involuntary seclusion or forced separation of the vulnerable adult from a person of their choice.

Sexual Abuse is contact or interaction of a sexual nature by a licensed provider involving a vulnerable adult, contact or interaction of a sexual nature with a vulnerable adult unable to give informed consent or when this conduct occurs without the vulnerable adult's informed consent. This includes, but is not limited to:

- Rape

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[25] Information in this section derived from CBSM - Consumer safeguards (last visited January 29, 2025) Emergency preparedness / Minnesota Department of Human Services (last visited January 29, 2025)
[26] Information in this section derived from CBSM - Adult protection (last visited January 29, 2025)

- Fondling or caressing
- Penetration or attempted penetration
- Sexual utilization of the vulnerable adult for gratification of others.

Financial exploitation includes:

- Use, theft, possession or control of funds or property of a vulnerable adult through undue influence, harassment, duress, deception or fraud
- Forcing, compelling or enticing a vulnerable adult to perform services for the profit or advantage of another.

Who can I call for help if someone is abusing me?

- If you are in immediate danger, call 911
- Your case manager
- Your QP
- Your PCA provider agency
- MAARC at 1-844-880-1574
- Long-term Care Ombudsman at (800) 657-3591 or (800) 627-3529 (TTY)
- Ombudsman for Mental Health and Developmental Disabilities (800) 657-3506

Mandated reporters, including law enforcement and health care personnel, social workers and other professionals, can report online at **mn.gov/dhs/reportadultabuse** or call the toll-free number. This new statewide system replaces a county system involving more than 160 phone numbers.

How do I report suspected abuse or neglect of children?

To report concerns about child abuse, neglect or sexual abuse, contact the county or reservation where the child lives during business hours. If the child is in immediate risk of harm, please contact your local law enforcement agency or dial 911.

It is the policy of Home at Heart Care to protect the minor children served by Home at Heart whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse and to require the reporting of suspected abuse of children, in accordance with the Home At Heart Care, Inc. Maltreatment of Minors Mandated Reporting Policy included in the H@HC Policy Booklet and as the same may be amended at any time and from time to time. All employees must comply with these policies and failure to comply will result in disciplinary action, up to and including immediate termination.

FRAUD[27]

What is Medicaid fraud?

Intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and knowing the deception violates the law or the public trust and could result in unauthorized personal benefit or benefit to others. For example:

- If you provide false information to the case manager to obtain services you don't need, that is fraud.

[27] Information in this section derived from https://mn.gov/dhs/general-public/office-of-inspector-general/report-fraud/ (last visited January 29, 2025).

- If you sign a timesheet that states a Caregiver worked 30 hours when he/she only worked 20 hours, that is fraud.

You or your Caregiver could be held legally responsible for Medicaid fraud. In Minnesota the "theft of public funds" is a felony, no matter the dollar amount. Possible penalties and consequences include:

- Affected immigration status
- Affected applications for other jobs
- Disqualification from working in a Medicaid/Medicare-funded job for five years
- Disqualification from Section VIII housing
- Jail time
- Repayment of money
- **Termination of Home at Heart Care Services**

Recipients/representatives verify Caregiver hours and request payment by signing Caregiver time sheets.

- Recipients/responsible parties must sign Caregiver time sheets
- Do not sign blank time cards
- Only sign timecards for time that Caregivers have worked
- Caregivers cannot be paid when they are traveling to and from your house or if they are "on call" by phone or pager

Where can I report suspected fraud?

- Submitting the Program Integrity Oversight hotline form (recommended)
- Calling the Program Integrity Oversight hotline at 651-431-2650 or 1-800-657-3750
- Sending your report via email to OID.Investigations.DHS@state.mn.us
- Sending a letter via US Mail to the Office of Inspector General – Program Integrity and Oversight Division – PO Box 64982, St. Paul, MN 55164-0982

EMPLOYEE SAFEGUARDS

You should know that employers also have obligations to protect their employees. Home at Heart Care will not tolerate physical, sexual, verbal or financial abuses committed against their staff by anyone while they are working. It is in your best interest and in Home at Heart Care's best interest too, if we only provide services where our employees feel safe and welcome.

Unfortunately, below are some of the abuses Minnesota Health Care Providers have experienced in the past and the actions that will be taken by Home at Heart Care:

- **Violence and Verbal Threats** directed at employees will be investigated by Home at Heart Care and reported to appropriate authorities. Any physical violence directed at an employee or indirectly affecting an employee will result in immediate termination of Home at Heart Care services as set forth in the Temporary Service Suspension and Termination policy located in the H@HC Policy Booklet.

- **Sexual Abuse** can occur if a client or someone else in the client's home or workplace touches an employee in a sexual way, asks them to show private body parts, speaks to them in a sexual

manner, or shows sexual material that makes the employee feel uncomfortable. Sexual abuse will be investigated and reported to the appropriate authorities. Home at Heart Care will terminate services for any client when the work environment becomes unsafe for a Home at Heart employee as set forth in the Temporary Service Suspension and Termination policy located in the H@HC Policy Booklet.

- **Financial Abuse** - Caregivers are Minnesota Health Care Providers and are prohibited under state law from giving financial kickbacks to their recipients of care. **Employees cannot divide paychecks with their recipients or recipient's family members.** This also means that they should not be asked to do errands for other family members that would result in a financial cost to the employee. It is also illegal for a client to ask that the employee pay for any client's expense that was not incurred by the employee. Employees who witness financial abuse are required by MN state law to report what they have witnessed. Employees who do not report the abuse may be subject to disciplinary action. Abuse of this nature will be investigated, documented and reported to appropriate authorities. Abuse of this nature can also adversely affect a client's access to Minnesota Home Care Services both now and in the future.

CONFIDENTIALITY

Information about your personal care needs is considered confidential and should not be shared with other people. It is illegal for your PCA/CFSS worker(s), agency staff and/or your Qualified Professional to talk with other people about your care. We may, however, share information in your care plan with new PCA/CFSS workers to ensure they are able to provide the assistance you need. This information will only be provided if someone is going to work for you.

Prior to beginning service, Home at Heart Care asks all clients to sign a release, authorizing Home at Heart Care to consult with their County Social Services and County Public Health Nurse for the purpose of initiating and providing services. In most cases, other than information transmitted for billing purposes or an emergency, these are the only people or organizations that your care is discussed with. However, if you request us to provide your health information to another party, we will ask for your signed authorization prior to disclosing your private information. Home at Heart Care's Notice of Privacy Practices Policy is included in the H@HC Policy Booklet for your reference.
If you feel your confidentiality has been violated, please contact Home at Heart Care or the Minnesota Department of Ombudsman for Long-Term Care[28] at 651-431-2555 or 800-657-3591.

MINNESOTA'S HOME AND COMMUNITY-BASED SERVICE PROGRAM[29]

Minnesotans with disabilities or chronic illnesses who need certain levels of care may qualify for the state's home and community-based waiver programs.

Medicaid home and community-based service (HCBS) waivers afford states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible people in hospitals,

[28] Information derived from Contact Us / Minnesota Office of Ombudsman for Long-Term Care (OOLTC) (last visited January 29, 2025)
[29] Information in this section derived from Home and community based service waivers / Minnesota Department of Human Services (last visited January 29, 2025).

nursing facilities or Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD). HCBS waivers allow states to put together various service options that are not available under regular Medical Assistance. These service options are available to people in addition to services covered by Medical Assistance. Generally, these services are targeted to people with specific needs or diagnosis.

DHS recognizes the importance of helping people live where they choose with appropriate services that assure their health and safety.

HOME AND COMMUNITY-BASED SERVICES OFFERED BY H@HC[30]

Home at Heart Care is a provider of Homemaker services ("Homemaking"), Individual Community Living Supports services ("ICLS") and Respite services ("Respite") described within this Client Handbook through the Minnesota Home and Community-Based Service program.

COORDINATED SERVICE AND SUPPORT PLAN AND ADDENDUM

A recipient of Homemaking, ICLS or Respite provided by Home at Heart Care will receive services pursuant to a written coordinated service and support plan and addendum.

PERSON-CENTERED PLANNING AND SERVICE DELIVERY REQUIREMENTS[31]

Home at Heart Care will provide Homemaking, ICLS and Respite in response to each person's identified needs, interests, preferences, and desired outcomes as specified in the coordinated service and support plan and the coordinated service and support plan addendum, and in compliance with the requirements set forth in Minnesota Statutes Chapter 245D as discussed in this section (Note: however, that Homemaking Cleaning will be provided pursuant to a written service agreement).

Home at Heart Care will provide services in a manner that supports each person's preferences, daily needs, and activities and accomplishment of the person's personal goals and service outcomes, consistent with the principles set forth below.

Person-centered service planning and delivery that:

- identifies and supports what is important to the person as well as what is important for the person, including preferences for when, how, and by whom direct support service is provided
- uses that information to identify outcomes the person desires
- respects each person's history, dignity, and cultural background

Self-determination that supports and provides:

- opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication
- the affirmation and protection of each person's civil and legal rights

Providing the most integrated setting and inclusive service delivery that supports, promotes, and allows:

[30] Information derived from HCBS Waiver Services (last visited January 29, 2025)
[31] Information in this section derived from Sec. 245D.07 MN Statutes (last visited January 29, 2025)

- inclusion and participation in the person's community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible and supports the person in developing and maintaining a role as a valued community member
- opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports
- a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety, or rights

The following questions can be used by persons receiving services licensed under chapter 245D to help identify how they want services provided to them. It is recommended that the support team or extended support team discuss these questions together when completing service assessments, planning, and evaluation activities to help ensure the goals of person-centered planning and service delivery are met for each person served.

Sample of Person-Centered Planning and Service Delivery Questions for Initial Planning[32]

- What are your goals for service outcomes?
- What are your preferences related to:
    a. Time you wake up in the morning?
    b. Time you go to bed?
    c. What your favorite foods are?
    d. What are foods you don't like?
    e. Whom you prefer to have direct support service provided from?
- Do you take any medications?
- Do you need help with your medications?
- What are some of your interests?
- Do you have any hobbies?
- What are things you like to do in the community?
- Is there an activity or skill that you would like to learn?
- Do you have any special relationships?
- Do you work in the community?

Sample of Person-Centered Planning and Service Delivery Questions for Program Evaluation and/or Progress Review:

- Do you feel your relationships are supported by staff?
- What do you like about your home?
- Is there anything that bothers you about your home?
- Do you like the people you live with?
- Do you feel the house you live in is safe?
- Do you feel any rules in your house are unfair?
- Do you have a private place to go to at home?

[32] Information derived from "Person-Centered Planning and Service Delivery" HCBS basic services sample policies / Minnesota Department of Human Services (last visited January 29, 2025)

- Do you have goals to meet at home?
- Do you want to work?
- Is there anything that bothers you at work?
- Do you have specific goals set at work?
- Do you feel that staff treats you with dignity and respect?
- Do you feel that your privacy is respected?
- Do you feel that decisions you make are respected?
- Do you feel that you are given the opportunity to be as independent as possible?

You or your support team may think of other questions that are important to you. You should feel free to discuss these questions with your service provider.

HOMEMAKING SERVICES[33]

Home at Heart Care is a Home and Community Based Waivered Services Provider, providing Homemaking services for individuals on BI, CAC, CADI, DD and EW Waivers. Homemaking services are also available as a private pay service.

Our Homemaking Services Include:
General household activities provided by a trained homemaker, when a person is unable to manage the home or when the person regularly responsible for these activities is temporarily absent or unable to manage the home. Services include:
- Homemaker/cleaning
- Homemaker/home management
- Homemaker/Assistance with activities of daily living ("ADLs").

Homemakers may monitor the person's well-being while in the home, including home safety.

Cleaning ("Housekeeping")

Homemaker/cleaning services include light housekeeping exclusively, such as:
- Light housekeeping tasks
- Laundry services

Home at Heart offers certain Homemaking services which consist **only** of cleaning services which are referred to as "Housekeeping Services". Housekeeping Services do not consist of "basic support services" which are offered by Home at Heart pursuant to its 245D Home and Community Based Services License.

Housekeeping Services are offered through the Home at Heart Care homemaking program to provide needed in-home cleaning services to persons unable to complete the tasks independently, thus making it possible for clients to remain in their homes for a greater period of time.

HCBS Client Handbook

[33] Information in this section derived from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_001906 (last visited January 29, 2025).

The duties of Home at Heart employees providing Housekeeping Services (“Housekeepers”) are limited *exclusively* to providing home cleaning services. Please note that a Housekeeper ***cannot*** provide any services which comprise “home management services” listed below.

Housekeeping Services are provided by Home at Heart Care pursuant to a written service agreement. Any questions as to whether a service which a Housekeeper is requested or directed to complete is a non-cleaning service should be directed to Home at Heart Care.

Home Management (“Homemaking”)

Homemaker home management providers deliver homemaker cleaning services and, while onsite, provide incidental assistance with home management activities as needed. However, homemaker cleaning must be the primary service provided.

Homemaker/home management services may include assistance with the following:

- Arranging for transportation
- Preparing meals
- Shopping for food, clothing and household supplies
- Performing simple household repairs

Assistance with ADLs

Homemaker assistance with ADLs providers deliver homemaker cleaning services and, while onsite, provide incidental assistance with ADLs as needed. However, homemaker cleaning must be the primary service provided. Assistance with ADLs includes assistance with:

- Ambulating
- Bathing
- Dressing
- Eating
- Grooming
- Toileting

INDIVIDUAL COMMUNITY LIVING SUPPORTS (ICLS)[34]

Home at Heart Care Caregivers can perform ICLS, an Elderly Waiver (EW) a bundled service that includes six service components. ICLS services offer assistance and support for older adults who need reminders, cues, intermittent/moderate supervision or physical assistance to remain in their own homes.
ICLS covers assistance and support for eligible people age 65 and older enrolled in the Alternative Care (AC) program or the Elderly Waiver (EW). It includes the following service components:

- Active cognitive support
- Adaptive support service
- Activities of daily living (ADLs) support
- Household management assistance
- Health, safety and wellness
- Community living engagement

[34] Information in this section derived from CBSM - Individual community living supports (ICLS) (last visited January 29, 2025)

The case manager/care coordinator completes the ICLS Planning form with you. In the form, the case manager/care coordinator:

- Identify the person's individual goals the ICLS service is intended to support.
- Describe and provide detail about the type of supports the person will receive within a minimum of two ICLS service components.
- Calculate the total amount of units and cost of ICLS services the person will receive each week.

Active Cognitive Support

This component of ICLS includes supports to help the person with cognitive challenges and issues that are important to them. Active cognitive supports are the only ICLS services that the person can receive both in-person and remotely.

Under this component, an ICLS provider can:

- Help problem-solve the person's concerns related to daily living.
- Provide assurance to the person.
- Observe and redirect to address the person's cognitive, orientation or other behavioral concerns.
- Provide check-ins to identify problems and resolve concerns.

Adaptive Support Service

This component of ICLS includes supports to help the person adopt ways to meet their needs. The supports encourage self-sufficiency and reduce reliance on human assistance.

ICLS services covered under this component include:

- Provide verbal, visual and/or touch guidance to help the person complete a task.
- Develop and demonstrate cues or reminder tools (e.g., calendars, lists).
- Help the person understand assistive technology directions or instructions to maintain independence.
- Practice strategies and similar support methods that promote continued self-sufficiency.

This component of ICLS includes supports to help the person with ADLs

- Provide reminders or cuing systems to complete ADLs.
- Cue and/or provide intermittent physical assistance with dressing, grooming, eating, toileting, mobility, transferring and positioning
- Cue and/or provide continual supervision and physical assistance with bathing, as needed

Note: ICLS is not an appropriate service to meet a person's need for constant supervision or physical assistance with ADLs throughout the task, except for bathing. Personal care assistance (PCA) is the service designed to meet this level of need for ADL assistance.

Household Management

This component of ICLS includes supports to help the person manage their home consisting of:

- Help with cleaning, meal planning/preparation and shopping for household and personal needs.
- Help with budgeting and money management.

- Help with communications (e.g., sorting mail, accessing email, making phone calls, scheduling appointments).
- Provide transportation when it is integral to ICLS household management goals and when community resources and/or informal supports are not available.

Health, Safety and Wellness

This component of ICLS includes supports to help the person maintain their overall well-being. Examples of ICLS services covered under this component include:

- Identify changes in the person's health needs and notify the case manager and/or informal caregivers as needed.
- Coordinate or implement changes to mitigate environmental risks in the home.
- Provide reminders about and assistance with exercises and other health maintenance or improvement activities.
- Provide medication assistance (e.g., medication refills, reminders, administration, preparation).
- Monitor the person's health according to written instructions from a licensed health professional and report any significant changes as instructed.
- Use medical equipment devices or adaptive technology according to written instructions from a licensed health professional.

Community Engagement

This component of ICLS includes supports to help the person have meaningful integration and participation in their community. Examples of ICLS services covered under this component include:

- Help the person access activities, services and resources that facilitate meaningful community integration and participation.
- Help the person develop and/or maintain their informal support system.
- Provide transportation when it is integral to ICLS community engagement goals and community resources and/or when informal supports are not available.

Non-covered Services

ICLS does not cover:

- ICLS services that do not include a minimum of two ICLS components.
- Duplication of authorized state plan home care or other EW services the person already receives.
- Specialized or adapted equipment for remote support.
- Transportation mileage

A person cannot receive ICLS if they receive any of the following services:

- Adult foster care
- Customized living (including 24-hour customized living)
- Comprehensive community support through Moving Home Minnesota

Remote ICLS[35]

ICLS can be delivered through remote support. Services delivered through remote support must meet all the requirements:

[35] Information derived from CBSM - Remote support (last visited January 29, 2025)

- Is chosen and preferred as a service delivery method by the person or their guiardian
- Appropriately meets the person's assessed needs
- Is provided within the scope of the service being delivered
- Is provided as specified in the person's support plan
- A maximum of 12 hours per day of service, which includes remote support delivery
- A minimum of one face-to-face, in-person support scheduled at least weekly

ICLS must be delivered in either of the following:

- Single-family home or apartment owned or rented by the person receiving services, as demonstrated by a lease agreement.
- Single-family home or apartment owned or rented by a friend or family member who has no financial interest in the ICLS service. Refer to examples in the next section about when a home/apartment owner can provide ICLS.

In a rental scenario, the person or their family must maintain control over the individual unit. A friend or family that owns the home/apartment where the person resides and receives ICLS services:

- Can be an employee of the provider agency
- Cannot be an owner of the provider agency or have any financial interest in the agency
- Cannot enroll with DHS as an individual provider (e.g., non-agency provider) of ICLS under the exclusions from 245D licensure.

ICLS Provider Standards & Qualifications[36]

An individual provider can be a relative (not a spouse) or a non-professional legal guardian/conservator of the person receiving ICLS services if the individual meets certain criteria.

An ICLS provider cannot:

- Be the person's spouse.
- Be a licensed assisted living provider where the person resides.
- Be a home care provider in an affordable housing setting, as defined under Minn. Stat. §256S.20, subd. 1, where the person resides.
- Be the person's professional legal guardian or conservator.
- Be the person's landlord.
- Have any financial interest in the person's housing.

RESPITE CARE[37]

Home at Heart Care Caregivers can perform In-Home Respite care for qualifying individuals. Respite Care services are short-term care services provided to a person when their primary caregiver is absent or needs relief. Respite coveres a level of supervision and care that is necessary to ensure the person's health and safety.

Covered Services

Home at Heart Care is approved to provide In-Home Respite Care only for recipients approved for BI, CAC, CADI, DD and EW waivers and authorized by the recipient's County case manager.

[36] Information derived from CBSM - Individual community living supports (ICLS) (last visited January 29, 2025)
[37] Information derived from CBSM - Respite (last visited January 29, 2025)

Respite care is only provided for a primary caregiver meeting the following criteria:

- Be principally responsible for the care and supervision of the person who receives services.
- Maintain their primary residence at the same address as the person.
- Own or lease the primary residence.

Respite can be provided in a person's own home, family home or in settings determined by provider standards and qualifications.

Out-of-home 24-hour respite is limited to a maximum of 30 consecutive days per respite occurrence. The length of the person's stay must be documented in the support plan.

SERVICE RECIPIENT RIGHTS[38]

Minnesota Statutes Section 245D.04 requires Home at Heart Care to provide a recipient of Homemaking Services or Respite Care Services from Home at Heart Care with notice of those service recipient's rights as set forth within Section 245D.04. Notice and explanation of those rights is set forth within the Home and Community-Based Service Recipient Rights.

[38] Information derived from https://mn.gov/dhs/partners-and-providers/licensing/hcbs-245d/intensive-services-sample-policies/ (last visited January 29, 2025).

APPENDIX 1 – SAMPLE WEEKLY PCA/CFSS TASK SCHEDULE

Sample Weekly Task Schedule

[MDHS Consumer Guidebook, p. 75]

Morning Tasks/Cares
(Every day of the week)
 Giving morning medications
 Draining leg bag
 Changing catheter and cleaning area
 Grooming (washing face and upper body, brushing teeth, combing hair, applying deodorant)
 Dressing (getting clothes out and helping me put them on)
 Transfer to wheelchair (preparing chair, transfer and positioning in chair)
 Preparing breakfast

Morning Tasks/Cares
(Monday-Friday)
 All the cares listed in every day of the week, and
 Showering and washing hair
 Preparing lunch to take to work
Morning Tasks/Cares
(Saturday-Sunday)
 All the cares listed in every day of the week and
 Preparing lunch

Evening Tasks/Cares
(Every day of the week)
 Preparing supper
 Cleaning up kitchen
 Giving evening medications
 Helping with undressing
 Transferring to bed and positioning once in bed
 Emptying leg bag
 Cleaning of urinary bags
 Charging wheelchair

Housekeeping Chores
 Monday — laundry
 Tuesday — dusting and vacuuming
 Wednesday — grocery shopping
 Thursday — cleaning kitchen and bathroom
 Friday — taking out recycling and garbage

Bowel Cares (Tuesday, Thursday and Sunday evenings)
 Emptying leg bag
 Cleaning of urinary bags
 Assistance with suppositories, evacuation and clean-up

HCBS APPENDIX 1 – SAFEKEEPING OF FUNDS & PROPERTY LOG

The purpose of this log is for clients and caregivers to document and track funds and property. It is Home at Heart's expectation that this log is used each time funds are exchanged. By initialing, the client and caregiver are confirming the information listed is accurate and appropriate.

Date	**Amount/Item Given**	**Purpose**	**Amount Returned**	**Client Initials**	**Caregiver Initials**
1/1/19	$5	Laundry	$3.75	JD	SS

Date	Amount/Item Given	Purpose	Amount Returned	Client Initials	Caregiver Initials