West Virginia Department of Health and Human Resources

Adult Protective Services Mandatory Reporting Form

Use this form to report suspected abuse, neglect, financial exploitation or an immediate risk of serious injury or death - press firmly.

Once a referral is made to Centralized Intake, the Mandatory Reporting Form MUST be FAXED to your LOCAL DHHR office.

Referral Number: _____ **Date referral was made to Centralized Intake:** ____/____/____

Alleged Victim Information: *Information about person who is being abused/neglected/financially exploited or risk of serious injury or death. A separate form is required for each victim.*

Name: _____ Age/Date of birth: _____

Address: _____

Phone: _____

Current location & directions: _____

Facility name: _____

Type of facility: _____

Describe physical/cognitive/emotional functioning of the alleged victim: _____

Substitute decision maker (type, name, address and telephone): _____

_____

Alleged Perpetrator Information: *Information about person who is abusing/neglecting/financially exploiting or causing serious injury or death of an adult.*

Name: _____ Age/Date of birth: _____

Home mailing address: _____

Current location and directions: _____

Title/relationship to victim: _____

Phone: _____

Allegations: *Information about the incident of abuse/neglect/financial exploitation or serious injury or death.*

Date of incident: _____ Time of incident: _____ Date this report completed: _____

Where incident occurred: _____

Describe incident/injuries: _____

_____

_____

Describe action(s) taken to prevent further abuse/neglect: _____

Was treatment outside facility required? Yes ___ No ___ If yes, provider of treatment: _____

Why is the adult unable to protect themselves? _____

How long has the abuse/neglect/financial exploitation existed? _____

Is anyone else aware of the incident? If yes, list the name(s) & relationship to alleged victim: _____

Are there witnesses to the incident? If yes, list the name(s) & relationship to alleged victim and contact information of all witnesses:

_____

_____

☐ **Check here if additional pages attached**

A copy of this report must be filed with the following parties by the person completing the form (within 48 hours).

1. Original (top sheet) to: Adult Protective Services Unit - local Department of Health and Human Resources office.
2. Copy to:

☐ Office of Health Facilities Licensure & Certification	if alleged victim is resident of a nursing home or residential facility
☐ State or Regional Long-Term Care Ombudsman	if alleged victim is resident of a nursing home or residential facility
☐ Facility administrator	if alleged victim is resident of a nursing home or residential facility ** [see instructions on back]
☐ Local law enforcement agency	when applicable - e.g. violent crime, domestic violence, serious injury, death
☐ Local prosecuting attorney	when applicable - e.g. violent crime, domestic violence, serious injury, death
☐ Local coroner or medical examiner	in case of death
☐ Medicaid Fraud Control Unit	if alleged victim is a resident of a nursing home, residential facility, board and care facility, or a hospital in-patient

Reporter information is confidential and must ONLY go to DHHR Adult Protective Services according to WV State Code 9-6-8.
Reporter identity must NOT be shared if this form is faxed.

Reporter Information:

Name: _____ (Preferred) Phone #: _____

Address: _____

Title/relationship to victim: _____

Rev. 08/17

Instructions for Completing the APS Mandatory Reporting Form

The APS Mandatory Reporting form was developed by the West Virginia Department of Health and Human Resources (DHHR) as a result of a change to the law in 2000, WV Code §9-6-11. The form is to be used by mandatory reporters for reporting to Adult Protective Services (APS) and/or other appropriate entities. Colored carbon copies of this form are to be sent, as appropriate, to:

White (original)	Pink	Yellow	Green	Gold	Blue
DHHR-APS	OHFLAC	Ombudsman	Facility Administrator	Law Enforcement	Prosecuting Attorney, Coroner/ME, Medicaid Fraud

WHO/WHEN TO COMPLETE:
All individuals identified as *Mandatory Reporters* of abuse, neglect and financial exploitation of incapacitated adults and residents of nursing homes or residential facilities are required to complete this form as part of the APS reporting process. Incidents of abuse/neglect must be reported immediately to DHHR's Centralized Intake. As follow-up to the immediate report, mandatory reporters are required to provide a written report to the local APS unit within 48 hours. This form will serve as the required written report. **Mandatory reporters include**: medical, dental or mental health professionals, Christian Science practitioners, religious healers, state and regional ombudsmen, social service workers, law enforcement officers, county humane officers and any employee of a nursing home or other residential facility.

Complete this report as thoroughly as possible. While anonymous reports will be accepted, the reporter is encouraged to provide personal information in the event additional information/follow-up is needed. If more space is required, additional pages may be attached. If so, mark the appropriate box to indicate that there is an attachment. On the attached page, indicate the section of the form that is being continued. Finally, be sure to include a copy of the attachment with all copies distributed to various parties.

REQUIRED FILING:
The person completing this form is responsible for filing a copy of the completed form with all appropriate parties. Appropriate parties are determined based on the circumstances of the allegation. It is not necessary to send a copy to all parties in all cases.

****Note: West Virginia state law requires that this form be filed with the APS agency (DHHR) and other parties, including the facility administrator (when applicable), within 48 hours. *However*, state and federal reporting requirements for facilities that are certified to receive Medicare or Medicaid funds have not changed as a result of implementation of this form. Filing of this form *does not* replace other applicable reporting requirements.**

MAILING ADDRESSES:
Reports that are to be filed with the Office of Health Facilities Licensure & Certification (OHFLAC), the Long-Term Care Ombudsman Program (LTCOP), and Medicaid Fraud Control Unit (MFCU) are to be mailed to the appropriate state entity. Mailing addresses for these agencies are:

West Virginia Department of Health and Human Resources
Office of Health Facilities Licensure & Certification
OR
Medicaid Fraud Control Unit
408 Leon Sullivan Way
Charleston, West Virginia 25301-1713

West Virginia State Long-Term Care Ombudsman
Bureau of Senior Services
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0160

Reports that are to be filed with the APS agency (DHHR), law enforcement, prosecuting attorney and coroner/medical examiner are to be sent to the appropriate local entity.

To request additional copies of this form:
Additional copies of this form may be obtained by submitting a written request to the West Virginia Department of Health and Human Resources.

West Virginia Department of Health and Human Resources
Materials Management
900 Bullitt Street
Charleston, West Virginia 25301
Phone (304) 558-3417 or FAX to (304) 558-1524

AGED AND DISABLED WAIVER FORMS INSTRUCTIONS

Form Name: Aged and Disabled Waiver Case Management Notification of Case Closure (Policy Section 501.16)
Purpose: To ensure that Economic Services is notified when a person's ADW case is closed.

This form should be faxed to the attention of the Economic Services Worker at the DHHR in the county of the person's residence. This form should also be uploaded into ADW CareConnection© by the Case Manager along with or in addition to the documentation for closure of the person's ADW case.

To begin:

- Enter the following information at the top of the form.
  - Date
  - Name of Economic Services Worker
  - Fax number of Economic Services Worker

- Complete the **"ADW Participant"** section of the form by documenting:
  - Person's last name
  - Person's first name
  - Person's middle initial
  - Person's address
  - Person's date of birth (dob)
  - Person's Medicaid Number

- Complete the **"Administrative"** section of the form by documenting:
  - Name of Case Management Agency
  - CM agency address
  - CM agency phone number
  - CM agency fax number
  - Closure date (date provider agency requested closure)
  - Indicate if hearing was requested by checking yes or no
  - Date of hearing request (if applicable/known)
  - Last date of service
  - Reason for closure:
    - No PA services for 180 days
    - unsafe environment
    - persistent non-compliance with service plan
    - no longer desires ADW services
    - no longer requires ADW services
    - can no longer be safely maintained in the community (very rare, must receive approval from Operating Agency before using this closure reason)
    - moved out of state
  - Case Manager's Signature
  - Date of CM's signature
  - Time of CM's signature

AGED AND DISABLED WAIVER
CASE MANAGEMENT NOTIFICATION OF CASE CLOSURE

Date_____

TO:_____
Economic Services Worker

FAX Number_____

****

Last Name: _____ First Name: _____ MI: _____

Address: _____ DOB: _____

Medicaid Number:_____

****

Case Management Agency: _____

Address: _____ Phone: _____ Fax: _____

Closure Date: _____

Hearing Requested: Yes _____ No_____ Date of Hearing Request: _____

Last Date of Service: _____

Reason for
Closure:_____
_____
_____
_____

Case Manager Signature: _____ Date: _____ Time: _____

Comments:
_____
_____
_____
_____

Completed form is to be FAXED to the ESW when the case closure has been approved by BoSS.
**Note: Upload to ADW CareConnection©*

UNSAFE ENVIRONMENT RISK ASSESSMENT

Code Red Alert: When there is a history of harm or violence, consider using the "Alert- Code Red. High Risk".

CODE RED ALERT
HIGH RISK ENVIRONMENT

Unsafe Environment Risk Assessment: To determine the level of unsafe environment, please use the assessment below which includes 3 levels of risk and codes. For code red, this is urgent and requires an immediate attention. Please let BoSS staff know if this is a Code Red Environment as those cases will be prioritized.

Disclaimer: This risk level does not predict harm in every situation. It is important to use professional skills and decision-making when dealing with any risky situation.

UNSAFE ENVIRONMENT RISK ASSESSMENT TOOL

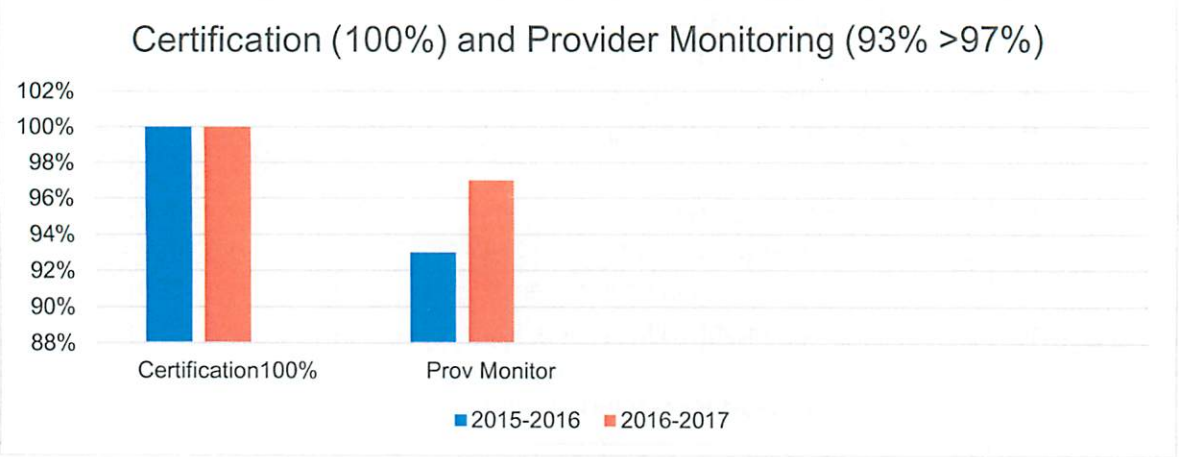
CODE	DEFINITION
RED	Level 1- High risk of injury to others, including staff ▪ Verbal threats of violence towards another person(s) ▪ Heated verbal encounters with staff ▪ Attempts to inflict injury on another person ▪ Past history of physical assault/violence toward staff ▪ Case note "Alert" for acts or threats of physical violence to staff ▪ Imminent risk of immediate danger to staff or others
YELLOW	Level 2- High risk of harm or harm related to the environment ▪ Illegal activity including drug use/misuse, drug dealing or guns ▪ History of illegal activity and high traffic in the home related to drugs ▪ Arrests or past legal history of crimes related to people or personal belongings ▪ Verbal threats with no history of harm ▪ Theft of money, medications, credit or debit cards or personal items ▪ Victim of domestic violence or financial exploitation ▪ Property damage to the home
GREEN	Level 3: Low risk of harm, injury or risk to others ▪ Anger or temper outbursts with no history of aggression ▪ Yelling, screaming or cussing with no history of aggression ▪ Reports of minor offenses or personality/behavioral issues

	▪ Phone hang ups, numerous calls, blaming workers, multiple workers ▪ Lack of plan follow through or compliance ▪ Home setting is an unsanitary or unsafe physically

AGED AND DISABLED WAIVER QUALITY UPDATE- PROVIDER MONITORING AND CERTIFICATION

Performance Measure	2016-2017	2015/2016
CERTIFICATION		
Agency staff whose health and welfare is current.	100%	100%
Agency staff whose abuse, neglect, exploitation training is current.	100%	100%
Agency staff whose CPR training is current.	100%	100%
Agency staff whose first aid training is current.	100%	100%
Agency staff whose direct care ethics training is current.	100%	100%
Agency staff whose personal attendant skills training is current.	100%	100%
State and federal finger print based checks returned with satisfactory results.	100%	99%
PROVIDER MONITORING		
Service Plans identified health and safety risks. *New Person-Centered Assessment and Service Plan/PAL.*	94%	87%
Service Plans identified assessed needs. *New Person- Centered Assessment and Service Plan/PAL*	98%	77%
Service Plans reflected the person's desired outcome. *New Person- Centered Assessment and Service Plan/PAL*	98%	87%
Service Plans reflected person's health care needs were coordinated. *New Person- Centered Assessment and Service Plan/PAL*	100%	88%
Service Plans with a current and appropriate backup/crisis plan.	91%	98%
Service Plans were updated annually, six months and revised as needed.	99%	96%
Files of people receiving services reviewed that reflected types, scope, duration, amount, and frequency of services specified in the Service Plan.	100%	92%
Unexplained, suspicious, and untimely deaths for which review and investigation did not result in identification of preventable causes.	100%	100%
Reported critical, abuse, neglect and exploitation incidents follow up by providers within established time frames (and marked resolved),	93%	100%
Incidents without restrictive interventions reported in the IMS.	100%	100%

AGED AND DISABLED WAIVER QUALITY UPDATE- PROVIDER MONITORING AND CERTIFICATION



ADW Q & A – October 11, 2017

1. Does MTM do transport to eye doctor appointment and audiologist?

   Answer: The provider must contact MTM for a trip number, be denied, document the denial, then they can bill ADW non-medical Transportation to take the person to the dentist, VA, eye doctor, audiologist, etc. They must make sure they document it on the PAL as somewhere the PA can take the person or there needs to be a note at the bottom of the PAL verifying that it was done and the RN approved it.

2. When the member has informal supports living in the home or the member lives with the PA, can we provide housekeeping?

   Answer: The informal support is responsible for all shared areas unless the informal support cannot physically assist with environmental care due to a documented health condition that severely limits the informal support's ability to assist the member (this does not include an informal that works outside the home). The direct care worker may clean the member's bedroom and if there is a private bath that as well. You must document this very well in your assessment or it will be disallowed. This does not mean that if the member was eating in the living room and had an accident or spilled a drink in the kitchen the direct care worker cannot clean it up. They can and should.

3. Is Copilot going to be approved by the state for electronic documentation?

Answer: BMS is still determining how EVV will be implemented in the State.

4. Can we provide additional time on Mondays for clean-up from the weekend?

   Answer: The PA cannot live in the home and there cannot be any informal supports that assist with this on the weekend. Additionally, it must be documented very well by the RN and CM in the RN assessment, Service Plan and CM assessment the reason the member is unable to clean-up after themselves. Additionally, the RN and CM need to evaluate why the member does not need weekend care if the home and or member are in such disarray after the weekend without care.

5. Can we (PARN) do monthly visits for education of the member or to check on the member after a hospitalization?

Answer: This program does not pay for monthly visits. If it is your agency's policy to do monthly visits, they cannot be billed to Medicaid. The only time additional visits should be made is if the member requires a change in their PAL. According to the ADW manual, there are specific billable PARN visits that are approved by Medicaid for reimbursement (501.18.2 of the policy manual). Any visits billed to Medicaid for reasons other than listed in the manual must stop immediately. Agencies that continue billing for unauthorized visits will be submitted for investigation by the fraud unit.

6. Can we (PARN/PCRN) do a visit when the member transfers from another PA/DCW agency?

   Answer: The visit would be a transfer assessment and billed as such using units under the nursing code T1002. New environments would need to be assessed for safety before placement of staff in the home. You must complete the assessment and develop the PAL/POC within 7 business days from the transfer date.

7. Can we (PARN) bill a visit when a member transfers to a different office in our company?

   Answer: When they move to a different location necessitating a transfer to a different office in your company, you can bill for a contact to assess the environment for safety before resuming services.

8. Do the dates for our annual and 6-month assessments change when an established member transfers to us?

   Answer: When an established member transfers to your agency, you need to assess the member within policy guidelines and complete a PAL/service plan. Once you have completed these duties, then you should revert to the established assessment/service planning schedule, if possible in an effort to prevent numerous nursing visits and billing for such.

9. Can I (PARN/PCRN) bill for a visit to follow up after an incident?

   Answer: Only if the incident resulted in an increased need for personal care services. Medicaid does not pay for skilled visits (evaluating the injury that resulted from the incident, educating the member on fall prevention face-to-face) to follow up on incidents. Your agency may require a follow up visit on certain incidents but, if this is the case and there is no significant justified reason for a change in services, the agency will be unable to bill for this visit. This type of visit would be an agency decision and they would be responsible for the cost of said visit.

10. When is it OK for a guardian, legally responsible persons, MPOA, POA, healthcare surrogate or other legal representative to be the PA/DCW?

Answer: A spouse, parent of a minor child or legal guardian is prohibited from being the DCW/PA. A Health Care Surrogate, POA, MPOA or other legal representative must work for a traditional agency to provide services.

11. Why are the monitors disallowing for the RN's review of the PAL/POC after the services were provided, the paperwork completed by the PA/DCW and verified by the member?

Answer: The unit allowed monthly for review of the PAL and POC is billable only if the RN examines the document for accuracy as it pertains to the PC standards/regulations and ADW policies. The RN is to ensure the POC/PAL is followed by the DCW/PA and is to document an explanation for any deviation from the plan. If changes are needed to the PAL/POC, the RN should develop a new POC/PAL addressing these changes. Review of the PAL/POC should ensure that the time spent for environmental and/or community activities/essential errands does not exceed the time spent on personal care.

For example, when the RN notices that the PA/DCW has documented staying at the home over the allotted time period to assist the participant/member with an art project, the RN should educate the PA/DCW that this is not a billable activity and the participant/member and the RN should mark through the time, have the participant/member initial the change and make a comment regarding the education and the change in time on the back of the worksheet.

Also for example, when the RN notices a pattern on the worksheet where the PA/DCW is not following the PAL/POC (not working the correct times, not completing duties listed on the worksheet on a regular basis, incorrectly completing the travel log section of the worksheet), the RN should question the PA/DCW to find out the reason for the deviations, and if necessary, the RN should revise the PAL/POC to meet the needs of the participant/member as documented by the PA/DCW. The RN should be documenting the reasons for the deviations in the comments section.

12. Is Case Management and Nursing Billing going to be changing? (Rumor: There will need to be daily billing).

Answer: BMS is moving providers toward daily billing. It will be implemented first in the Personal Care program.

13. For dual clients, if all ADW hours are utilized and they equal 7 hours/day, the dual client is authorized 8 hours a day PC, can the full 8 hours be used as well?

Answer: All hours must be justified. The PC POC time allotted should generally not exceed the time allotted on the ADW PAL. In all actuality, in 7 hours on the ADW PAL, the PA should be able to complete all duties and the PC POC should address such things as feeding, medication prompt, incontinence clean-up, dressing for bed, mouth care, transferring and ambulation as appropriate. Environmental support, essential errands and community activities should be the sole responsibility of the ADW program (after the direct care services of bathing, dressing, grooming completed) and the PC program should focus on personal care needs only. Services cannot be duplicated, must be justified and contain no respite hours for either program.

PC Q & A – October 11, 2017

1. When the member has informal supports living in the home or the member lives with the DCW, can we provide housekeeping?

   Answer: The informal support is responsible for all shared areas unless the informal support cannot physically assist with environmental care. The direct care worker may clean the member's bedroom and if there is a private bath that as well. You must document things such as these very well in your assessment or it will be disallowed. This does not mean that if the member was eating in the living room and had an accident or spilled a drink in the kitchen the direct care worker cannot clean it up. They can and should.

2. Can we do a visit when the member transfers from another PA/DCW agency?

   Answer: The visit would be a transfer assessment and billed as such using units under the nursing code T1002. New environments would need to be assessed for safety before placement of staff in the home. You must complete the assessment and develop the PAL/POC within 7 business days from the transfer date.

3. Can we bill a visit when a member transfers to a different office in our company?

   Answer: When they move to a different location necessitating a transfer to a different office in your company, you can bill for a contact to assess the environment for safety before resuming services.

4. Do the dates for our annual and 6-month assessments change when an established member transfers to us?

   Answer: When an established member transfers to your agency, you need to assess the member within policy guidelines and complete a PAL/service plan. Once you have completed these duties, then you should revert to the established assessment/service planning schedule, if possible in an effort to prevent numerous nursing visits and billing for such.

5. Can I bill for a visit to follow up after an incident?

   Answer: Only if the incident resulted in an increased need for Personal Care services. Medicaid does not pay for skilled visits (evaluating the injury that resulted from the incident, educating the member on fall prevention face-to-face) to follow up on incidents. Your agency may require a follow up visit on certain incidents but, if this is the case and there is no significant justified reason for a change in services, the agency will be unable to bill for this visit.

This type of visit would be an agency decision and they would be responsible for the cost of said visit.

6. Does the PC RN have to do an assessment for a dual service or can they just use the ADW RN assessment? How do we bill?

   Answer: The PC RN is to use the ADW RN's assessment of the member. The program no longer requires the PC RN to do their own assessment although your agency may still choose to do an assessment. The only billable RN time for visits is for the SP meeting. You would need to bill that in units under code T1002 for both SP meetings attended throughout the year.

7. Why are the monitors disallowing for the RN's review of the PAL/POC after the services were provided, the paperwork completed by the PA/DCW and verified by the member?

   Answer: The unit allowed monthly for review of the PAL and POC is billable only if the RN examines the document for accuracy as it pertains to the PC standards/regulations and ADW policies. The RN is to ensure the POC/PAL is followed by the PA/DCW and is to document an explanation for any deviation from the plan. If changes are needed to the PAL/POC, the RN should develop a new POC/PAL addressing these changes. Review of the PAL/POC should ensure that the time spent for environmental and/or community activities/essential errands does not exceed the time spent on personal care.

   For example, when the RN notices that the PA/DCW has documented staying at the home over the allotted time period to assist the participant/member with an art project, the RN should educate the PA/DCW that this is not a billable activity and the participant/member and the RN should mark through the time, have the participant/member initial the change and make a comment regarding the education and the change in time on the back of the worksheet.

   Also for example, when the RN notices a pattern on the worksheet where the PA/DCW is not following the PAL/POC (not working the correct times, not completing duties listed on the worksheet on a regular basis, incorrectly completing the travel log section of the worksheet), the RN should question the PA/DCW to find out the reason for the deviations, and if necessary, the RN should revise the PAL/POC to meet the needs of the participant/member as documented by the PA/DCW. The RN should be documenting the reasons for the deviations in the comments section.

8. Do tasks need to be justified by specific minutes on the plan of care? For example, dishes= 10 mins.

   Answer: Yes. Times must be allotted as per the Personal Care Standards of Care for all environmental support.

9. Is Copilot going to be approved by the state for electronic documentation?

   Answer: BMS is still determining how EVV will be implemented in the State.

10. Is Case Management and Nursing Billing going to be changing? (Rumor: There will need to be daily billing).

    Answer: BMS is moving providers toward daily billing. It will be implemented first in the Personal Care program.

11. For dual clients, if all ADW hours are utilized and they equal 7 hours/day, the dual client is authorized 8 hours a day PC, can the full 8 hours be used as well?

    Answer: All hours must be justified. The PC POC time allotted should generally not exceed the time allotted on the ADW PAL. In all actuality, in 7 hours on the ADW PAL, the PA should be able to complete all duties and the PC POC should address such things as feeding, medication prompt, incontinence clean-up, dressing for bed, mouth care, transferring and ambulation as appropriate. Environmental support, essential errands and community activities should be the sole responsibility of the ADW program (after the direct care services of bathing, dressing, grooming completed) and the PC program should focus on personal care needs only. Services cannot be duplicated, must be justified and contain no respite hours for either program.