



## REQUEST FOR PROPOSAL

### *Personal Care Assistance Services for the Residents of Southern Columbia County*

The Columbia County Board of Supervisors will receive and publicly open proposals at the County Office Building, 401 State Street, Hudson, New York 12534 on December 18, 2018, at 10:00 A.M..

The County of Columbia reserves the right to reject in whole or in part any and all bids and proposals.

Proposals mailed or otherwise submitted must be received no later than the stated date and time.

Proposals submitted later than the above mentioned time will not be considered.

An original and 4 copies of all proposals are to be submitted to:

**County of Columbia  
Board of Supervisors  
County Office Building  
c/o Deputy County Attorney Christopher J. Muller  
401 State Street  
Hudson, New York 12534  
Phone: (518) 828-1527**

**ATTENTION:** Failure to indicate "REQUEST FOR PROPOSAL: Personal Care Assistance Services for the Residents of Southern Columbia County" on the outside of the proposal envelope might necessitate the premature opening of the proposal which might compromise its confidentiality.



**REQUEST FOR PROPOSAL**

*Personal Care Assistance Services for the Residents of Southern Columbia County*

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Schedule of Key Events

RFP Release Date	November 9, 2018
Letter of Interest Due	November 19, 2018
Written Questions Due	November 26, 2018
Response to Written Questions	December 3, 2018
Proposal Due Date	December 17, 2018

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**BIDDER'S CERTIFICATION & ASSIGNMENT OF CLAIM**

**TO: County of Columbia  
Board of Supervisors  
County Office Building  
c/o Deputy County Attorney Christopher J. Muller  
401 State Street  
Hudson, New York 12534  
Phone: (518) 828-1527**

We, the undersigned, herewith propose and agree to furnish to the County of Columbia, any one or all of the items upon which we have bid, for the prices indicated herein, in accordance with the Specifications, Special Conditions, and other related Formal Quotation Documents.

The undersigned bidder certifies to having read these Specifications, Special Conditions, and other related Formal Quotation Documents and offers to furnish the articles specified to the County of Columbia in exact accordance with the Specifications, Special Conditions, and other related Formal Quotation Documents and at the prices stated.

Provider hereby assigns to the County of Columbia and the State of New York any and all of its claim for overcharges associated with this contract which arise under the antitrust laws of the United States, 15 U.S.C. Section 1, et seq. and the antitrust laws of the State of New York, G.B.L. Section 340, et seq.

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Firm name

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Address

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City, State & Zip Code

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Phone

---

By: Print Name and Title

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Authorized Signature

**NOTE:** This Bidder's Certification **must** be signed and the Affidavit of Non-Collusion Certificate **must** be signed and notarized on Pages 7-8 of this Request for Proposals. Failure to complete **both** will result in the proposal being rejected.

**INSTRUCTIONS ACCOMPANYING THE**  
**AFFIDAVIT OF NON-COLLUSION**

1. The Affidavit of Non-Collusion must be executed by a member, officer or employee of the bidder. It must be executed by the person who makes the final decision with regard to the prices and amount quoted in the bid. If for good reason that person is not available to execute the Affidavit, the Affidavit may be executed by another member, officer, or employee of the firm who has been authorized in writing by such person to make the statements set out in the Affidavit on his or her behalf and on behalf of the firm. The written authorization must be attached to the Affidavit at the time of its submission.
2. Bid rigging, combinations or conspiracies to restrain competition, and the making of false sworn statements in connection with the submission of bids are unlawful and may be subject to criminal prosecution. It is imperative that the person who will execute the Affidavit examine it carefully before signing it and assure himself or herself that each of the statements in it are true and accurate. If for any reason the affiant cannot attest to each of the statements in the Affidavit without qualification or reservation, the necessary qualification or reservation must be noted in the Affidavit. The facts and circumstances on which such qualification or reservation are based must be set out in a writing submitted as a part of or together with the executed Affidavit.
3. In the case of a bid submitted by a joint venture, each party to the venture must be identified in the bidding documents, and Affidavit must be submitted separately on behalf of each party.
4. The term "complementary bid" as used in the Affidavit has the meaning commonly associated with that term in the procurement business and construction industry, and includes the knowing submission of bids higher than the bid of another firm, any intentionally high or non-competitive bid, and any other form of bid submitted for the purpose of giving a false appearance of competition.
5. In order to carry out the requirements of paragraph 7 of the Affidavit, the affiant must make diligent inquiry of all other persons employed by or associated with the bidder with responsibilities relating to the preparation, approval, or submission of the bid. Such inquiries need not be made of secretarial or clerical employees, and other persons performing purely ministerial functions, who do not have either actual or apparent authority to act on behalf of the firm with regard to the project.
6. Failure to file an Affidavit in compliance with these instructions may result in disqualification of the bid.

**AFFIDAVIT OF NON-COLLUSION CERTIFICATE**

I hereby attest that I am the person responsible within my firm for the final decision as to price(s) and amount of this bid or, if not, that I have written authorization, enclosed herewith, from that person to make the statements set out below on his or her behalf and on behalf of my firm.

I further attest that:

1. The price(s) and amount of this bid have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition with any other provider, bidder, or potential bidder.
2. Neither the price(s) nor the amount of this bid have been disclosed to any other firm or person who is a bidder or potential bidder on this project, and will not be so disclosed prior to bid opening.
3. No attempt has been made or will be made to solicit, cause or induce any firm or person to refrain from bidding on this project, or to submit a bid higher than the bid of this firm, or any intentionally high or non-competitive bid or other form of complementary bid.
4. The bid of my firm is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary bid.
5. My firm has not offered or entered into a subcontract or agreement regarding the purchase of materials or services from any firm or person, or offered, promised or paid cash or anything of value to any firm or person, whether in connection with this or any other project, in consideration for an agreement or promise by any firm or person to refrain from bidding or to submit a complementary bid on this project.
6. My firm has not accepted or been promised any subcontract or agreement regarding the sale of materials or services to any firm or person, and has not been promised or paid cash or anything of value by any firm or person, whether in connection with this or any other project, in consideration for my firm's submitting a complementary bid, or agreeing to do so, on this project.
7. I have made a diligent inquiry of all members, officers, employees, and agents of my firm with responsibilities relating to the preparation, approval, or submission of my firm's bid on this project and have been advised by each of them that he or she has not participated in any communication, consultation, discussion, agreement, collusion, act or other conduct inconsistent with any of the statements and representations made in this affidavit.

**BID NOT ACCEPTABLE WITHOUT ABOVE AFFIDAVIT NON-COLLUSION  
CERTIFICATION HERE SET FORTH AND CERTIFIED BY A NOTARY PUBLIC**

\_\_\_\_\_  
Firm name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State & Zip Code

\_\_\_\_\_  
Phone

\_\_\_\_\_  
By: Print Name and Title

\_\_\_\_\_  
Authorized Signature

Sworn to before me this

\_\_\_\_\_ day of \_\_\_\_\_ 2018

\_\_\_\_\_  
Notary Public



## REQUEST FOR PROPOSAL

### *Personal Care Assistance Services for the Residents of Southern Columbia County*

#### **Intent**

It is the intent of Columbia County to contract for personal care assistance services for Southern Columbia County residents (defined as Ancram, Copake, Elizaville, Gallatin, Hillsdale and Taghkanic) in need of said services meeting professionally recognized standards. The provider will service an existing client base along with future applicants throughout Columbia County. The County is desirous of contracting with a provider with expertise in the field of personal care.

#### **Submission of Proposals**

An original and 4 copies of all proposals are to be submitted to:

**County of Columbia  
Board of Supervisors  
County Office Building  
c/o Deputy County Attorney Christopher J. Muller  
401 State Street  
Hudson, New York 12534  
Phone: (518) 828-1527**

**NO LATER THAN DECEMBER 17, 2018 at 4:00 P.M.**

**Clearly mark envelope:** "REQUEST FOR PROPOSAL: Personal Care Assistance Services for the Residents of Southern Columbia County."

Proposals received after the submission deadline shall be returned unopened and will not be considered. The County is not responsible for delivery delays and the clock at the Columbia County Board of Elections shall indicate the official time of receipt.

The signer of the proposal, guaranteeing authenticity must initial any alterations, interlineations or erasure on the proposal.

All changes in connection with this proposal will be issued in the form of a written addendum and sent to all known potential respondents, providers of record and any other party requesting a copy of this RFP not less than five (5) working days prior to the proposal due date. Signed acknowledgement of receipt of each addendum must be submitted with each proposal.

A proposal, including all prices, may not be withdrawn, modified or canceled by the

provider for a period of sixty (60) days following the proposal deadline and the provider so agrees upon submittal of the proposal. Once selected, the provider agrees to extend submitted prices, if needed, during the contract negotiation period.

Columbia County will serve as the sponsor and conduit for any applicable State and Federal funds to support this project. Columbia County retains the right to reject any or all proposals and to withdraw this solicitation at any time.

Columbia County is an equal opportunity employer. Statistical data regarding current service population is found in Appendix "A". The County offers this general information, but makes no representation that the provider will be guaranteed this number of clients.

### **Letters of Interest**

Potential bidders shall submit a written letter of interest to notify Columbia County of the bidder's intention to develop a Proposal in response to this RFP. This Letter of Interest alerts Columbia County of the Bidder's intentions and assures the Bidder will receive all further correspondence on this RFP. Only Proposals preceded by a Letter of Interest will be considered. This Letter should include the name of the Bidder, address and be signed by an authorized representative of the organization. Letters of interest should be sent to same address as designated for the Submission of Proposals on page nine (9) of this document.

### **Bidder Questions**

All questions must be submitted in writing, citing the particular RFP page, section and paragraph where applicable. Questions must arrive no later than 4:00 pm time on, November 26, 2018, and should be mailed to the Columbia County Board of Supervisors at the same address as designated for the Submission of Proposals on page nine (9) of this document or emailed to Deputy County Attorney Christopher J. Muller at christopher.muller@columbiacountyny.com. Questions received after the closing date for inquiries will not be answered. Only written answers are official and will be post marked no later than December 3, 2018. All Questions and Answers will be issued as addenda to this RFP and will be provided in writing to all parties that have previously submitted a Letter of Interest.

### **Bid Opening**

The Columbia County Board of Supervisors will receive and publicly open proposals at the County Office Building, 401 State Street, Hudson, New York 12534 on December 18, 2018, at 10:00 A.M.. Bidders may attend the bid opening, at which a Columbia County representative will publicly announce the names of Bidders who have submitted proposals. To ensure adequate space for attendees, Bidders must notify the designated contact(s) identified on the Summary Information Form (Page 1 of this RFP) of their desire to attend the bid opening.

## **Evaluation Process**

Submission of a proposal implies the provider's acceptance of the evaluation criteria and provider recognition that subjective judgments must be made by the County.

All proposals will be examined. Proposals that do not conform to the instructions contained in this document or do not address all questions and/or requirements as specified may be eliminated from consideration. However, the County reserves the right to accept such a proposal if it is determined to be in the County's best interest.

The award of the contract shall be made to the provider whose proposal best meets the goals and objectives of the County as set forth in the Request for Proposals.

The following criteria will be used to make a selection:

- a. Provider's understanding of the project; identification of methods and techniques.
- b. Provider's management capability; experience and history in the industry.
- c. The proposals will be evaluated in part on the extent to which they minimize the impact on the County financially.
- d. Financial capacity of firm to perform service.
- e. Experience: of the firm in providing personal care assistance services as well as the personnel involved (including but not limited to system manager, aides, schedulers, fiscal managers), experience with State and Federal aid programs, reporting requirements and regulations.
- f. Safety record: number of complaints.
- g. Quality of Proposed Service: addressing the requirements of the RFP; types of service and frequency thereof, number of aides.
- h. Ability to preserve continuity and dependability of service upon transitioning from current provider.
- i. Number of years of experience, within the last 10 years, providing similar services.

The County reserves the right to reject any and all proposals as a whole or in part.

## **Definitions**

Whenever the following terms or abbreviations are used in the proposal, the intent and meaning shall be interpreted as follows:

“Client” means the individual receiving personal care services.

"County" means Columbia County.

“Housekeeping” means for those who because of disability and/or age related ailments need assistance with, but they do not need help with "personal care" tasks such as bathing or dressing.

“Southern Columbia County” means the towns of Ancram, Copake, Elizaville, Gallatin, Hillsdale and Taghkanic.

“Personal Care” means housekeeping, cleaning, meal preparation, grocery shopping, and laundry tasks PLUS assistance with personal needs - bathing, dressing, grooming, toileting, walking, feeding, assisting with administering medications, preparing meals with special diets, routine skin care, turning and positioning.

“Personal Care Aide” means an individual that delivers personal care services.

“Personal Care Services” means assistance of a personal care aide with nutritional, environmental support, and personal care functions.

“Provider” means firm contracted to provide personal care assistance services.

“Service Call” means an appointment where personal care services are provided to a client.

## **Relationship between Selected Provider and Columbia County after Award**

After selection, the successful provider will enter into a contract with Columbia County (see SAMPLE AGREEMENT at Appendix “C”). Columbia County will administer the contract, monitor Provider performance and serve as the designated recipient of all federal and state grant funds that have been designated to support this service.

## **Proposal Format**

Each proposal shall contain the following in the specified order:

1. Transmittal Letter
2. Introduction and Summary Description of Services

3. Exceptions (if necessary)
4. Pricing
5. Terms and Conditions
6. Provider Information
7. References

All proposals must be typed on standard 8 ½" x 11" paper.

The completed proposal shall be sealed for delivery to the County per instructions above.

All documents included in the proposal and outside of the envelope must be labeled with the Provider's name and the title of the request for proposal.

### **Transmittal Letter**

Responses shall contain a transmittal letter that must be typed on the Provider's 8½" x 11" stationary and include the following:

1. The identification of the Provider submitting the proposal.
2. The name, title, phone, email address and fax numbers of the person or persons authorized to contractually obligate the Provider with this proposal and in future negotiations.
3. The names, titles, phone numbers and email addresses of the persons to be contacted for clarifications.
4. An indication of acceptance of the general requirements and contract terms as described within this request for proposal.
5. An acknowledgment of receipt of all amendments to this request.
6. A person who is authorized to obligate the Provider in a contract offer must sign the letter.

### **Introduction and Summary**

Each proposal shall include a general overview of the Provider's planned solution.

### **Description of Services**

The proposal shall include a detailed functional description of the services to be provided and how these services are to be delivered.

### **Exceptions**

Unless explicitly stated in the proposal, the County shall assume that all Proposals are in

full compliance with all specifications, without exception.

All items in the proposal that are not in full compliance or that vary from any of the specifications shall be clearly defined as exception. Specific reference to the relevant section(s) in the specifications and the precise nature of the variance or non-compliance shall be clearly stated in the proposals.

The County reserves the right to accept any and/or all/none of the exceptions(s) substitution(s) deemed to be in the best interest of the County.

Non-compliance or variance with any items in the specifications shall not necessarily result in rejection of a proposal.

### **Pricing**

Pricing is to be based on the total cost to manage and provide personal care assistance services to the residents of Columbia County during the project period from the contract date until to December 31, 2019; as such services are specified in this Request for Proposal. In awarding the contract to the successful Provider, the total cost submitted as a result of this solicitation will be converted to a per hour rate and payment to the successful Provider will be based on the actual personal care hours of service provided as well as travel time. Actual beginning date of service will be dependent on the execution of a contract between the County and the successful Provider and the successful Provider's compliance with any applicable Medicaid regulations concerning the delivery of personal care assistance services.

The annual personal care hours to be provided under the proposed service are estimated to be in excess of ten thousand hours. The County offers this as general information, but makes no representation that the Provider will be guaranteed this number of "personal care hours".

"Personal care hours" means the actual hours expended by the Provider's aide while providing personal care services as specified in Appendix "A" and including travel time traveling to and from the service location. Travel time between service locations will only be calculated and counted as either "to" the next service location or "from" the previous service location. Travel time expended traveling to other locations between service locations will not be compensated. As such, Providers should factor into their per hour and/over overall bid reimbursement for travel and overhead expenses.

### **Terms and Conditions**

**Proposals:** All proposals are open to negotiation until a contract is executed. The County shall not be liable for any costs incurred by the Provider in preparing a response to this solicitation. Providers will submit proposals at their own risk and expense. The County makes no guarantee that any services will be contracted as a result of this solicitation, and reserves the right to reject any and all proposals. All proposals and their accompanying documentation will

become the property of the County. The County will not be obligated to the Provider for services until authorized County officials have a signed contract.

**Payment:** The County does not make payment upon signing of a contract. Payment is only made after receipt and acceptance of detailed monthly invoices which include a report of the number of service hours and travel time. Final payment will not be made until completion of all aspects of the contract resulting from this request for proposal.

**Confidentiality:** To the extent permitted by law, Providers may request in writing non-disclosure of confidential data. Such data shall accompany the proposal, be clearly identified, and shall be placed in an envelope clearly marked "Confidential Data" and submitted with the proposal. Any request to keep the entire proposal confidential can not be honored. Pricing becomes public information at the time of the opening.

**Regulatory Requirements:** Any contract entered into pursuant to these specifications will be subject to the applicable terms and conditions of any of the County's financial assistance agreements with the State of New York.

The Provider shall comply with all Federal, State, and local licensing and/or regulatory requirements (including permits) for the provision of personal care assistance services.

All practices, materials, supplies, and equipment shall comply with the Federal Occupational Safety and Health Act, as well as any pertinent Federal, State and/or local safety or environmental codes.

**Subcontracting:** Any purported delegation of duties or assignment of rights under this Agreement without the prior express written consent of the County is prohibited. The Provider shall not subcontract any part of the work without the prior written consent of the County. All subcontracts shall provide that subcontractors are subject to all terms and conditions set forth in the contract documents. All work performed by a subcontractor shall be deemed work performed by the Provider.

**Licenses, Permits & Taxes:** The successful Provider shall be appropriately licensed for the work required as a result of the contract. The cost for any required licenses or permits shall be the responsibility of the Provider. The Provider is liable for any and all taxes due as a result of the contract.

**Protest Procedure:** Any Provider who makes a claim that Columbia County violated general law concerning this procurement and subsequent award may file a protest with the Columbia County Attorney. Protests must be filed in writing within five (5) days following the

day the Notice of Intent to Award is provided to the unsuccessful Provider. The County Attorney shall issue a written determination no later than seven (7) days after receipt of a written protest. The decision of the County Attorney shall be considered final.

**Severability:** In the event any provision of the contract is declared or determined to be unlawful, invalid, or unconstitutional, such declaration shall not affect, in any manner the legality of the remaining provisions of the contract and each provision of the contract will be and is deemed to be separate and severable from each other provision.

### **Reserved Rights**

The County reserves the following rights in connection with this RFP:

1. Reject any or all proposals received in response to this RFP.
2. Waive or modify minor irregularities in proposals received after prior notification to the applicant.
3. Negotiate with applicants responding to this RFP within the requirements.
4. Modify the detail specifications should no proposals be received that meet all these requirements.
5. If the County is unsuccessful in negotiating a contract with the selected bidder within an acceptable time frame, the County may begin contract negotiations with the next qualified bidder(s).

### **Provider Information**

The successful Provider must be a reputable, established and financially stable Provider of the service requested. The County requires assurance that the Provider has a high probability of remaining in business during the term of the contract resulting from this request.

### **References**

A list of current and past customers to whom the Provider is or has performed similar services shall be provided including names of the organization, addresses, contact persons and telephone numbers. Other pertinent references may be given at the Provider's discretion.



## **SPECIFICATIONS**

### **Scope**

Columbia County requires a firm with expertise in the personal care assistance field to deliver and maintain personal care services for Southern Columbia County residents.

Personal Care Services include the following types of services which may or may not be required for individual patients.

- 1) Making and changing beds;
- 2) Dusting and vacuuming the rooms the patient uses;
- 3) Light cleaning of the kitchen, bedroom and bathroom;
- 4) Dishwashing;
- 5) Listing needed supplies;
- 6) Shopping for the patient if no other arrangements are possible;
- 7) Patient's laundering, including necessary ironing and mending;
- 8) Payment of bills and other essential errands;
- 9) Preparing meals, including food preparation according to medically prescribed diets;
- 10) Bathing of the patient in the bed, the tub or in the shower;
- 11) Dressing the patient;
- 12) Grooming, including hair care, shaving and ordinary care of nails, teeth and mouth;
- 13) Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
- 14) Walking, beyond that provided by durable medical equipment, within the home and outside the home, transferring from bed to chair or wheelchair;
- 15) Feeding the patient;
- 16) Administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;
- 17) Providing skin care;
- 18) Using medical supplies and equipment such as walkers and wheelchairs;
- 19) Changing of simple dressings.

For more information on the mode of provision of these services please consult 18 NYCRR 505.14(a)(6), attached hereto as Appendix "D" and 9 NYCRR 6654.17, attached hereto as Appendix "E".

### **Applicable Laws**

The applicable laws, regulations, policies and standards for the Personal Care Services

are as follows:

1. Title XIX of the Social Security Act (42 U.S.C. 1396, et. seq.) enables states to create Medical Assistance programs, which include the furnishing of personal care services to needy individuals. Funding for such programs is also authorized, requiring State contribution.
2. New York State authorizes the provision of personal care services in Social Services Law Section 365-a. Applicable sections of Social Services Law Section 365-a pertaining to the provision of personal care are implemented by NYSDOH through 18 NYCRR 505.14, which is attached hereto as Appendix “D” and 9 NYCRR 6654.17, attached hereto as Appendix “E”.
3. The contracting agency must possess a valid current license under 10 NYCRR 765, governing the approval and licensure of home care services agencies, or be certified under 10 NYCRR parts 760 and 761 if not licensed.
4. To receive payment for the provision of services, the contracting agency must be enrolled in the Medical Assistance program in accordance with 18 NYCRR 504.
5. All claims for payment must be in conformity with 18 NYCRR 540.6 and applicable state and federal laws.
6. The New York State policy guidelines for contracting for personal care services are outlined in the State Medicaid Handbook and NYSDOH Administrative Directives.
7. The County administers the Medical Assistance program for eligible persons as an agent of NYSDOH. In addition to requirements under the State and Federal programs, compliance with all applicable County laws and the fulfillment of the County’s overall policy goals is required.

### **Contract Period**

The contract resulting from this request for proposals shall be from contract date to December 31, 2019, commencing on the date a contract is signed between the Provider and the County. The County shall have the option to renew its contract with the successful Provider subject to negotiation and agreement between both parties. The renewal will be on a per hour payment basis.

### **Provider Responsibilities**

The selected Provider will provide complete management, operations, and maintenance services to support the proposed service.

The selected Provider shall be knowledgeable of New York State and Federal requirements, permits, and other authorities needed to perform the scope of services described herein. Evidence of such authorities shall be provided with the Provider's proposal. The selected Provider shall obtain any appropriate New York State permits and operating authority to deliver this service prior to the start of service. Provider shall have a NYSDOH-approved training program in accordance with 18 NYCRR 505.14(e), 9 NYCRR 6654.17 and trained personnel.

Have insurance coverage for liability and Workman's Compensation, as specified in Appendix "C".

Omission of any requirement from this Section does not relieve the selected Provider from its obligation in this area.

### **Coverage Area**

The selected Provider shall provide services to individuals residing in Southern Columbia County. As such, proposals must serve the needs of residents in every part of Southern Columbia County. Proposals that do not serve all of Southern Columbia County will be dismissed as incomplete.

It is each Provider's responsibility to familiarize themselves with each area of Columbia County prior to submitting their Proposal.

### **Estimated Service Population**

Information contained in APPENDICES is provided only to assist Providers in assessing the market, which shall be solely the responsibility of the Provider.

### **On-Time Performance**

The Provider will be required to meet on-time performance standards.

Those in need of personal care services shall be provided with a consistent monthly assistance schedule with aides arriving consistently and within no more than fifteen (15) minutes of the scheduled times.

Consistency and dependability shall be maintained except where/when adverse weather or road conditions may prohibit. (See Appendix "B").

### **Personnel**

The Provider shall furnish adequate, qualified, trained personnel to manage, deliver, and

maintain the personal care assistance services as described by this Request for Proposal.

Provider shall be solely responsible for payment of all employee and/or subcontractor wages and benefits. The Provider shall comply with the requirements of employee liability, Worker's Compensation, unemployment insurance, Social Security, and all other applicable laws.

### **Phone Service**

A local line shall be dedicated and staffed during operating hours. Schedule information shall be readily available and understandable to the persons receiving personal care assistance.

The Provider shall be required to keep a log of all complaints and comments received concerning service and to bring such complaints and comments to the attention of the County within two working days of receipt. If there has been a complaint about service, the Provider shall reply, in writing, to the County indicating the corrective action taken to remedy any deficiency.

### **Personal Care Aides**

The Provider shall supply the required number of properly qualified personnel to manage and to provide the required services. Each of the Provider's employees shall, at all times while on duty in the performance of services required herein, be neatly and cleanly dressed and maintain a courteous and cooperative attitude in their contact with the public.

### **Vehicles**

Personal care aides shall hold a valid driver's license. Personal care aides shall operate legally registered, insured and inspected vehicles. Personal care aides shall operate these vehicles in a manner consistent with the laws of the state of New York.

### **Licensing**

It shall be the Provider's responsibility to ensure that personal care aide operating personal vehicles are fully licensed and said vehicles are inspected and registered in accordance with the laws of the State of New York.

### **Vehicle Usage**

During the performance of the duties covered in this RFP vehicles should be used solely for the providing this service and not for the transportation of passengers or for the performance

of duties unrelated to the performance of this service. Proof of insurance and driver's license shall be presented to the Provider for any personal care aide seeking travel time reimbursement.

### **Insurance/Accident Requirements**

All accidents must be reported immediately to the referring County agency and the Columbia County Sheriff. All moving violations issued to drivers must immediately be reported to the referring County agency.

### **Personal Care Aide Misconduct**

Upon the receipt of a complaint of misconduct against a personal care assistance service aide, the County reserves the right to exclude said individual from providing services to individuals covered under this proposal until said complaint is resolved in the favor of the employee. If said, complaint is not resolved in favor of the employee, the County reserves the right to permanently exclude the individual from delivering services to individuals covered under this proposal.

### **Drug and Alcohol Use**

No person acting in the capacity of a personal care aide shall perform said duties under the influence of illegal drugs or alcohol. Upon the receipt of a complaint of said nature, the County reserves the right to exclude said individual from providing services to individuals covered under this proposal unless said complaint is resolved in the favor of the employee. If said, complaint is not resolved in favor of the employee; the County reserves the right to permanently exclude the individual from delivering services to individuals covered under this proposal.

### **Billing**

On a weekly basis, the Provider will provide Columbia County with a detailed invoice. Each invoice shall document the number of clients served, dates and times of service along with aide activity sheets.

Columbia County will pay the Provider, upon receipt and approval of a complete and accurate invoice, within the County's prescribed Provider payment schedule. Columbia County may, at any time, conduct an audit of any and/or all records kept by the Provider of this service. Any overpayment uncovered in such an audit may be charged against the Provider's future invoices.

**Population Fluctuation**

The Provider will work closely with the County to determine and meet client needs, propose options and alternatives. The selected Provider will demonstrate an ability to work closely with the County towards continued coordination of all personal care services to fulfill unmet needs and reduce duplication of services. Any change in the service or schedule shall be at the option of the County. Columbia County reserves the right to terminate or expand service. Should this occur, payment to the Provider by the County shall be reduced or increased proportionately according to the agreed upon cost per hour.

**Exclusivity**

Should the Provider be unable to deliver services to each individual in need of said services in Columbia County for a period of two (2) weeks the County reserves the right to contract with additional service Providers in order to meet the needs of the residents of Columbia County.

**Records Review**

The County reserves the right to review all records associated with the personal care services provided pursuant to the subsequent contract entered into with the successful bidder.

## APPENDIX A

**Columbia County Office for the Aging  
Personal Care 1 & 2 Services as of 11/7/18**

<b>Town</b>	<b>Clients</b>	<b>Weekly Service Hours</b>	<b>Annual Service Hours</b>
<b>Ancram</b>	0	0	0
<b>Canaan</b>	2	10	520
<b>Chatham</b>	0	0	0
<b>Claverack</b>	9	31	1,612
<b>Copake</b>	6	16	832
<b>Germantown</b>	5	10	520
<b>Ghent</b>	1	5	260
<b>Greenport</b>	10	33	1,716
<b>Hudson</b>	11	36	1,872
<b>Kinderhook</b>	6	16	832
<b>Livingston</b>	3	17	884
<b>New Lebanon</b>	1	8	416
<b>Stockport</b>	3	8	416
<b>Stuyvesant</b>	1	2	104
<b>Taghkanic</b>	1	2	104
<b>Total</b>	<b>59</b>	<b>194</b>	<b>10,008</b>

**\* Currently 5 Additional Clients Are Being Assessed for Services**

**Claverack (1)  
Greenport (2)  
Kinderhook (2)**

## **APPENDIX B**

### **PERFORMANCE STANDARDS**

1. The Provider shall attain within three (3) months a minimum standard of "on-time service call" of at least ninety percent (90%) on a daily basis and shall maintain same ninety percent (90%) "on-time service calls throughout the contract period.
2. "On-time" shall be defined as between within fifteen (15) minutes of the scheduled appointment time.
3. The Provider shall, at a minimum, complete ninety-nine percent (99%) of all scheduled appointments on a weekly basis.
  - a. Missing two consecutive service appointments for any individual client is prohibited.
  - b. If appointments are missed, it shall be immediately reported to the referring County Agency with an explanation as to why the appointment was missed.
4. Extenuating circumstances due to weather or other causes immediately reported to and approved by the referring County agency, will provide for exemption from the standards set forth in paragraph 1, 2 & 3 above. The County shall be the sole judge as to the validity of the reported extenuating circumstances.
5. The Provider will accept penalties for non-performance.
  - a. Non-performance shall include, but not be limited to:
    1. Five (5) or more documented instances of violations of performance standards.
    2. Failure to provide the referring County agency personnel with requested documentation as per contract.
    3. Third consecutive monthly failure to meet standard regarding scheduled appointments, statistics to be considered monthly by the referring County agency.
    4. Missing three (3) consecutive appointments on an individual client.



- b. No penalty will be applied without the Provider receiving written notice from County.
- c. If the Provider shall adequately remedy non-performance as notified by County within ten (10) working days after notification of non-performance, and the same is acceptable to the County, no penalty will be assessed. Likewise, if the Provider, within seven (7) days after notification of non-performance by the County, informs the County of extenuating circumstances contributing to or responsible for non-performance, and such extenuating circumstances are acceptable to the County as to excuse the Provider for non-performance, no penalty will be assessed or a reduced penalty will be imposed.
- d. If adequate steps are not taken to remedy the non-performance, the penalty will be applied. The penalty shall be:
  - 1. Forfeiture of Two Thousand Dollars (\$2,000.00) for the first violation of a non-performance item.
  - 2. Forfeiture of Five Thousand Dollars (\$5,000.00) each for the second and third violation of a non-performance item.
  - 3. Cancellation of the contract, for cause, for the fourth (4th) violation of a non-performance item.

**APPENDIX C**

**SAMPLE AGREEMENT**

**BETWEEN A LOCAL SOCIAL SERVICES DISTRICT AND A CONTRACTING AGENCY FOR PERSONAL CARE SERVICES (PURSUANT TO TITLE 11 OF ARTICLE 5 OF THE NEW YORK SOCIAL SERVICE LAWS AND TITLE XIX OF THE UNITED STATES SOCIAL SECURITY ACT).**

**FOR TITLE XIX SERVICES ONLY**

**MADE THIS 1ST DAY OF JANUARY, 2018**

**BETWEEN**

**COLUMBIA COUNTY DEPARTMENT OF SOCIAL SERVICES**

**LOCATED AT 25 RAILROAD AVENUE, HUDSON, NEW YORK 12534**

**(HEREINAFTER CALLED THE DISTRICT),**

**AND**

***(INSERT PROVIDER NAME)***

**LOCATED AT NEW YORK, NEW YORK 10001**

**(HEREINAFTER CALLED THE PROVIDER)**

Authorized by the Columbia County Board of Supervisors on the \_\_\_<sup>th</sup> day of \_\_\_\_\_, 2018, pursuant to Resolution No.: \_\_\_\_201\_.

This Agreement is between the Columbia County Department of Social Services, a municipal corporation of the State of New York, hereinafter referred to as the Social Services District, having its principal office at 25 Railroad Avenue, Hudson, New York 12534 and \_\_\_\_\_ (Provider ) having its principal office at \_\_\_\_\_, New York \_\_\_\_\_.

The parties hereto desire to make available to the County of Columbia, Personal Care Services under Title XIX of the Federal Social Security Act.

The Social Services District is authorized, pursuant to Section 365-a(2)(e) of the New York State Social Services Law and 18 New York Code of Rules and Regulation (NYCRR) and/or other New York State Department of Health regulations, to provide personal care services to persons eligible to receive said services; and

The Social Services District is desirous of obtaining personal care services to be rendered to recipients of Medical Assistance (Medicaid) for which reimbursement is available pursuant to Title XIX of the Federal Social Security Act and applicable state law; and

The Provider herein represents that he or she will provide services that are authorized pursuant to Title XIX of the Federal Social Security Act and applicable state law and which are eligible for reimbursement thereto;

THEREFORE, the parties signing and executing this instrument do in consideration of the above agree as follows:

**1. Providers as Independent Contractors**

The Social Services District and the Provider agree that the Provider is an independent contractor and is not in any way to be deemed an employee of the Social Services District or the State Department of Health. The Provider agrees that it will, at all times, indemnify and hold the Social Services District and the State Department of Health and their officers or employees harmless and free and clear of any and all liability arising from any act of omission or commission by the Provider, its officers or employees with respect to this Agreement and any of the terms thereof. It is further understood and agreed that no agent, servant, or employee of the Provider shall, at any time, or under any circumstances, be deemed to be an agent, servant, or employee of the Social Services District or State Department of Health. Notwithstanding the foregoing, the Provider shall be required to defend, indemnify, and hold harmless the Social Services District or the State Department of Health for any losses resulting solely from the provider's negligence.

**2. Provision of Personal Care Services**

The Provider agrees to provide personal care services, as defined in New York State 18 NYCRR to recipients of Medicaid, as defined in Title 11 of Article 5 of the New York State Social Services Law and /or Title XIX of the Federal Social Security Act, if requested to provide said services by a social services district, pursuant to the order(s) and/or prescription(s) of a physician, in accordance with a plan of care and to be supervised by a registered nurse, subject to the conditions set forth in the regulations of New York State 18 NYCRR or superseding provisions.

**3. Authorization and Request for Personal Care Services**

It shall be the sole responsibility of the Social Services District to determine the eligibility of a client. The Social Services District and/or eMedNY shall not reimburse the Provider for personal care services provided to persons who have not been determined eligible and authorized by the Social Services District to receive such services and when such services are not provided in accordance with the written authorization of the Social Services District. The Social Services District and/or eMedNY shall reimburse the Provider only for such personal care services authorized and provided in accordance with the policies and procedures of the Social

Services District.

It shall be the sole responsibility of the Social Services District to notify the Provider of the service authorization of each client including the functions and tasks required.

The Social Services District will forward to the Provider written confirmation of each telephoned service authorization within seven working days of such notification.

**4. Obligation to Utilize Provider**

The Social Services District shall not be obligated to utilize the services of the Provider(s).

**5. District's Termination of Contract**

The Social Services District shall have the right to terminate this Agreement under the following conditions:

a. Upon receipt of notification that Federal and/or State reimbursement is no longer available for the services to be provided.

b. Failure of the personal care agency to perform its obligations pursuant to this Agreement and the requirements of 18 NYCRR 505.14.

c. Violation by the Provider of any of the material terms of this Agreement or participation in Medicaid fraud.

d. Except for emergencies when the patient's health and safety is in immediate jeopardy, the Social Services District shall give the Provider thirty (30) days written notice of intention to terminate services of the Provider under this Agreement; in the event of termination, the Provider shall, within five (5) working days, transfer copies of any and all records pertaining to any individual who has been or is receiving services provided by the Provider to the Social Services District. The Provider shall retain its original client care records and, within five (5) working days, transfer a copy of any and all client care records in lieu of originals which shall be retained by the Provider for at least six (6) years beyond the date of termination of the contract between Provider and the district.

e. The cessation of services to a particular recipient shall not render this entire Agreement void or voidable.

**6. Provider's Termination of Contract**

The Provider shall have the right to terminate this Agreement under the following conditions:

a. If there is an imposition of new or additional requirements by the Federal or State

governments as a condition to continued Federal or State reimbursement which the Provider reasonably finds unacceptable;

b. The State Department of Health has, pursuant to the provisions of this Agreement, reduced the rate paid to the Provider and the Provider finds such reduced rate to be unacceptable.

c. The provider shall give the Social Services District thirty (30) days written notice of its intention to terminate services to the district or any individual who would otherwise remain eligible to continue receiving personal care services. This written notice of termination shall contain the reasons for termination and the effective dates.

## **7. Close-Out Procedures**

Upon termination or expiration of this Agreement, the Provider shall comply with all State Department of Health and Social Services District's close-out procedures, including, but not limited to:

a. Turn over to the State Department of Health or the Social Services District all books, client records, client documents and material relating to client services.

b. Not incur or pay any further obligations pursuant to this Agreement beyond the termination date. Any obligation necessarily incurred by the Provider on account of this Agreement prior to receipt of notice of termination and falling due after such date shall be paid by the Social Services District in accordance with the terms of this Agreement if the Social Services District receives notice of such obligations within thirty (30) days after the date of termination.

c. Account for and refund to the Social Services District within thirty (30) days after the date of termination, overpayments of funds paid in excess of Allowable Payments which have been paid to the Provider pursuant to this Agreement.

d. Submit to the State Department of Health within ninety (90) days after the date of termination or expiration, a final report of receipt and expenditure of funds relating to this Agreement. The report shall be made by a certified public accountant.

## **8. Terms of Agreement**

This Agreement will be in effect for one year and will be automatically renewed at the end of the year and each subsequent year unless terminated. Either party may terminate this agreement at any time, with or without cause, by providing at least thirty days advance written notice of the termination to the other party. Such termination will have no effect upon the rights and obligations resulting from any transactions occurring prior to the effective date of termination.

**9. Jurisdiction of District**

The Provider agrees that its employees or agents rendering personal care services shall be subject to the jurisdiction of the district and/or its designee, when such designee has been approved by the State Department of Health. It is understood and agreed that the Social Services District retains the right to maintain and continue case management for any recipients of Medicaid and that the activities of the Provider shall be subject to the monitoring of the Social Services District and the State Department of Health, in accordance with the requirements of 18 NYCRR.

**10. Agreement to Renegotiate**

The parties agree to renegotiate this Agreement in the event that the United States Department of Health and Human Services or the State Department of Health issue new or revised requirements on the Social Services District as a condition for receiving continued Federal or State reimbursement.

**11. Amendment of Contract**

This Agreement may be amended whenever determined necessary by the Social Services District and the Provider, if such amendments are approved by the State Department of Health. All amendments must be in writing, duly signed by both parties, and be annexed to the contract.

**12. Fair Hearings**

The Social Services District shall be responsible for providing notice to recipients of the recipient's right to a State fair hearing as required by Federal and State Law and regulations, and the manner in which a State fair hearing may be requested. The Provider, upon request of the Department, shall participate in State fair hearings when necessary for the determination of issues.

**13. Adequacy of Service Notices**

This contractual arrangement shall not diminish the Provider agency's responsibility for maintaining adequacy of service notices thereof to recipients, reports, surveys, studies, audits, court or judicial proceedings, and any other matters of procedures relating to the furnishing of personal care services by the Provider.

**14. Adequacy of Provider Services**

This contractual arrangement shall not diminish the Provider agency's responsibility for maintaining adequacy of services provided by the agency. As required in 10 NYCRR 766.10 (d), notwithstanding any other provisions in this contract, the Provider agency remains responsible for: a) ensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State and local statutes, rules and regulations; b) ensuring the quality of all services provided by the agency; and c) ensuring adherence by the agency staff to

the plan of care established for patients.

**15. Liability Insurance**

The Provider shall obtain and maintain in full force and effect liability or other insurance in an amount sufficient to protect the Social Services District and the State Department of Health from any potential liability that may accrue as a result of any actions of the Provider; such coverage may be an endorsement to an existing policy of the Provider. Regardless of the form or manner of coverage, the insurer shall be requested by the Provider to provide the Social Services District with a written acknowledgment of coverage, the terms and conditions thereof, and a commitment to notify the Social Services District at least ten days before any cancellation, reduction or other change in coverage becomes effective (pursuant to usual insurance “hold harmless” or “loss payee” provisions).

**16. Other Insurance**

Statutory Workers’ Compensation, Employer’s liability and New York State Disability in accordance with the Workers’ Compensation and disability benefits laws of the State of New York.

**17. Fiscal Reports**

The Provider shall make the necessary and/or required employer payroll reports, deductions, and tax, insurance, or other payments, including, but not limited to, providing for worker’s compensation insurance, disability insurance, U.S. Social Security taxes, federal and state unemployment insurance benefits, withholding federal, state and local income taxes; and comply with any other legal or customary requirements.

**18. Performance Standards**

The Provider shall provide services which assure the health and safety of the client and assist the client to live as independently as possible. To assure the quality of the service, the following shall apply:

a. The Provider shall commence services as expeditiously as possible upon receipt of an oral or written authorization from the Social Services District. If notice to commence services is received on a Friday, Saturday, Sunday, or Official State Holiday, the said hour period shall begin to run on the next business day following such Friday, Saturday, Sunday or State Holiday.

b. The Provider shall establish and maintain procedures in order to ensure uninterrupted service in accordance with service authorizations, including the following:

i) The Provider shall establish and maintain a 24 hour per day, seven day per week system for emergency replacement of personal care aides.

ii) The Provider shall establish and submit to the Social Services District for review and approval a holiday coverage plan for the provision of services.

iii) Providers who are certified in accordance with Part 760 of 10 NYCRR or licensed in accordance with Part 765 of 10 NYCRR shall share with the Social Services District their plan for emergency and disaster preparedness prepared in accordance with Section 763.8 of 10 NYCRR and Section 766.5 of 10 NYCRR. Those agencies which are not required to be certified or licensed and are providing services exclusively under 18 NYCRR shall establish and submit to the Social Services District for its prior approval a plan for maintaining services in the event of an emergency, including snowstorms and power failures.

iv) The Provider shall promptly notify the client and the Social Services District when the Provider is unable to provide continuing services in accordance with service authorization. The Provider shall make such emergency arrangements as shall be necessary to ensure that the safety of the client is not endangered by the inability of the Provider to provide the authorized services.

c. The Provider shall notify the Social Services District when personal care services appear to be no longer appropriate. The Provider shall in no event terminate services to a client without the prior approval of the Social Services District.

d. The Provider shall notify in writing all their employees that the personal care aides cannot cash checks, do banking or pay bills for the client without special written permission from the Social Services District. If such permission is granted, all such transactions shall be documented in writing.

e. The personal care aide shall not directly or indirectly solicit any gift or accept any gift, whether in the form of money, services, loans, time off, telephone usage, travel or any other form.

## **19. Administrative Supervision**

The Provider agrees to perform administrative supervision activities to assure that personal care services are provided as authorized by the case management agency. To assure that services are provided according to the level, amount, frequency and duration authorized, the provider agrees to:

a. Notify the case management agency within 24 hours of the initial referral whether the agency accepts or rejects an assigned case. If the provider accepts the client, the provider agency must notify the case management agency of the arrangements made to provide personal care services. If the provider rejects the client, the provider agrees to notify the case management agency of the reason for rejecting the referral.

b. Assign a personal care aide(s) to the client which can meet his/her needs. In making such a determination, the Provider agrees to take the following into consideration:



- i) the skills needed by the patient;
  - ii) the patient's cultural background, primary language, personal characteristics and geographic location; and
  - iii) the ability of the personal care aide to communicate with the patient or on the patient's behalf;
- c. Promptly provide a replacement when the assigned personal care aide:
  - i) is unavailable;
  - ii) does not work effectively with the patient or care givers or provides personal care services inappropriately or unsafely; or
  - iii) is not performing to the satisfaction of the client.
- d. Promptly notify the case management agency when the provider is unable to maintain coverage including cases requiring service at night, weekends and holidays, or when there are questions regarding the adequacy of the authorized personal care services.
- e. Participate in, or arrange for, the orientation of persons providing personal care services to the employment policies and procedures of the agency;
- f. Evaluate, at a minimum annually, the overall job performance of persons providing personal care services;
- g. Check time cards for required documentation and maintain scheduling records and any other records necessary to fulfill required administrative activities.

## **20. Provider Records**

- a. The provider agrees to maintain books, records, documents and acceptable accounting procedures and practices which adequately reflect all direct and indirect costs of any nature expended in the performance of this Agreement. The Provider also agrees to collect and maintain program and statistical records as prescribed by and on forms furnished by the Social Services District and authorized by the State Department of Health.
- b. The Provider agrees to retain all books, records, and other documents relevant to this Agreement for six (6) full years after final payment. Federal and/or State auditors and any persons duly authorized by the Social Services District shall have full access to and the right to examine any of said materials during said six (6) year period.
- c. The Social Services District and the Provider shall observe and require the observance of applicable Federal and State requirements relating to confidentiality or records and information, and each agrees not to allow examination of records or disclose information, except

for examination of records by the Social Services District and/or the State Department of Health as may be necessary to assure that the purpose of the Agreement will be effectuated. The Social Services District also agrees that the physician's orders, the nursing and the social assessments will be maintained within their records provided that the district furnishes copies of such written documentation and information, including copies of the physician's orders and nursing assessment, and access to its staff, as may be required by the State Department of Health or by the licensed Provider agency, to assure compliance with applicable statues, rules and regulations.

**21. Cooperative Agreements**

The Provider agrees that it has notified or will notify, the Social Services District and/or the State Department of Health of any affiliated entities with which it has direct or indirect cooperative agreements, contracts for services, or any other type of formal or informal arrangement whereby the costs and/or the amounts received in reimbursement for services rendered to recipients are shared among or transferred between the Provider and any other entity(ies); if the Provider makes any disbursement directly or indirectly to any entity receiving reimbursement from any governmental agency, the Social Services District and/or the State Department of Health shall also be notified.

**22. Rates of Payment**

The Social Services District shall reimburse the provider at the rate(s) set forth by the State Department of Health and approved by the State Division of the Budget. Unless otherwise stated, the rate of payment set forth shall be the total gross amount of payment and no additional reimbursement to the Provider will be made for any subsidiary or other services supplementary or in addition to the terms herein set forth. The terms set forth on the rate page appended hereto shall be made a part hereof and shall be incorporated herein.

**23. Local Variations**

Local variations, if any, shall be set forth in Appendix "B", appended hereto and shall be effective only if the terms and form of such variations do not conflict with the contents of this contract. The words and meaning of the terms in the main body shall be controlling to the exclusion of the local variations unless a separate executed Agreement between the State Department of Health and the Social Services District deliberately changes said effect and a copy of said Agreement is appended thereto.

**24. Civil Rights Requirements**

The Provider agrees to comply with the requirements of the United States Civil Rights Act of 1964 as amended and Executive Order No. 11246 entitled "Equal Employment Opportunities" and the regulations issued pursuant thereto as shall be deemed to exist or to bind any of the parties hereto.

**25. Non-Discrimination Requirements**

The Provider agrees to observe and comply with the Federal regulations contained in 45 CFR 84 entitled “Non-discrimination on the Basis of Handicap; Programs and Activities Receiving or Benefiting from Federal Financial Assistance.”

**26. Effective Dates**

This Agreement contains all the terms and conditions agreed upon by the parties. All items incorporated by reference are to be attached. No other understandings, oral or otherwise, regarding the subject matter of this Agreement, shall be deemed to exist or to bind any other parties hereto. Terms of this Agreement shall be effective beginning January 1, 2018 to December 31, 2018.

**27. Signatures**

In Witness Whereof, the parties hereunto have signed and executed this Agreement on the date(s) indicated opposite their respective signature.

COLUMBIA COUNTY DEPARTMENT OF HEALTH (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Jack Mabb, Director

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY DEPARTMENT OF SOCIAL SERVICES (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Robert M. Gibson, Commissioner

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY OFFICE FOR AGING

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Kevin McDonald, Administrator

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY BOARD OF SUPERVISORS

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Matt B. Murell, Chairman

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

(PROVIDER)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

***SUB-APPENDIX A***

The parties to the attached contract further agree to be bound by the following, which are hereby made a part of said contract:

I. This contract may not be assigned by the Provider or its right, title or interest therein assigned, transferred, conveyed, sublet or disposed of without the previous consent, in writing, of the State Department of Health.

II. This contract shall be deemed executory only to the extent of money available to the State for the performance of the terms hereof and no liability on account thereof shall be incurred by the State of New York beyond moneys available for the purpose thereof.

III. The provider specifically agrees, as required by Labor Law, Sections 220 and 220-d, as amended that:

- a. No laborer, workman or mechanic, in the employ of the provider, subprovider or other person doing or contracting to do the whole or; any part of the work contemplated by the contract shall be permitted or required to work more than eight (8) hours in any one calendar day or more than five (5) days in any one week, except in the emergencies set forth in the Labor Law.
- b. The wages paid for a legal day's work shall not be less than the prevailing rate of wages as defined by law.
- c. The minimum hourly rate of wage to be paid shall not be less than that stated in the specifications, and any redetermination of the prevailing rate of wages after the contract is approved shall be deemed to be incorporated herein by reference as of the effective date of redetermination and shall form a part of these contract documents.
  1. The Labor Law provides that the contract may be forfeited and no sum paid for any work done thereunder on a second conviction for willfully paying less than;
    - a. the stipulated wage scale as provided in Labor Law, Section 220, subdivision 3, as amended, or
    - b. less than the stipulated minimum hourly wage scale as provided in Labor Law, Section 220-d, as amended.

IV. The Provider specifically agrees, as required by the provisions of the Labor Law, Section 220-e as amended, that:

- a. In hiring of employees for the performance of work under this contract or any

subcontract hereunder, or for the manufacture, sale or distribution of materials, equipment or supplies hereunder, no provider, sub-provider nor any person acting on behalf of such provider or sub-provider, shall by reason of race, creed, color, sex or national origin discriminate against any citizen of the State of New York who is qualified and available to perform the work to which the employment relates.

- b. No provider, sub-provider, nor any person on his behalf shall, in any manner, discriminate against or intimidate any employee hired for the performance of work under this contract on account of race, creed, color, sex or national origin.
- c. There may be deducted from the amount payable to the provider by the State under this contract a penalty of fifty dollars for each person for each calendar day during which such person was discriminated against or intimidated in violation of the provisions of the contract.
- d. This contract may be canceled or terminated by the State or municipality and all moneys due or to become due hereunder may be forfeited for a second or any subsequent violation of the terms or conditions of the contract.
- e. The aforesaid provisions of this section covering every contract for or on behalf of the State or a municipality for the manufacture, sale or distribution of materials, equipment or supplies shall be limited to operations performed within the territorial limits of the State of New York.

V. During the performance of this contract, the provider agrees as follows:

- a. The provider will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, age, disability or marital status.
- b. If directed to do so by the Commissioner of Human Rights, the provider will send to each labor union or representative of workers with which the provider has or is bound by a collective bargaining or other agreement or understanding, a notice, to be provided by the State Commissioner of Human Rights, advising such labor union or representative of the provider's agreement under clauses (a) through (g) (hereinafter called "non-discrimination clauses"). If the provider was directed to do so by the providing agency as part of the bid or negotiation of this contract, the provider shall request such labor union or representative to furnish a written statement that such labor union or representative will not discriminate because of race, creed, color, sex, national origin, age, disability or marital status, and that such labor union or representative will cooperate, within the limits of its legal and contractual authority, in the implementation of the policy and provisions of these non-discrimination clauses and that it consents and agrees that recruitment, employment and the terms and conditions of employment under this contract shall be in accordance with the purposes and provisions of these non-discrimination

clauses. If such labor union or representative fails or refuses to comply with such a request that it furnish such a statement, the provider shall promptly notify the State Commissioner of such failure of refusal.

- c. Books, records and accounts by the State Commissioner for the purposes of investigation to ascertain compliance with these non-discrimination c. If directed to do so by the Commissioner of Human Rights, the provider will post and keep posted in conspicuous places, available to employees and applicants for employment, notices to be provided by the State Commissioner of Human Rights setting forth the substance of the provisions of clauses (a) and (b) and such provisions of the State's laws against discrimination as the State Commissioner of Human Rights shall determine.
- d. The Provider will state, in all solicitations or advertisement for employees placed by or on behalf of the Provider, that all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, sex, national origin, age, disability, or marital status.
- e. The Provider will comply with the provisions of Sections 290- 299 of the Executive Law and with the Civil Rights Law, will furnish all information and reports deemed necessary by the State Commissioner of Human Rights under these non-discriminatory clauses and such sections of the Executive Law, and will permit access to the provider's clauses and such sections of the Executive Law and Civil Rights Law.
- f. This contract may be forthwith canceled, terminated or suspended, in whole or in part, by the providing agency upon the basis of a finding made by the State Commissioner of Human Rights that the provider has not complied with these non-discrimination clauses, and the provider may be declared ineligible for future contracts made by or on behalf of the State or public authority or agency of the State, until the Provider satisfies the State Commissioner of Human Rights that the Provider has established and is carrying out a program in conformity with the provisions of these not-discrimination clauses. Such finding shall be made by the State Commissioner of Human Rights after conciliation efforts by the Commissioner have failed to achieve compliance with these non-discrimination clauses and after a verified complaint has been filed with the Commissioner, notice thereof has been given to the provider and an opportunity has been afforded the provider to be heard publicly in accordance with the Executive Law. Such sanctions may be imposed and remedies invoked independently of or in addition to sanctions and remedies otherwise provided by Law.
- g. The provider will include the provisions of clauses (a) through (f) in every subcontract or purchase order in such a manner that such provisions will be binding upon each sub-provider or vendor as to operations to be performed within the State of New York. The Provider will take such action in enforcing such provisions of such subcontract or purchase order as the State Commissioner of

Human Rights or the providing agency may direct, including sanctions or remedies for non-compliance. If the provider becomes involved in or is threatened with litigation with a subcontractor or vendor as a result of such direction by the State Commissioner of Human Services of the providing agency, the Provider shall promptly so notify the Attorney General, requesting the Attorney General to intervene and protect the interests of the State of New York.

VI. The agreement shall be void and of no force and effect unless the provider shall provide coverage for the benefit of, and keep covered during the life of this agreement, such employees as are required to be covered by the provisions of the Worker's Compensation Law.

VII. In accordance with Section 200-f of the Labor Law and Section 139-h of the State Finance Law and the regulations of the Comptroller of the State of New York promulgated thereunder, the provider agrees, as a material condition of the contract:

- a. That neither the provider nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the provisions of the United States Export Administration Act of 1969, as amended, or the Export Administration Act of 1979, as amended, or the regulations of the United States Department of Commerce promulgated thereunder;
- b. That if the Provider or any substantially owned or affiliated person, firm, partnership or corporation has been convicted or subjected to a final determination by the United States Commerce or any other appropriate agency of the United States of a violation of the United States Export Administration Act of 1969, as amended, or the Export Administration Act of 1979, as amended, or the regulations of the United States Department of Commerce promulgated thereunder, the provider shall notify the Comptroller of such conviction or determination in the manner prescribed by the Comptroller's regulations.



**SUB-APPENDIX B**  
(Local variations)

**COLUMBIA COUNTY – ADDITION TO PARAGRAPH 1 OF THE AGREEMENT–  
PROVIDERS AS INDEPENDENT CONTRACTORS:**

The Provider, in accordance with its status as an independent contractor, shall conduct itself consistent with such status; shall neither hold itself out as nor claim to be an officer or employee of the Social Services District and/or State Department of Health by reason hereof; and shall not, by reason hereof, make any claim, demand, or application to or for any right or privilege applicable to an officer or employee of the Social Services District and/or the State Department of Health, including but not limited to workers' compensation coverage, unemployment insurance benefits, Social Security coverage or retirement membership or credit.

**COLUMBIA COUNTY INSURANCE REQUIREMENTS:**

The PROVIDER agrees to hold harmless and indemnify the Columbia County Department of Social Services, and the officers, agents and employees of said Department, from and against all loss, damage, claims, demands, causes of action, and judgments arising out of bodily injury of whatever kind or nature, and property damage of whatever kind or nature, caused by the PROVIDER, and its staffing companies and arising out of PROVIDER'S or staffing company's performance of this Agreement. Additionally, the PROVIDER agrees to procure and maintain, at its own expense, insurance of the kinds and in the amount hereinafter provided, with insurance companies authorized to do business in the State of New York, covering all operations under this Agreement, whether performed by the PROVIDER and its staffing companies or by its subcontractor. Before commencing work on behalf of the County of Columbia PROVIDER shall furnish Certificates of Insurance that have complied with these requirements, which certificates shall provide:

- a. Coverage shall not be canceled or reduced until thirty (30) days after written notice has been given to the County of Columbia.
- b. Underwriters will have no rights of recovery or subrogation against the County of Columbia and/or the DEPARTMENT; it being the intention of the parties that the insurance policies so effected shall protect both parties.
- c. The insurance company(ies) issuing the policy(ies) shall have no recourse against the County of Columbia or the DEPARTMENT for payment of any premiums or assessments under any form of the policy.
- d. Any and all deductible and self-insurance retentions in the above-described insurance policies shall be assumed and at the risk of the PROVIDER in the amounts as indicated in such policies.
- e. The insurance policy shall contain a "tail" covering claims made within three (3) years from the termination of the policy for acts alleged to have occurred during the policy period.

The coverage parts and amount of insurance required are as follows:

**Commercial General Liability insurance with minimum limits of \$1,000,000 per occurrence, subject to a \$2,000,000 annual aggregate. Coverage shall include bodily injury, property damage, personal injury and blanket contractual liability. The County of Columbia and the Columbia County Department of Social Services shall be named additional insured.**

**Automobile Liability insurance with minimum limits of \$1,000,000 each accident. Coverage shall provide for any vicarious liability of the County of Columbia and/or DEPARTMENT and be applicable to all owned, non-owned, hired, borrowed or temporarily used vehicles of the PROVIDER.**

**Statutory Workers' Compensation and New York State Disability in accordance with the Compensation laws of the State of New York.**

**Professional Liability Insurance with minimum limits of \$1,000,000 per occurrence and a \$3,000,000 annual aggregate. The County of Columbia and the Columbia County Department of Social Services shall be named additional insured.**

**CASE MANAGEMENT SERVICES:**

The parties further agree that the Provider will provide Case Management Services as follows:

**1. The Responsibilities to be delegated to the case management agency:**

- (a) Receives referral for Personal Care Services from the district;
- (b) Completes the nursing and social assessment, including the completion of the home care assessment instrument, the DMSI and care plan;
- (c) Make referrals in the event that they can no longer provide appropriate service to the client, or that the client requires or requests a different service program i.e. LTHHC, Hospice, CDPAP;
- (d) Negotiating with informal caregivers;
- (e) Determining the level, amount, frequency and duration of Personal Care Services to be authorized or reauthorized;
- (f) Sending out timely and adequate notices; (including a copy to Columbia County Department of Social Services to be a part of the Local District Record)
- (g) Arranging for the delivery of Personal Care Services; and
- (h) Provides nursing supervision for the Personal Care case.
- (i) Assist clients with Medicaid spend downs as identified by the Columbia County Department of Social Services, in order to ensure continuity of services and to prevent provision of services with no payment method available.

**Responsibilities to be retained by Columbia County:**

- (a) Determine and maintain Medicaid eligibility; (as defined in Exhibit A – Recertification Record of the Case Management Plan)
- (b) Determine eligibility of Medicaid recipient for Personal Care Services including requesting necessary physician’s orders;
- (c) Contracting for provision of Personal Care Services;
- (d) Auditing to determine contract compliance;
- (e) Entering prior approval on the on-line system; and
- (f) Identify clients with a Medicaid spend down to ensure continuity of services and to prevent provision of services with no payment method available.

**2. The Delegation of Responsibilities**

The delegation of responsibility assures adherence to the program mandates of the New York State Department of Health included but not limited to responsibilities as specified in 18 NYCRR 505.14.

**3. Quality Assurance**

Columbia County Department of Social Services will make quarterly site visits to all contracting agencies that provide personal care case management services.

A sampling (20%) of records (unduplicated) will be reviewed to insure compliance with all NYS Health Department regulations as they pertain to case management activities.

Contact will be made via client survey with the recipients of personal care services to determine level of client satisfaction.

Client surveys will be sent out in the third month of the six-month Personal Care authorization period. The results will be screened and immediate concerns will be addressed in a timely manner. Other established patterns of concerns will be compiled and be presented at the annual review to the Case Management Agency by the Director of Services and the Supervisor of Adult and Family Services for discussion. The annual review will be conducted in accordance with 18 NYCRR 505.14c(9).

All nursing supervision reports will be forwarded to and reviewed against the Personal Care authorization and customer satisfaction by Columbia County Department of Social Services.

The Contracted Personal Care Case Management agencies will employ a program to insure continuous quality improvement and a plan to monitor the quality improvement. This quality assurance plan will be reviewed by the Columbia County Department of Social Services.

The tools used by the Contracted Personal Care Case Management Agencies to implement their quality assurance plan will include but are not limited to: Clinical and employee record review; evaluation of services and scope of care; client satisfaction questionnaire; quality improvement plan; quality assurance audits of agency offices; sample indicators; coordination of services; and an annual program quality evaluation.

#### **4. Cost Containment**

Contracted personal care agencies will determine the frequency and duration of personal care services during the assessment of an individual for personal care services. By contractual agreement, the Columbia County Department of Social Services will permit the contracted personal care agency to service up to 15 hours per week per recipient for task-oriented services.

Any hours in excess of 15 hours per week required or requested will be presented to Columbia County Department of Social Services as a subject for approval with appropriate documentation. If a disagreement ensues between the Columbia County Department of Social Services and the Case-Management Agency regarding the number of hours required by an individual for task-oriented personal care services, the issue will be submitted to the Columbia County Medical Director for an independent review.

The case management provider will forward the required physician's order and the social and nursing assessments required by 18 NYCRR 505.14 of the Department's regulations to the Columbia County Department of Social Services on any case requiring an independent medical review according to 18 NYCRR 505.14(b)(4)(i) of the Department's regulations.

All personal care referrals located in the geographical area identified by the Columbia County Department of Social Services, as the population included in the Shared Aide Program locale will first be referred to the agency contracted with by the Department to provide the Shared Aide Program. If that Provider is unable to provide the required Personal Care Service under the Shared Aide Program, the referral will then be entered into the rotation of referrals to the other Personal Care Case Management Providers.

Based on established guidelines, the Personal Care Management Agency will refer clients in need of PERS to the Columbia County Department of Social Services for case conference. A mutual decision will be made and the Columbia County Department of Social Services will authorize the PERS when indicated.

In Columbia County, hospital discharges are routinely referred to a CHHA for assessment by the discharge planning staff. When no skilled nursing need is present or when the case no longer requires skilled nursing, the CHHA refers the

case to the Columbia County Department of Social Services for Personal Care Services, thus utilizing Medicare maximization.

## **5. Interagency Referral Process**

All referrals to the CDPAP Program will be made by the Department of Social Services staff.

All referrals to the Shared Aide Program will be made by the Columbia County Department of Social Services staff to the agencies contracted to provide Shared Aide Personal Care Services.

All other referrals for personal care services will be referred on a rotating basis to a contracted agency providing Case Management activities. Referral will be made first by telephone followed by a referral form both faxed and mailed. (Historically, Personal Care referrals made by the Columbia County Department of Social Services are usually either accepted or rejected at the point of the telephone referral) This will assure that the nursing assessment will be completed within five (5) working days of receiving the referral. In the event that none of the contracting case management providers are able to accept a referral for assessment, the Columbia County Health Department will conduct the initial nursing and social assessment and open the case as first to fill.

The Department of Social Services staff will maintain responsibilities for re-referring any rejected referrals to the next case management provider.

Once a referral is accepted and assessed, the case management provider will return a "Referral Acceptance" form that is attached to the MMIS prior approval form that contains client data and number of hours and frequency.

Any time the case management agency has determined that they can no longer provide appropriate service to the client, or that the client requires or request a different service program i.e. LTHC, Hospice, CDPAP, they must notify the Columbia County Department of Social Services within one business day.

The Columbia County Department of Social Services will maintain records containing all referral information that is case specific.

The Personal Care Case Management Agency will contact Columbia County Adult Protective and/or Child Protective Services to discuss and/or refer any clients suspected to be at risk.

At the Columbia County Department of Social Service, the Supervisor of Adult and Family Services is the direct supervisor for both the Medicaid Home Care Programs and Adult Protective Services. Any PSA referral from Personal Care Case Management agencies would be made directly to the PSA Unit.

The Columbia County Department of Social Services will maintain records containing all referral information that is case specific.

The Columbia County Department of Social Services will provide Adult and Child Protective Services in-services for the Personal Care Case Management Agencies on a regular basis.

**6. Procedure for Social Service District Access, Audit and Review of Service Delivery**

The Personal Care Case Management Agency must allow the Columbia County Department of Social Services staff to access the case management records on demand.

The Personal Care Case Management Agency must share information regarding personnel upon request and openly participate in any PSA Investigations to which an employee might be a party.

The Personal Care Case Management Agency shall be willing to meet with the Columbia County Department of Social Services to review any client complaints and assist immediately to meet client needs.

The Columbia County Department of Social Services, upon completion and computation of the Department's client survey, will share the results with the Personal Care Case Management Agency for the purposes of information, discussion and corrective action as warranted.

The Columbia County Department of Social Services will review the contracted Personal Care Case Management Agency's quality assurance plan on an annual basis.

The Personal Care Case Management Agency staff will meet with the Supervisor of Adult and Family Services and the Director of Services on an annual basis to review service delivery; including a discussion of implementing recommended modifications or review the need for any program modifications.

**7. Procedures for Initiation, Denial or Termination of Services Will Meet the Department Mandates for Timely and Adequate Notice and Consider the Client's Health and Safety**

The Personal Care Case Management Agency will be responsible to send out all timely and adequate notices (denial, reduction, discontinuation, increase, reauthorization, or suspension of services). These notices will inform the patient of the patient's right to request a fair hearing and to have services continue unchanged until the fair hearing decision is issued (aid continuing) in accordance

with Part 358 of this Title. These timely and adequate notices will be provided on a form required by the Department.

The Columbia County Department of Social Services will maintain responsibility for preparing for and conducting the Fair Hearing process.

**8. All Personal Care Case Management Responsibilities Will Adhere to the Provisions Contained in 18 NYCRR 505.14**

The Columbia County Department of Social Services will have a contract pursuant to the Department of Health Subdivision 505-14c of Section g-2 with all agencies that perform personal care case management duties.

The Columbia County Department of Social Services will provide a copy of this plan to all contracting agencies for Case Management. The Columbia County Department of Social Services also will provide training on the contents of this plan to all contracted Case Management agencies.

The Delegation for personal care case management activities as defined above will be approved by the New York State Department of Health.

The Columbia County Department of Social Services will monitor all case management activities provided by agencies under contract to ensure that such activities comply with all Department of Health regulations specified in 18 NYCRR 505.14.

**SUB-APPENDIX C**

**AGREEMENT BETWEEN A LOCAL DEPARTMENT OF SOCIAL SERVICES AND A  
CONTRACTING AGENCY FOR PERSONAL CARE SERVICES (PURSUANT TO  
TITLE 11 OF ARTICLE 5 OF THE NEW YORK SOCIAL SERVICES LAW)  
(FOR TITLE XIX SERVICES ONLY)**

**ADDENDUM TO AN AGREEMENT**

Between:

**COLUMBIA COUNTY DEPARTMENT OF SOCIAL SERVICES**  
(Social Services District)

and:

**-----**

(Provider)



**NURSING SUPERVISION**

WHEREAS, an agreement has been or is simultaneously being executed between the parties hereto for the provision of home health care and personal care services; and,

WHEREAS, nursing supervision for personal care may be provided by a registered nurse who is an employee of a voluntary or proprietary agency pursuant to 18 NYCRR 505.14(f), and

WHEREAS, the Provider(s) herein represent(s) that he, she, it or they will provide said nursing supervision services as authorized pursuant to applicable state law and which are eligible for reimbursement thereto.

NOW, THEREFORE, the parties signing and executing this instrument do, in consideration of the above, covenant and agree as follows:

- A. All the terms and conditions contained in the agreement to which this addendum is appended shall continue in effect and the terms and conditions in this addendum are to be supplementary and subordinate thereto.
- B. The Provider(s) agree(s) to provide nursing supervision for personal care, as defined in 18 NYCRR 505.14, for services rendered to recipients of medical assistance (Medicaid), as defined in Title 11 of Article 5 of the New York State Social Services law, if requested to provide said services by a social services district subject to the conditions set forth in the regulations of the New York State Department of Social Services 18 NYCRR 505.14 or superseding provisions; said

nursing supervision services shall be rendered subject to the same terms and conditions set forth for personal care services in the agreement to which this addendum is appended.

- C. The Provider(s) agree(s) that all nursing supervision services performed under its direction shall be performed by a registered nurse who possesses the qualifications required by New York State Department of Social Services regulations 505.14 and/or any other state or federal law and/or regulations; all persons rendering such nursing supervision services shall be employees of the Provider in accordance with the requirements of the New York State Department of Health and the New York State Department of Social Services 18 NYCRR 505.14.
- D. The Social Services District shall reimburse the Provider at the rate(s) set forth by the New York State Department of Health and approved by the State Division of Budget. Unless otherwise stated, the rate of payment set forth shall be the total gross amount of payment, and no additional reimbursement to the Provider will be made for any subsidiary or other services supplementary or in addition to the terms herein set forth. The terms set forth on the rate page appended hereto shall be made a part hereof and shall be incorporated herein.
- E. This addendum shall be valid and binding for the time period set forth in the agreement to which this addendum is appended.
- F. This addendum contains all the additional terms and conditions agreed upon by the parties. All items incorporated by reference are to be attached. No other understandings, oral or otherwise, exist regarding the subject matter of this

agreement, shall be deemed to exist or bind any of the parties hereto, and any amendments, modifications, or revisions shall be subject to the terms and/or conditions set forth in the agreement to which this addendum is appended.

IN WITNESS WHEREOF, the parties hereunto have signed and executed this agreement on the date(s) indicated opposite their respective signatures. This addendum shall be valid and binding for the time period set forth in the Agreement to which the addendum is appended.

COLUMBIA COUNTY DEPARTMENT OF HEALTH (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Jack Mabb, Director

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY DEPARTMENT OF SOCIAL SERVICES (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Robert M. Gibson, Commissioner

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY OFFICE FOR AGING

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Kevin McDonald, Administrator

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY BOARD OF SUPERVISORS

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Matt B. Murell, Chairman

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

(PROVIDER)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

**HOMEMAKER SERVICES (TITLE XX)**

- I. In conformance with the above referenced Agreement and any and all Amendments thereto, the rate per unit of service (one hour) shall be as set and determined by the New York State Department of Health.
  
- II. Notwithstanding any other provision of this Agreement the Provider remains responsible for: (a) ensuring that any service provided pursuant to this Agreement complies with all pertinent provisions of federal, state and local statutes, rules and regulations; (b) ensuring the quality of all services provided by the agency; (c) ensuring adherence by agency staff to the agency plan of care established for patients; (d) homemakers will be required to be fingerprinted for the purpose of a criminal history record check performed by the Division of Justice in accordance with the provisions set forth in Section 443.8 of 18 NYCRR; and (e) homemakers will be required to complete forms which are necessary for the Columbia County Department of Social Services to inquire of the Office of Children and Family Services whether the homemaker is the subject of an indicated child abuse or maltreatment report on file with the Statewide Central Register of Child Abuse and Maltreatment in accordance with the provisions set forth in Section 443.2 of 18 NYCRR.
  
- III. All other provisions of the original Agreement, its addenda and amendments shall remain in full force and effect.

COLUMBIA COUNTY DEPARTMENT OF HEALTH (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Jack Mabb, Director

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY DEPARTMENT OF SOCIAL SERVICES (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Robert M. Gibson, Commissioner

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY OFFICE FOR AGING

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Kevin McDonald, Administrator

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY BOARD OF SUPERVISORS

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Matt B. Murell, Chairman

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

(PROVIDER)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

**ADDENDUM**

**Legal Compliance:**

The Provider agrees to comply with all Federal, State, and local laws and regulations governing the provision of goods and services under this Contract. Further, Provider agrees to comply with the rules and regulations of Columbia County. Columbia County’s Compliance Plan can be reviewed at [www.columbiacountyny.com](http://www.columbiacountyny.com), or a copy can be obtained upon request. The Provider agrees to abide by the terms of this Plan when delivering services under this Contract and shall ensure that each individual that provides such services under this contract is provided with a copy of the Plan or given access to the Plan.

Furthermore, Columbia County strongly encourages all healthcare providers contracting with Columbia County to implement their own compliance program which addresses each of the seven elements of compliance recommended by the Office of Inspector General, as well as the eight elements as recommended and/or mandated by the New York State office of the Medicaid Inspector General.

**Exclusion Screening Statement for contracts:**

Columbia County is committed to maintaining high quality care and service as well as integrity in its financial and business operations. Therefore, Columbia County will conduct appropriate screening of providers, employees, independent contractors, vendors, and agents to ensure and verify that they have not been sanctioned/excluded by Federal or State law enforcement, regulatory or licensing contractor.

Columbia County will also verify that entities and businesses that provide and/or perform services for Columbia County have not been the subject of adverse governmental actions and/or excluded from the Federal healthcare programs.

By signing this contract, you are attesting to that fact that you and/or the provider, which you represent, have not been sanctioned nor excluded by any of the aforementioned entities.

COLUMBIA COUNTY DEPARTMENT OF HEALTH (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Jack Mabb, Director

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY DEPARTMENT OF SOCIAL SERVICES (DISTRICT)

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Robert M. Gibson, Commissioner

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY OFFICE FOR AGING

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Kevin McDonald, Administrator

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

COLUMBIA COUNTY BOARD OF SUPERVISORS

BY: \_\_\_\_\_ Date: \_\_\_\_\_

Matt B. Murell, Chairman

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public



(PROVIDER)

BY: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2018.

\_\_\_\_\_

Notary Public

## APPENDIX D

### 18 NYCRR 505.14

#### Section 505.14. Personal care services

(a) *Definitions and scope of services.*

(1) **Personal care services** means assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with this section; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

(2) **Continuous personal care services** means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

(i) The patient's medical condition shall be *stable*, which shall be defined as follows:

(a) the condition is not expected to exhibit sudden deterioration or improvement; and

(b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and

(c)

(1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or

(2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

(ii) The patient shall be self-directing, which shall mean that he/she is capable of making choices about his/her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice. Patients who are nonself-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services, except under the following conditions:

(a) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household; or

(b) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or

(c) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The local social services department may be the outside agency.

(iii)

(a) Personal care services, including continuous personal care services and live-in 24 hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

(b) The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.

(4) **Live-in 24-hour personal care services** means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

(b) Before continuous personal care services or live-in 24-hour personal care services may be authorized, additional requirements for the authorization of such services, as specified in clause (b)(4)(i)(c) of this section, must be met.

(6) **Shared aide** means a method of providing personal care services under which a social services district authorizes one or more nutritional and environmental support functions or personal care functions for each personal care services recipient who resides with other personal care services recipients in a designated geographic area, such as in the same apartment building, and a personal care services provider completes the authorized functions by making short visits to each such recipient.

(b) *Criteria and authorization for provision of services.*

(1) When the local social services department receives a request for services, that department shall determine the applicant's eligibility for medical assistance.

(2) The initial authorization for personal care services must be based on the following:

- (i) a physician's order that meets the requirements of subparagraph (3)(i) of this subdivision;
- (ii) a social assessment that meets the requirements of subparagraph (3)(ii) of this subdivision;
- (iii) a nursing assessment that meets the requirements of subparagraph (3)(iii) of this subdivision;
- (iv) an assessment of the patient's appropriateness for hospice services and assessments of the appropriateness and cost-effectiveness of the services specified in subparagraph (3)(iv) of this subdivision; and
- (v) such other factors as may be required by paragraph (4) of this subdivision.

(3) The initial authorization process shall include the following procedures:

- (i) A physician's order must be completed on the form required by the department.

(a) The physician's order form must be completed by a physician licensed in accordance with article 131 of the Education Law, a physician's assistant or a specialist's assistant registered in accordance with article 131-B of the Education Law, or a nurse practitioner certified in accordance with article 139 of the Education Law.

(1) Such medical professional must complete the physician's order form within 30 calendar days after he or she conducts a medical examination of the patient, and the physician's order form must be forwarded to a social services district or another entity in accordance with clause (c) of this subparagraph.

(2) Such medical professional must complete the physician's order form by accurately describing the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks and by providing only such other information as the physician's order form requires.

(3) Such medical professional must not recommend the number of hours of personal care services that the patient should be authorized to receive.

(b) A physician must sign the physician's order form and certify that the patient can be cared for at home and that the information provided in the physician's order form accurately describes the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks, at the time of the medical examination.

(c) Within 30 calendar days after the medical examination of the patient, the physician, other medical professional, the patient or the patient's representative must forward a completed and signed copy of the physician's order form to the social services district for completion of the social assessment; however, when the social services district has delegated, pursuant to subdivision (g) of this section, the responsibility for completing the social assessment to another agency, the physician, other medical professional, the patient or the patient's representative must forward a completed and signed copy of the physician's order form to such other agency rather than to the social services district.

(d) When the social services district, or the district's designee pursuant to subdivision (g) of this section, is responsible for completing the social assessment but is not also responsible for completing the nursing assessment, the district or its designee must forward a completed and signed copy of the physician's order form to the person or agency responsible for completing the nursing assessment.

(e) The physician's order is subject to the provisions of Parts 515, 516, 517 and 518 of this Title. These Parts permit the department to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services, or supplies when medical care, services, or supplies that are unnecessary, improper or exceed patients' documented medical needs are provided or ordered.

(ii) The social assessment shall be completed by professional staff of the social services district on forms approved by the Department.

(a) The social assessment shall include a discussion with the patient to determine perception of his/her circumstances and preferences.

(b) The social assessment shall include an evaluation of the potential contribution of informal caregivers, such as family and friends, to the patient's care, and shall consider all of the following:

- (1) number and kind of informal caregivers available to the patient;
- (2) ability and motivation of informal caregivers to assist in care;
- (3) extent of informal caregivers' potential involvement;
- (4) availability of informal caregivers for future assistance; and
- (5) acceptability to the patient of the informal caregivers' involvement in his/her care.

(c) When live-in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide.

(d) The social assessment shall be completed on a timely basis and shall be current.

(iii) The nursing assessment shall be completed by a nurse from the certified home health agency, a nurse employed by, or under contract with, the local social services department, or a nurse employed by a voluntary or proprietary agency under contract with the local social services department.

(a) A nurse employed by, or under contract with, the local social services department or by a voluntary or proprietary agency under contract with the local social services department shall have the following minimum qualifications:

- (1) a license and current registration to practice as a registered professional nurse in New York State; and
- (2) at least two years of satisfactory recent experience in home health care.

(b) The nursing assessment shall be completed within five working days of the request and shall include the following:

- (1) a review and interpretation of the physician's order;
- (2) the primary diagnosis code from the ICD-9-CM;
- (3) an evaluation of the functions and tasks required by the patient;
- (4) an evaluation whether adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, can meet the patient's need for assistance with personal care functions and whether such equipment or supplies can be provided safely and cost-effectively;
- (5) development of a plan of care in collaboration with the patient or his/her representative; and
- (6) recommendations for authorization of services.

(iv) Assessment of other services.

(a) Before authorizing or reauthorizing personal care services, a social service district must assess each patient to determine the following:

(1) whether personal care services can be provided according to the patient's plan of care, whether such services are medically necessary and whether the social services district reasonably expects that such services can maintain the patient's health and safety in his or her home, as determined in accordance with the regulations of the Department of Health;

(2) whether the patient can be served appropriately and more cost-effectively by personal care services provided under a consumer directed personal assistance program authorized in accordance with [section 365-f of the Social Services Law](#);

(3) whether the functional needs, living arrangements and working arrangements of a patient who receives personal care services solely for monitoring the patient's medical condition and well-being can be monitored appropriately and more cost-effectively by personal emergency response services provided in accordance with section 505.33 of this Part;

(4) whether the functional needs, living arrangements and working arrangements of the patient can be maintained appropriately and more cost-effectively by personal care services provided by shared aides in accordance with subdivision (k) of this section;

(5) whether a patient who requires, as a part of a routine plan of care, part-time or intermittent nursing or other therapeutic services or nursing services provided to a medically stable patient, can be served appropriately and more cost-effectively through the provision of home health services in accordance with section 505.23 of this Part;

(6) whether the patient can be served appropriately and more cost-effectively by other long-term care services, including, but not limited to, services provided under the long-term home health care program (LTHHCP), the assisted living program or the enriched housing program;

(7) whether the patient can be served appropriately and more cost-effectively by using adaptive or specialized medical equipment or supplies covered by the MA program including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens; and

(8) whether personal care services can be provided appropriately and more cost-effectively by the personal care services provider in cooperation with an adult day health program.

(b) If a social services district determines that a patient can be served appropriately and more cost-effectively through the provision of services described in subclauses (a)(2) through (8) of this subparagraph, and the social services district determines that such services are available in the district, the social services district must first consider the use of such services in developing the patient's plan of care. The patient must use such services rather than personal care services to achieve the maximum reduction in his or her need for home health services or other long-term care services.

(c) A social services district may determine that the assessments required by subclauses (a)(1) through (6) and (8) of this subparagraph may be included in the social assessment or the nursing assessment.

(d) A social services district must have an agreement with each hospice that is available in the district. The agreement must specify the procedures for notifying patients who the social services district reasonably expects would be appropriate for hospice services of the availability of hospice services and for referring patients to hospice services. A social services district must not refer a patient to hospice services if the patient's physician has determined that hospice services are medically contra-indicated for the patient or the patient does not choose to receive hospice services.

(v) An authorization for services shall be prepared by staff of the local social services department.

(4) The initial authorization process shall include additional requirements for authorization of services in certain case situations:

(i) An independent medical review of the case shall be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the local social services department to review personal care services cases when:

(a) there is disagreement between the physician's order and the social, nursing and other required assessments; or

(b) there is question about the level and amount of services to be provided; or

(c) the case involves the provision of continuous personal care services or live-in 24-hour personal care services as defined in paragraphs (a)(2) and (4), respectively, of this section. Documentation for such cases is subject to the following requirements:

(1) The social assessment shall demonstrate that all alternative arrangements for meeting the patient's medical needs have been explored and are infeasible including, but not limited to, the provision of personal care services in combination with other formal services or in combination with voluntary contributions of informal caregivers. In cases involving live-in 24-hour personal care services, the social assessment shall also evaluate whether the patient's home has sleeping accommodations for a personal care aide. When the patient's home has no sleeping accommodations for a personal care aide, continuous personal care services must be authorized for the patient; however, should the patient's circumstances change and sleeping accommodations for a personal care aide become available in the patient's home, the district must promptly review the case. If a reduction of the patient's continuous personal care services to live-in 24-hour personal care services is appropriate, the district must send the patient a timely and adequate notice of the proposed reduction.

(2) The nursing assessment shall document the following:

(i) whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding;

(ii) the specific personal care functions with which the patient needs frequent assistance during a calendar day;

(iii) the frequency at which the patient needs assistance with these personal care functions during a calendar day;

(iv) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and

(v) whether, were live-in 24-hour personal care services to be authorized, the personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(ii) The local professional director, or designee, must review the physician's order and the social and nursing assessments in accordance with the standards for services set forth in subdivision (a) of this section, and is responsible for the final determination of the amount and duration of services to be authorized.

(iii) When determining whether continuous personal care services or live-in 24-hour personal care services should be authorized, the local professional director, or designee, must consider the information in the social and nursing assessments.

(iv) The local professional director or designee may consult with the patient's treating physician and may conduct an additional assessment of the patient in the home. The final determination must be made with reasonable promptness, generally not to exceed seven business days after receipt of the physician's order and the completed social and



nursing assessments, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding the amount or duration of services to be authorized.

(5) The authorization for personal care services shall be completed prior to the initiation of services.

- (i) The social services district shall authorize only the hours of services actually required by the patient.
- (ii) The duration of the authorization period shall be based on the patient's needs as reflected in the required assessments. In determining the duration of the authorization period, the following shall be considered:
  - (a) the patient's prognosis and/or potential for recovery; and
  - (b) the expected length of any informal caregivers' participation in caregiving; and
  - (c) the projected length of time alternative services will be available to meet a part of the patient's needs.
- (iii) No authorization for personal care services shall exceed six months. The local social services department may request approval for an exception to allow for authorization periods up to 12 months. The request must be accompanied by the following:

- (a) a description of the patients who will be considered for an expanded authorization period; and
- (b) a description of the local social services department's process to assure that the delivery of services is responsive to changes in the patient's condition and allows immediate access to services by the patient, patient's physician, assessing nurse and provider agency if the need for services changes during the expanded authorization period.

(iv)

- (a) The social services district must deny or discontinue personal care services when such services are not medically necessary or are no longer medically necessary or when the social services district reasonably expects that such services cannot maintain or continue to maintain the client's health and safety in his or her home.
- (b) The social services district must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services on forms required by the department. The client is entitled to a fair hearing and to have such services continued unchanged until the fair hearing decision is issued (aid-continuing) in accordance with the requirements outlined in Part 358 of this Title.
- (c) The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice.

(J) Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

- (i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;
- (ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
- (iii) the client is not self-directing and has no one to assume those responsibilities;
- (iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;

- (v) the client refused to cooperate in the required assessment;
- (vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
- (vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and
- (viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

(2) Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

(iii) the client refused to cooperate in the required reassessment;

(iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify.

(d) The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.

(v) When services are authorized, the local social services department shall provide the agency or person providing services, the patient receiving the services, and the agency or individual supervising the services, with written information about the services authorized, including the functions and tasks required and the frequency and duration of the services.

(vi) All services provided shall be in accordance with the authorization. No change in functions or tasks or hours of services delivered shall be made without notification to, and approval of, the social services district.

(vii) The local social services department shall notify the patient in writing when a change in the amount of

services authorized is being considered. Notification shall be provided in accordance with the requirements specified in subparagraph (b)(5)(v) of this section.

(viii) Reauthorization for personal care services shall follow the procedures outlined in paragraphs (2) through (4) of this subdivision, with the following exceptions:

(a) Reauthorization of Level I services shall not require a nursing assessment if the physician's order indicates that the patient's medical condition is unchanged.

(b) Reauthorization of Level II services shall include an evaluation of the services provided during the previous authorization period. The evaluation shall include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

(ix) When an unexpected change in the patient's social circumstances, mental status or medical condition occurs which would affect the type, amount or frequency of personal care services being provided during the authorization period, the social services district is responsible for making necessary changes in the authorization on a timely basis in accordance with the following procedures:

(a) When the change in the patient's services needs results solely from a change in his/her social circumstances including, but not limited to, loss or withdrawal of support provided by informal caregivers, the local social services department shall review the social assessment, document the patient's social circumstances and make changes in the authorization as indicated. A new physician's order and nursing assessment shall not be required.

(b) When the change in the patient's services needs results from a change in his/her mental status including, but not limited to, loss of his/her ability to make judgments, the local social services department shall review the social assessment, document the changes in the patient's mental status and take appropriate action as indicated.

(c) When the change in the patient's services needs results from a change in his/her medical condition, the local social services department shall obtain a new physician's order and a new nursing assessment and shall complete a new social assessment.

(6) Nothing in this subdivision shall preclude the provision of personal care services in combination with other services when a combination of services can appropriately and adequately meet the patient's needs.

(7) This paragraph sets forth expedited procedures for social services districts' determinations of medical assistance ("Medicaid") eligibility and personal care services eligibility for Medicaid applicants with an immediate need for personal care services.

(i) The following definitions apply to this paragraph:

(a) A Medicaid applicant with an immediate need for personal care services means an individual seeking Medicaid coverage who:

(1)

(i) is not currently authorized for Medicaid coverage; or

(ii) is currently authorized for Medicaid coverage only for community-based coverage without long-term care services; and

(2) provides to the social services district:

(i) a physician's order for personal care services; and

(ii) a signed attestation on a form required by the Department that the applicant has an immediate need for personal care services ("attestation of immediate need") and that:

(A) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the applicant;

(B) no home care services agency is providing needed assistance to the applicant;

(C) adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers, or wheelchairs, are not in use to meet, or cannot meet, the applicant's need for assistance; and

(D) third party insurance or Medicare benefits are not available to pay for needed assistance.

(b) A complete Medicaid application means a signed Medicaid application and all documentation necessary for the social services district to determine the applicant's Medicaid eligibility. For purposes of this paragraph, an applicant who would otherwise be required to document accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts. After the determination of Medicaid eligibility, if the commissioner or the district has information indicating an inconsistency between the value or dollar amount of such resources and the value or dollar amount to which the applicant had attested prior to being determined eligible for Medicaid, and the inconsistency is material to the individual's Medicaid eligibility, the district must request documentation adequate to verify such resources.

(ii) The social services district must determine whether the applicant has submitted a complete Medicaid application. If the applicant has not submitted a complete Medicaid application, the district must notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide such documentation.

(a) When the applicant submits the Medicaid application together with the physician's order and the signed attestation of immediate need, the district must provide such notice as soon as possible and no later than four calendar days after receipt of these documents.

(b) When the applicant submits the Medicaid application and subsequently submits the physician's order, the signed attestation of immediate need, or both such documents, the district must provide such notice as soon as possible and no later than four calendar days after receipt of both the physician's order and the signed attestation of immediate need.

(iii) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for personal care services, but no later than seven calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must determine whether the applicant is eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and notify the applicant of such determination.

(iv) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for personal care services, but no later than 12 calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must:

(a) obtain or complete a social assessment, nursing assessment, and an assessment of other services pursuant to subparagraphs (3)(ii) through (3)(iv) of this subdivision; and

(b) determine whether the applicant, if determined eligible for Medicaid, would be eligible for personal care services and, if so, the amount and duration of the personal care services that would be authorized should the applicant be determined eligible for Medicaid; provided, however, that personal care services shall be authorized only for applicants who are determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services. In no event shall personal care services be authorized for a Medicaid applicant unless the applicant has been determined eligible for Medicaid,

including Medicaid coverage of community-based long-term care services.

(v) Social services districts must provide Medicaid applicants with the required attestation of immediate need form and such other information regarding the expedited Medicaid eligibility determination and personal care services assessment procedures set forth in this paragraph as the Department may require.

(8) This paragraph sets forth expedited personal care services assessment procedures for medical assistance ("Medicaid") recipients with an immediate need for personal care services.

(i) A Medicaid recipient with an immediate need for personal care services means an individual seeking personal care services who:

(a)

(1) is exempt or excluded from enrollment in a managed long term care plan operating pursuant to [Section 4403-f of the Public Health Law](#) or a managed care provider operating pursuant to [Section 364-j of the Social Services Law](#); or

(2) is not exempt or excluded from enrollment in a plan or provider described in subclause (1) of this clause but is not yet enrolled in any such plan or provider; and

(b)

(1) was a Medicaid applicant with an immediate need for personal care services pursuant to paragraph (7) of this subdivision who was determined, pursuant to such paragraph, to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who was also determined pursuant to such paragraph to be eligible for personal care services; or

(2) is a Medicaid recipient who has been determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who provides to the social services district:

(i) a physician's order for personal care services; and

(ii) a signed attestation on a form required by the Department that the recipient has an immediate need for personal care services ("attestation of immediate need") and that:

(A) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the recipient;

(B) no home care services agency is providing needed assistance to the recipient;

(C) adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers, or wheelchairs, are not in use to meet, or cannot meet, the recipient's need for assistance; and

(D) third party insurance or Medicare benefits are not available to pay for needed assistance.

(ii) With regard to a Medicaid recipient with an immediate need for personal care services who is described in subclause (i)(b)(1) of this paragraph, the social services district must promptly notify the recipient of the amount and duration of personal care services to be authorized and issue an authorization for, and arrange for the provision of, such personal care services, which must be provided as expeditiously as possible. With respect to those recipients who are neither exempt nor excluded from enrollment in a managed long term care plan or managed care provider, the district must authorize personal care services to be provided until such recipients are enrolled in such a plan or provider.

(iii)

(a) With regard to a Medicaid recipient with an immediate need for personal care services who is described in subclause (i)(b)(2) of this paragraph, the social services district, as soon as possible after receipt of the physician's order and signed attestation of immediate need, but no later than 12 calendar days after receipt of such documentation, must:

(1) obtain or complete a social assessment, nursing assessment, and an assessment of other services pursuant to subparagraphs (3)(ii) through (iv) of this subdivision; and

(2) determine whether the recipient is eligible for personal care services and, if so, the amount and duration of the personal care services to be authorized.

(b) The social services district must promptly notify the recipient of the amount and duration of personal care services to be authorized and issue an authorization for, and arrange for the provision of, such personal care services, which must be provided as expeditiously as possible. With respect to those recipients who are neither exempt nor excluded from enrollment in a managed long term care plan or managed care provider, the district must authorize personal care services to be provided until such recipients are enrolled in such a plan or provider.

(iv) Social services districts must provide Medicaid recipients with the required attestation of immediate need form and such other information regarding the expedited personal care services assessment procedures set forth in this paragraph as the Department may require.

(c) *Contracting for the provision of personal care services.*

(1) Each social services district must have contracts or other written agreements with all agencies or persons providing personal care services or any support functions for the delivery of personal care services. As used in this subdivision, support functions for the delivery of personal care services include, but are not necessarily limited to, nursing assessments, nursing supervision and case management, when provided according to subdivisions (b), (f) and (g) of this section, respectively.

(2) The social services district must use the model contract for personal care services that the department requires to be used, except as provided in paragraph (4) of this subdivision.

(3)

(i) Under the following conditions, the social services district may attach local variations to the model contract:

(a) The local variations do not change the model contract's requirements.

(b) The social services district submits its proposed local variations to the department on forms the department requires to be used.

(ii) The social services district must not implement any local variations to the model contract until the department approves the local variations. The department will notify the social services district in writing of its approval or disapproval of the local variations within 60 business days after it receives the local variations. If the department disapproves the local variations, the social services district may submit revisions to the local variations. The department will notify the social services district in writing of its approval or disapproval of such revisions within 60 business days after it receives the revisions.

(4)

(i) Under the following conditions, the social services district may use a local contract or other written agreement as an alternative to the model contract:

(a) The social services district cannot use the model contract due to local programmatic, legal, or fiscal

concerns;

(b) The social services district can demonstrate that the local contract or agreement includes a provision comparable to each provision contained in the model contract and, if the local contract or agreement is with another public or governmental agency, it includes all requirements specified in this section; and

(c) The social services district submits a request for use of a local contract or agreement to the department on forms the department requires to be used.

(ii) The social services district must not implement a local contract or agreement until the department approves it. The department will notify the social services district in writing of its approval or disapproval of the local contract or agreement within 60 business days after it receives the district's request to use the local contract or agreement. The district's request must be accompanied by the proposed local contract or agreement and a comparison of the contents of the proposed local contract or agreement with the department's requirements. If the department disapproves the local contract or agreement, the social services district may submit revisions to the contract or agreement. The department will notify the social services district in writing of its approval or disapproval of such revisions within 60 business days after it receives the revisions.

(5)

(i) The social services district must use a contract or other written agreement for support functions for the delivery of personal care services, including case management, nursing assessments and nursing supervision, that the department approves to be used.

(ii) The social services district must not implement any contract or agreement for case management, nursing assessments, nursing supervision, or any other support function until the department approves such contract or agreement.

(iii) The department will notify the social services district in writing of its approval or disapproval of the contract or agreement within 60 business days after it receives the contract or agreement. If the department disapproves the contract or agreement, the social services district may submit revisions to the contract or agreement. The department will notify the social services district in writing of its approval or disapproval of such revisions within 60 business days after it receives the revisions.

(6) The social services district must include in each contract or other written agreement with a provider of personal care services the rate at which the provider will be reimbursed for the provision of personal care services or for any support functions for the delivery of personal care services. The rate at which the provider will be reimbursed is determined in accordance with subdivision (h) of this section.

(7) The social services district must base the duration of the contract or other written agreement on the district's fiscal year, or a portion thereof.

(8) Before entering into a contract or other written agreement with any provider agency, the social services district must determine that:

(i) the provider agency is certified in accordance with 10 NYCRR Parts 760 and 761, licensed in accordance with 10 NYCRR Part 765 or exempt from licensure in accordance with 10 NYCRR Subpart 765-2 because it provides personal care services exclusively to persons who are eligible for medical assistance (MA);

(ii) the provider agency, without subcontracting with other provider agencies, is able to provide personnel who meet the minimum criteria for providers of personal care services, as described in subdivision (d) of this section, and who have successfully completed a training program approved by the department, as provided in subdivision (e) of this section;

(iii) the provider agency is fiscally sound;

(iv) the provider agency has obtained appropriate insurance coverage to protect the social services district from liability claims resulting from acts, omissions, or negligence of provider agency personnel that cause personal injuries to personal care services recipients or such personnel and that the provider agency has agreed to maintain such insurance coverage while its contract with the social services district is in effect; and

(v) the provider agency has agreed that it will not substitute another provider agency to provide personal care services to an MA recipient unless the provider agency has notified the district of the provider agency's need to substitute another provider agency and the district has approved such substitution.

(9) Each social services district must have a plan to monitor and audit the delivery of personal care services provided pursuant to its contracts or other written agreements with provider agencies. The social services district must submit this plan to the department for approval. At a minimum, the plan must include the following:

(i) an evaluation of the provider agency's ability to deliver personal care services, including the extent to which trained personnel are available to provide such services;

(ii) a comparison of the provider agency's performance with the requirements of this section and with the performance standards specified in the contract or agreement; and

(iii) a review of the provider agency's fiscal practices.

(10) When the provider agency is a home care services agency that provides personal care services exclusively to persons eligible for MA and is therefore exempt from licensure, the social services district must include the following items in the monitoring plan in addition to those required by paragraph (11) of this subdivision:

(i) a review of the provider agency's administrative and personnel policies;

(ii) a review of all provider agency recordkeeping relevant to the provision of personal care services; and

(iii) an evaluation of the quality of care the provider agency provides.

(11) Each social services district must also have a plan to monitor and audit any support functions for the delivery of personal care services, as defined in paragraph (1) of this subdivision. The social services district must submit this plan to the department for approval.

(12) The social services district must maintain a record of its monitoring activities. The district must include a report of such monitoring activities in the annual plan the district submits to the department pursuant to subdivision (j) of this section.

(d) *Providers of personal care services.*

(1) Personal care services may be provided by persons with the title of homemaker, homemaker-home health aide, home health aide, or personal care aide. Such persons must meet all other requirements of this section. When Level I (environmental and nutritional) personal care functions only, as defined in subdivision (a) of this section, are required, persons with the title of housekeeper may be used.

(2) The local social services department shall use one or a combination of the following to provide personal care services:

(i) local social services department staff employed and trained to provide personal care services and other home care services;

(ii) a contractual agreement with a long-term home health care program for services of a person providing personal care services;



(iii) a contractual agreement approved by the department and the State Director of the Budget with a certified home health agency for the services of a person providing personal care services;

(iv) a contractual agreement approved by the department and the State Director of the Budget with a voluntary homemaker-home health aide agency for the service of persons providing personal care services;

(v) a contractual agreement approved by the department and the State Director of the Budget with a proprietary agency for the service of persons providing personal care services;

(vi) a contractual agreement approved by the department and the State Director of the Budget with an individual provider of service for the provision of Level I (environmental and nutritional) personal care functions only;

(vii) a contractual agreement approved by the department and the State Director of the Budget with an individual provider of service when the service needs require more than Level I (environmental and nutritional) personal care functions only. Such providers of service may be used only under the following conditions:

(a) prior approval has been received by the local social services department from the department to use individual providers in cases where the local social services department can justify that such providers of service are the only alternative available to the district. Such approval will be based upon the justification provided by the local department of social services and the agency's plan for the use of such individual providers of service;

(b) the local social services department shall review and evaluate the qualifications of each individual provider in accordance with procedures established by the local department of social services and approved by the department;

(c) in each case where an individual provider of personal care services is used, the individual provider shall receive on-the-job instruction and on-going nursing supervision from a nurse on staff of the local department of social services or a nurse from a certified home health agency. When such supervision is provided under contract with a certified home health agency, the local social services department shall monitor the case to assure that the service is delivered as authorized;

(d) the local social services department shall conform with all State and Federal requirements for employment benefits and taxes and shall follow appropriate procedures for payment for this service under this Title. Appropriate insurance coverage shall be provided to cover both personal injury and property damage liability; and

(e) State approval shall be limited to a period or periods not in excess of one year, but may be renewed.

(3) The provider agency or the local department of social services shall assign a person to provide the required services according to the authorization. In the event that this person is unable to meet the client's needs or is unacceptable to the client, the local department of social services shall request assignment of another person. Attention should be given in the selection of a person to provide services to assure that the person can communicate with a patient or on behalf of the patient.

(4) The minimum criteria for the selection of all persons providing personal care services shall include, but are not limited to, the following:

(i) maturity, emotional and mental stability, and experience in personal care or homemaking;

(ii) ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;

(iii) sympathetic attitude toward providing services for patients at home who have medical problems;

(iv) good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of Health requires for employees of certified home health agencies pursuant to [10 NYCRR 763.4](#);

(v) a criminal history record check to the extent required by 10 NYCRR Part 402; and

(vi) compliance with Part 403 of Title 10 NYCRR, as required in that Part.

(e) *Required training.*

(1) Each person performing personal care services other than household functions only shall be required as a condition of initial or continued participation in the provision of personal care services under this Part to participate successfully in a training program approved by the department.

(2) An approved training program shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision.

(i) Basic training shall meet the following minimum requirements:

(a) Include content related to:

(1) orientation to the agency, community and services;

(2) the family and family relationships;

(3) the child in the family;

(4) working with the elderly;

(5) mental illness and mental health;

(6) body mechanics;

(7) personal care skills;

(8) care of the home and personal belongings;

(9) safety and accident prevention;

(10) family spending and budgeting; and

(11) food, nutrition and meal preparation.

(b) Total 40 hours in length.

(c) Be directed by a registered professional nurse, or a social worker, or home economist who has, at a minimum, a bachelor's degree in an area related to the delivery of human services or education.

(d) Involve appropriate staff and community resources, such as public health nurses, home economics, physical therapists and social workers. Skills training in personal care techniques shall be taught by a registered nurse.

(e) Include, as an integral part, evaluation of each person's competency in the required content. Criteria

and methods for determining each person's successful completion of basic training shall be established. Criteria shall include attendance at all classes or equivalent instruction. Additional criteria shall be established to determine whether each person can competently perform required tasks and establish good working relationships with others. Methods of evaluating competency may include written, performance and oral testing; instructor observations of overall performance, attitudes and work habits; preparation of assignments/home study materials or any combination of these and other methods. Attendance records and evaluation materials for determining each person's successful completion of basic training shall be maintained.

(ii) In-service training shall be provided, at a minimum, for three hours semi-annually for each person providing personal care services to develop specialized skills or knowledge not included in basic training or to review or expand skills or knowledge included in basic training.

(iii) On-the-job training shall be provided, as needed, to instruct the person providing personal care services in a specific skill or technique, or to assist the person in resolving problems in individual case situations. Criteria and methodology for evaluating the overall job performance of each person providing personal care services shall be established. The supervising professional registered nurse shall be responsible for evaluating each person's ability to function competently and safely and for providing or arranging for necessary on-the-job training.

(3) Prior to performing any service, each person providing personal care services, other than household functions only, shall successfully complete the prescribed part of the basic training program. The prescribed part of basic training shall include the following content areas:

- (i) orientation to the agency, community and the service;
- (ii) working with the elderly;
- (iii) body mechanics;
- (iv) personal care skills;
- (v) safety and accident prevention; and
- (vi) food, nutrition and meal preparation.

The entire basic training program shall be completed by each person providing personal care services within three months after the date he is so hired.

(4) The requirement for completion of a basic training program may be waived by the department if the person performing personal care services can demonstrate competency in the required areas of content included in the basic training as specified in clause (2)(i)(a) of this subdivision. Methods of evaluating competency shall be approved by the department and shall meet the following minimum requirements:

- (i) Be designed for persons having:
  - (a) documented training through related training programs such as nurse's aide and home health aide training programs; or
  - (b) documented related experience in an institutional or home setting which involves the performance of skills included in required basic training.
- (ii) Include procedures and instruments for evaluating each person's competency. Content of evaluation instruments shall be compatible with required basic training program content, and shall assess appropriate skills and understandings of persons providing personal care services.

(iii) Identify the standard(s) of competency which shall be achieved through application of the procedures and instruments included.

(iv) Include a plan for remedial basic training of persons who fail to meet the standard(s) of competency established. Remedial basic training shall be provided which includes the prescribed part of basic training set forth in paragraph (3) of this subdivision.

(v) Include a mechanism for documenting successful demonstration of competency. Certificates awarded on the basis of successful demonstration of competency shall be designed to reflect issuance on this basis.

(5) Persons performing household tasks only shall be oriented to their responsibilities at the time of assignment by the supervising registered professional nurse.

(6) Each local social services department shall require that agencies with whom they contract for services submit to them a training program for providers of personal care services. This training program shall be submitted by the local social services department to the department for approval. The department shall notify the local social services department of its decision within 45 days of the plan's receipt by the department.

(7) The successful participation of each person providing personal care services in approved basic training, competency testing and continuing in-service training programs shall be documented in that person's personnel records. Documentation shall include the following items:

(i) a completed employment application or other satisfactory proof of the date on which the person was hired; and

(ii)

(a) for persons who completed a training program before September 25, 2009, a dated certificate, letter or other satisfactory proof of the person's successful completion of a basic training program approved by the department; or

(b) for persons who completed a training program on or after September 25, 2009, that information required by Part 403 of Title 10 NYCRR.

(iii) dated certificates, written references, letters or other satisfactory proof that the person:

(a) meets the qualifications specified in clause (4)(i)(a) or (b) of this subdivision; and

(b) has successfully completed competency testing and any remedial basic training necessary as a result of such testing. The dated and scored competency testing instruments and record of any remedial training provided shall be maintained;

(iv) an in-service card, log or other satisfactory proof of the employee's participation in three hours of in-service training semiannually.

(8) The local social services district shall develop a plan for monitoring the assignments of individuals providing personal care services to assure that individuals are in compliance with the training requirements. This plan shall be submitted by the local social services district to the Department for approval and shall include, as a minimum, specific methods for monitoring each individual's compliance with the basic training, competency testing, and in-service requirements specified in this subdivision. Methods of compliance with the basic training, monitoring may include: onsite reviews of employee personnel records; establishment of a formal reporting system on training activities; establishment of requirements for submittal of certificates or other documentation prior to each individual's assignment to a personal care service case; or any combination of these or other methods. The monitoring plan must include provision for assuring that training programs have complied with the requirement Part 403 of Title 10 NYCRR related to the home care services worker registry.

(9) When a provider agency is not in compliance with department requirements for training, or when the agency's training efforts do not comply with the approved plan for that agency, or the agency has failed to comply with the requirements of Part 403 of Title 10 NYCRR, the Department shall withdraw the approval of that agency's training plan. No reimbursement shall be available to local social services districts, and no payments shall be made to provider agencies for services provided by individuals who are not trained in accordance with department requirements and the agency's approved training plan.

(f) *Administrative and nursing supervision.*

(1) All persons providing personal care services are subject to administrative and nursing supervision.

(2) Administrative supervision must assure that personal care services are provided according to the authorization of the agency responsible for case management (the case management agency) for the level, amount, frequency and duration of personal care services to be provided and the social services district's contract or other written agreement with the agency providing such services.

(i) The agency providing personal care services is responsible for administrative supervision.

(ii) Administrative supervision includes the following activities:

(a) receiving initial referrals from the case management agency, including its authorization for the level, amount, frequency and duration of personal care services to be provided;

(b) notifying the case management agency when the agency providing services accepts or rejects a patient; and

(1) when accepted, the arrangements made for providing personal care service; or

(2) when rejected, the reason for such rejection;

(c) initially assigning a person to provide personal care services to a patient according to the case management agency's authorization for the level, amount, frequency and duration of personal care services to be provided. In making assignments, the agency providing services must consider the following:

(1) the patient's cultural background, primary language, personal characteristics and geographic location;

(2) the experience and training required of the person providing personal care services; and

(3) the ability of the person providing personal care services to communicate with the patient or on the patient's behalf;

(d) assigning another person to provide personal care services to a patient when the person the agency providing services initially assigned is:

(1) unable to work effectively with the patient and any informal caregivers involved in the patient's care; or

(2) providing personal care services inappropriately or unsafely; or

(3) unavailable to provide personal care services due to unexpected illness or other reasons;

(e) promptly notifying the case management agency when the agency providing services cannot assign another person to provide personal care services to the patient;

(f) verifying that the patient is receiving personal care services according to the case management agency's authorization;

(g) notifying the case management agency, or cooperating with the nurse supervisor to notify such agency, when the agency providing services has questions regarding the adequacy of the case management agency's authorization for personal care services;

(h) promptly notifying the case management agency when the agency providing services is unable to maintain case coverage, including cases requiring services at night, on weekends or on holidays;

(i) participating in, or arranging for, the orientation of persons providing personal care services to the employment policies and procedures of the agency providing services;

(j) evaluating the overall job performances of persons providing personal care services, or assisting the nurse supervisor or other personnel of the agency providing nursing supervision, with such evaluations;

(k) giving support to persons providing personal care services;

(l) checking time cards of persons providing personal care services for required documentation;

(m) maintaining scheduling records and any other records necessary to implement required administrative activities; and

(n) complying with the requirements for advance directives that are set forth in [10 NYCRR 700.5](#) or any successor regulation. The agency providing personal care services, as well as any individual provider of personal care services who provides services pursuant to his or her contract with the social services district, may contract with another entity, including but not limited to a case management agency, to perform such agency's or individual provider's advance directive responsibilities.

(3) Nursing supervision must assure that the patient's needs are appropriately met by the case management agency's authorization for the level, amount, frequency and duration of personal care services and that the person providing such services is competently and safely performing the functions and tasks specified in the patient's plan of care.

(i) Nursing supervision must be provided by a registered professional nurse employed by a voluntary, proprietary, or public agency with which the social services district has a contract or other written agreement or by the social services district. When an individual provider of personal care services is used, nursing supervision must be provided in accordance with the requirements specified in subdivision (d) of this section.

(ii) The agency providing nursing supervision must employ nurses meeting the qualifications in subparagraph (iii) of this paragraph in sufficient numbers to perform the activities in subparagraph (iv) of this paragraph.

(iii) Nursing supervision must be provided by a registered professional nurse who:

(a) is licensed and currently certified to practice as a registered professional nurse in New York State;

(b) meets the health requirements specified in subparagraph (d)(4)(iv) of this section; and

(c) meets either of the following qualifications:

(1) has at least two years satisfactory recent home health care experience; or

(2) has a combination of education and experience equivalent to the requirement described in subclause (1) of this clause, with at least one year of home health care experience; or

(d) acts under the direction of a registered professional nurse who meets the qualifications listed in clauses (a) and (b) of this subparagraph and either of the qualifications listed in subclause (c)(1) or (2) of this subparagraph.

(iv) Nursing supervision includes the following activities:

(a) orienting the person providing personal care services to his or her responsibilities.

(1) Except as otherwise provided in subclause (3) of this clause, the nurse supervisor must conduct an orientation visit in the patient's home when the person providing personal care services is also present.

(i) For all initial authorizations of personal care services, the nurse supervisor must conduct an orientation visit within seven calendar days after the person providing personal care services is assigned to the patient.

(ii) Scheduling of orientation visits for all initial authorizations of personal care services should be based on the following four criteria:

(A) the patient's ability to be self-directing, as defined in subparagraph (a)(3)(ii) of this section;

(B) the availability of any informal caregivers who will be involved in the patient's plan of care;

(C) the scope and complexity of the functions and tasks identified in the patient's plan of care; and

(D) the training and experience the person providing personal care services has in performing the functions and tasks identified in the patient's plan of care.

(2) The nurse supervisor must perform the following functions during the orientation visit and document his or her performance of these functions in the report he or she prepares pursuant to subparagraph (vii) of this paragraph:

(i) review, with the person providing personal care services, the patient, and the patient's family, the plan of care received from the case management agency to assure that all parties understand the functions and tasks that the person providing services must perform and the frequency at which the person must perform these functions and tasks;

(ii) instruct the person providing personal care services in the observations the person must make and the oral and written reports and records the person must submit and maintain; and

(iii) demonstrate, when indicated, any procedures that the person providing personal care services is to perform with or for the patient.

(3) The nurse supervisor is not required to conduct an orientation visit when:

(i) personal care services are reauthorized, the patient requires a continuation or resumption of services initially authorized and the patient's mental status, social circumstances and medical condition have not changed; or

(ii) the person providing personal care services is temporarily substituting for or replacing the person assigned to provide services; the patient's plan of care is current and available to the person providing personal care services; the patient is self-directing, as defined in subparagraph (a)(3)(ii) of this section or, if non-self-directing, has a self-directing individual or other agency willing to assume responsibility for making choices about the patient's activities of daily living, as provided in such subdivision; and the person providing personal care services has the documented training or experience to appropriately and safely perform the functions and tasks identified in the patient's plan of care.

(4) The nurse supervisor must continue to perform the functions specified in items (iv)(a)(2)(i) and (ii) of this paragraph when an exception is made to the requirement for a home orientation visit.

(b) Making nursing supervisory visits at the frequency established pursuant to subparagraph (vi) of this paragraph.

(1) The supervisory visit must be made to the patient's home when the person providing personal care services is present, except when a supervisory visit is made solely to obtain the patient's evaluation of the person's job performance.

(2) The nurse supervisor must perform the following functions during the supervisory visit and document his or her performance of these functions in the report he or she prepares pursuant to subparagraph (vii) of this paragraph:

(i) evaluate the patient's needs to determine if the level, amount, frequency and duration of personal care services authorized continue to be appropriate;

(ii) evaluate the skills and performance of the person providing personal care services, including the person's ability to work effectively with the patient and the patient's family;

(iii) arrange for or provide on-the-job training according to subparagraph (e)(2)(iii) of this section;

(c) immediately notifying the case management agency when either of the following occurs:

(1) there is a change in the patient's social circumstances, mental status or medical condition that would affect the level, amount, frequency or duration of personal care services authorized or indicate the patient needs a different type of service; or

(2) the actions taken by persons involved in the patient's care are inappropriate or jeopardize the patient's health and safety;

(d) participating in case conferences to discuss individual patient cases;

(e) assisting in complaint investigations according to the policies and procedures of the agency that employs the nurse supervisor;

(f) participating, if requested, in basic, supplementary and in-service training, as defined in subdivisions (a) and (e) of this section, of persons providing personal care services;

(g) being available to the person providing personal care services for nursing consultation while such person is in the patient's home;

(h) evaluating the overall job performance of persons providing personal care services, or assist the administrative supervisor or other personnel with such evaluations;

(i) reviewing reports prepared by persons providing personal care services;

(j) preparing, maintaining or forwarding written reports of orientation visits and nursing supervisory visits, according to subparagraph (vii) of this paragraph; and

(k) reporting to the registered professional nurse responsible for directing a nurse supervisor lacking home health care experience, when applicable, and in accordance with policies and procedures of the agency that employs the nurse supervisor.

(v) The registered professional nurse who provides direction to nurse supervisors without the home health care experience specified in clause (3)(iii)(c) of this subdivision is responsible for the following activities:

(a) training and orienting the nurse supervisor to his or her supervisory responsibilities;

(b) consulting with the nurse supervisor regarding patients or persons providing personal care services;



- (c) monitoring orientation visits and nursing supervisory visits to assure that such visits are performed at the required frequencies;
- (d) assuring availability of nursing consultation to the person providing personal care services when such person is in the patient's home;
- (e) reviewing the orientation visit reports and nursing supervisory reports and assuring that copies are maintained or forwarded according to subparagraph (vii) of this paragraph; and
- (f) evaluating each nurse supervisor's overall job performance or assisting with such evaluations.

(vi) The nurse who completes the nursing assessment, as specified in subparagraph (b)(3)(iii) of this section, must recommend the frequency of nursing supervisory visits for a personal care services patient and must specify the recommended frequency in the patient's plan of care.

(a) Frequency of nursing supervisory visits must be recommended on an individual patient basis. The following factors must be considered:

- (1) the patient's ability to be self-directing, as defined in subparagraph (a)(3)(ii) of this section;
- (2) the patient's need for assistance in carrying out specific functions and tasks in the plan of care; and
- (3) the skills needed by the person who will be providing personal care services.

(b) The nursing supervisor must make nursing supervisory visits at least every 90 days for a personal care services patient except that:

(1) nursing supervisory visits must be made more frequently than every 90 days when:

- (i) the patient's medical condition requires more frequent visits; or
- (ii) the person providing personal care services needs additional or more frequent on-the-job training to perform assigned functions and tasks competently and safely; and

(2) supervisory and nursing assessment visits may be combined and conducted every six months when:

- (i) the patient is self-directing, as defined in subparagraph (a)(3)(ii) of this section; and
- (ii) the patient's medical condition is not expected to require any change in the level, amount or frequency of personal care services authorized during this time period.

(vii) The nurse supervisor must prepare a written report of each orientation visit and each nursing supervisory visit. These reports must be prepared on a form prescribed by the department.

(a) The nurse supervisor must maintain a copy of each report in the patient's record.

(b) The nurse supervisor must maintain a copy of each report in the personnel record of the person providing personal care services or forward a copy, within 14 calendar days of the orientation visit or nursing supervisory visit, to the provider agency for inclusion in such person's personnel record.

(c) The nurse supervisor must forward a copy of each report to the case management agency, if different from the agency providing nursing supervision, within 14 calendar days of each orientation visit or nursing supervisory visit.

(viii) Arrangements for nursing supervision must be reflected in the social services district's annual plan for the delivery of personal care services.

(ix) Arrangements for nursing supervision provided by a voluntary, proprietary or public agency must be specified in the contract or other written agreement between the social services district and the agency providing nursing supervision.

(g) *Case management.*

(1) All patients receiving personal care services must be provided with case management services according to this subdivision.

(2) Case management may be provided either by social services district professional staff who meet the department's minimum qualifications for caseworker, professional staff of one or more agencies to which the district has delegated case management responsibility and that meet standards established by the department, or both.

(i) The social services district may delegate, pursuant to standards established by the department, responsibility for performance of either or both of the following:

(a) one or more of the case management activities listed in paragraph (3) of this subdivision;

(b) one or more such case management activities at specific times, such as during weekends or at night.

(ii) A social services district may delegate responsibility for case management activities only when:

(a) the department has approved the delegation of case management responsibilities;

(b) the social services district and each agency that is to perform case management activities have a contract or other written agreement pursuant to subdivision (c) of this section; and

(c) the social services district monitors the case management activities provided under the contract or other written agreement to ensure that such activities comply with the requirements of this subdivision.

(3) Case management includes the following activities:

(i) receiving referrals for personal care services, providing information about such services and determining, when appropriate, that the patient is financially eligible for medical assistance;

(ii) informing the patient or the patient's representative that a physician's order is needed, making copies of the physician's order form available to hospital discharge planners, physicians, and other appropriate persons or entities, and assisting the patient to obtain a physician's order when the patient or the patient's representative is unable to obtain the order;

(iii) completing the social assessment according to subdivision (b) of this section, including an evaluation of:

(a) the potential contribution of informal caregivers to the patient's plan of care, as specified in subparagraph (b)(3)(ii) of this section;

(b) the patient's physical environment, as determined by a visit to the patient's home; and

(c) the patient's mental status;

(iv) obtaining or completing the nursing assessment according to subparagraph (b)(3)(iii) of this section;

(v) assessing the patient's eligibility for hospice services and assessing the appropriateness and cost-

effectiveness of the services specified in subparagraph (b)(3)(iv) of this section;

(vi) forwarding the physician's order; the social and nursing assessments; the assessments required by subparagraph (b)(3)(iv) of this section; for an independent medical review according to subparagraph (b)(4)(i) of this section;

(vii) negotiating with informal caregivers to encourage or maintain their involvement in the patient's care;

(viii) determining the level, amount, frequency and duration of personal care services to be authorized or reauthorized according to subdivisions (a) and (b) of this section, or, if the case involves an independent medical review, obtaining the review determination;

(ix) obtaining or completing the authorization for personal care services, according to subdivision (b) of this section;

(x) assuring that the patient is provided written notification of personal care services initially authorized, reauthorized, denied, increased, reduced, discontinued, or suspended and his or her right to a fair hearing, as specified in Part 358 of this Title and subparagraph (b)(5)(iv) of this section;

(xi) arranging for the delivery of personal care services according to subdivision (c) of this section;

(xii) forwarding, prior to the initiation of personal care services, a copy of the patient's plan of care developed by the nurse responsible for completion of the nursing assessment, as specified in subdivision (a) of this section, to the following persons or agencies:

(a) the patient or the patient's representative;

(b) the agency providing personal care services under a contract or other written agreement with the social services district; and

(c) the agency providing nursing supervision under a contract or other written agreement with the social services district;

(xiii) monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met;

(xiv) obtaining or completing a copy of the orientation visit report and the nursing supervisory visit report and forwarding a copy of these reports in accordance with subparagraphs (f)(3)(vi) and (vii) of this section;

(xv) allowing access by the patient to his or her written records, including physicians' orders and nursing assessments and, pursuant to [10 NYCRR 766.2\(e\)](#), by the State Department of Health and licensed provider agencies;

(xvi) receiving and promptly reviewing recommendations from the agency providing nursing supervision for changes in the level, amount, frequency or duration of personal care services being provided;

(xvii) promptly initiating and complying with the procedures specified in subparagraph (b)(5)(ix) of this section when the patient's social circumstances, mental status or medical condition unexpectedly change during the authorization period;

(xviii) assuring that capability exists 24 hours per day, seven days per week for the following activities:

(a) arranging for continued delivery of personal care services to the patient when the agency providing such services is unable to maintain case coverage; and

(b) making temporary changes in the level, amount or frequency of personal care services provided or

arranging for another type of service when there is an unexpected change in the patient's social circumstances, mental status or medical condition;

(xix) informing the patient or the patient's representative of the procedure for addressing the situations specified in subparagraph (xv) of this paragraph;

(xx) establishing linkages to services provided by other community agencies including:

(a) providing information about these services to the patient and the patient's family; and

(b) identifying the criteria by which patients are referred to these services;

(xxi) establishing linkages to other services provided by the social services district including, but not limited to, adult protective services as specified in paragraph (5) of this subdivision;

(xxii) arranging for the termination of personal care services when indicated and, when necessary, making referrals to other types of services or levels of care that the patient may require; and

(xxiii) complying with the requirements for advance directives that are set forth in the regulations at [10 NYCRR 700.5](#) or any successor regulation when personal care services are provided by social services district employees. For purposes of this subparagraph, the term *facility/agency* as used in such regulations is deemed to mean the case management agency.

(4) The case management agency must maintain current case records on each patient receiving personal care services. Such records must include, at a minimum, a copy of the following documents:

(i) the physician's orders;

(ii) the nursing and social assessments;

(iii) the assessment of the patient's eligibility for hospice services and the assessments of the appropriateness and cost-effectiveness of the services specified in subparagraph (b)(3)(iv) of this section;

(iv) for a patient whose case must be referred to the local professional director or designee in accordance with subparagraph (b)(4)(i) of this section, a record that the physician's order, the social and nursing assessments, and the assessments required by subparagraph (b)(3)(iv) of this section were forwarded to the local professional director or designee;

(v) for a patient whose case must be referred to the local professional director or designee in accordance with subparagraph (b)(4)(i) of this section, a copy of the local professional director's or designee's determination;

(vi) the patient's plan of care;

(vii) any consent form signed by the patient authorizing release of confidential information;

(viii) the authorization for personal care services;

(ix) the written notification of personal care services initially authorized, reauthorized, denied, increased, reduced, discontinued, or suspended and the patient's right to a fair hearing;

(x) notifications of acceptance, rejection or discontinuance of the case by the agency providing personal care services;

(xi) the orientation visit and nursing supervisory reports;

(xii) the case narrative notes; and

(xiii) any criminal investigation or incident reports involving the patient or any person providing personal care services to the patient.

(5)

(i) Social services district professional staff responsible for personal care services and staff responsible for adult protective services, as specified in Part 457 of this Title, must coordinate their activities to assure that:

(a) they identify and understand the criteria for referring personal care services patients to adult protective services and for referring adult protective services clients to the personal care services program;

(b) mechanisms exist to discuss individual patients;

(c) personal care services as part of an adult protective services plan are provided according to existing requirements; and

(d) staff understand their respective responsibilities in cases involving the provision of personal care services as part of adult protective services plans.

(ii) Professional staff responsible for adult protective services have primary responsibility for case management for a patient who:

(a) is eligible for protective services for adults, as defined in section 457.1(b) of this Title;

(b) receives or requires personal care services as part of an adult protective services plan; and

(1) is nonself-directing and has no self-directing individual or agency to assume responsibility for his or her direction, as specified in subparagraph (a)(3)(ii) of this section; or

(2) is self-directing, as defined in subparagraph (a)(3)(ii) of this section, but refuses to accept personal care services in accordance with the plan of care developed by the nurse who completed the nursing assessment.

(iii) Professional staff responsible for personal care services must assist adult protective services staff with arrangements for provision of personal care services.

(6) Arrangements for case management, including arrangements for delegation of case management activities, must be reflected in the social services district's annual plan for the delivery of personal care services.

(h) *Payment.*

(1) No payment to the provider shall be made for authorized service unless such claim is supported by the documentation of the time spent in provision of service for each individual patient. Such documentation must be maintained by the provider pursuant to section 540.7(a)(8) of this Title.

(2) Payment for personal care services shall not be made to a patient's spouse, parent, son, son-in-law, daughter or daughter-in-law, but may be made to another relative if that other relative:

(i) is not residing in the patient's home; or

(ii) is residing in the patient's home because the amount of care required by the patient makes his presence necessary.

(3) For personal care services, payment shall be made as follows:

(i) If services are provided directly by the staff of the local department of social services, payment shall be based upon the local department's salary schedule. The local department is responsible for withholding all applicable income taxes and payment of the employer's share of FICA, Workers' Compensation, Unemployment Insurance and all other benefits covered under labor management contracts.

(ii)

(a) When personal care services are provided by a voluntary, proprietary or public personal care services provider, payment is based upon the following:

(1) For providers having contracts with social services districts for the provision of personal care services during a rate year or years beginning prior to January 1, 1994, payment will be made at the lower of the local prevailing rate or a rate that is negotiated between the district and the provider, unless a different rate has been ordered by a court for any such rate year or years. The social services district must submit the rates to the department on forms the department requires to be used and must not implement the rates until the department and the Director of the Budget approve them. Such rates are also subject to the provisions of paragraph (5) or (6), as applicable, of this subdivision.

(2) For providers having contracts with social services districts for the provision of personal care services during a rate year or years beginning on or after January 1, 1994, payment will be made in accordance with paragraph (7) of this subdivision.

(b) Providers must pay salaries to the personal care workers they employ; comply with all required State, Federal or local income tax or other payroll withholding requirements; and pay FICA, workers' compensation, unemployment insurance, and other employee benefits included in the providers' labor contracts.

(iii) If the services are provided by or under arrangements with an individual provider of personal care services, or an individual nurse under contract with the social services district for the performance of nursing assessments, payment is made directly to the individual provider of service or such nurse at a rate approved by the department and the Director of the Budget. The social services district is responsible for establishing policies for the withholding of all applicable income taxes and payment of the employer's share of FICA, workers' compensation, unemployment insurance and any other benefits included in the contract with the provider.

(4) Payment for assessment and supervisory services provided by a certified home health agency as part of a local social services department's plan for delivery of personal care services shall be at rates established by the State Commissioner of Health and approved by the State Director of the Budget.

(5)

(i) This paragraph applies to Medical Assistance (MA) payments to personal care services providers that had personal care services payment rates in effect for the rate or contract year beginning prior to July 1, 1990, and seek approval of personal care services payment rates for the rate or contract year beginning on or after July 1, 1990.

(ii) For the rate or contract year beginning on or after July 1, 1990, MA payments to a provider of personal care services must be based on and, except as provided in subparagraph (iv) of this paragraph, be at or below the provider's personal care services payment rate in effect for the rate or contract year beginning prior to July 1, 1990, as adjusted by a personal care services trend factor that the department establishes with the approval of the Director of the Budget.

(iii) The department will establish the personal care services trend factor by designating an external price indicator for each of the three components that comprise the total costs of personal care services, determining the average percentage of total personal care services costs that each component represents, and weighing each

component's average percentage of total personal care services costs by the external price indicator for that component. The three components of the costs of personal care services are listed below:

- (a) an aide wage and benefit component;
- (b) an administrative and operating component; and
- (c) a clinical component.

(iv) At the written request of a social services district and with the approval of the Director of the Budget, the department may grant an exception to the requirement that a personal care services provider's payment rate must be based on, and be at or below, the provider's personal care services payment rate in effect for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor. The personal care services provider must cooperate with the social services district's exception request by providing such reports or other information that may be necessary to justify the exception request. The department will grant a social services district's exception request only when the social services district demonstrates to the department's and the Director of the Budget's satisfaction that:

- (a) the social services district will otherwise be unable to ensure that personal care services recipients will receive the personal care services for which they are authorized;
- (b) additional payment for personal care services is necessary to maintain the quality of services provided; or
- (c) additional payment for personal care services is necessary due to extraordinary or other circumstances, as specified in department guidelines.

(v) A social services district must submit each proposed personal care services payment rate to the department in a format that the department requires. The district must not implement any proposed personal care services payment rate until the department and the Director of the Budget approve the rate.

(vi) Within two months after the day on which the department and the Director of the Budget receive a proposed personal care services payment rate that is equal to or less than the provider's personal care services payment rate for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor, the department and the Director of the Budget will approve the rate. The department will send the social services district written notice of the approval of the rate.

(vii) Within four months after the day on which the department and the Director of the Budget receive a proposed personal care services payment rate that exceeds the provider's personal care services payment rate for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor, and for which the social services district has requested an exception to the trend factor requirement, the department and the Director of the Budget will approve, disapprove, or otherwise act upon the rate. The department will send the social services district written notice of the approval or disapproval of the proposed personal care services rate or the results of the department's and the Director of the Budget's other action regarding the proposed rate. If the department and the Director of the Budget disapprove a proposed personal care services payment rate, the social services district may submit a revised rate for the department's and the Director of the Budget's approval, disapproval, or other action.

(viii) The department and the Director of the Budget, when determining whether to approve a proposed personal care services payment rate, may consider various factors including, but not limited to, the following:

- (a) whether the proposed personal care services payment rate exceeds the provider's personal care services payment rate for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor; and
- (b) if the proposed personal care services payment rate exceeds the provider's personal care services

payment rate for such rate or contract year, as adjusted by the personal care services trend factor, whether the social services district has requested an exception to the trend factor requirement and demonstrated to the department's and the Director of the Budget's satisfaction that an exception should be granted.

(6)

(i) This paragraph applies to MA payments to the following personal care services providers:

(a) a provider that did not have a personal care services payment rate in effect for a rate or contract year beginning prior to July 1, 1990; and

(b) a provider that had a personal care services payment rate in effect for a rate or contract year beginning prior to July 1, 1990, and seeks approval of a personal care services payment rate for a rate or contract year beginning prior to July 1, 1990.

(ii) The department and the Director of the Budget, when determining whether to approve a proposed personal care services payment rate under this paragraph, may consider various factors including, but not limited to, the following:

(a) the justification the social services district provides, in a format the department requires, for the proposed rate;

(b) any changes in the appropriate consumer price index for urban or rural consumers;

(c) any changes in federal or State-mandated standard payroll deductions;

(d) the applicable minimum wage laws;

(e) a comparison of the proposed personal care services payment rate to other personal care services providers' payment rates in the social services district and to personal care services providers' payment rates in social services districts of similar size, geography and demographics; and

(f) a comparison of the proposed personal care services payment rate for the provider to the provider's personal care services payment rate, if any, for the previous rate or contract year.

(iii) A social services district must submit each proposed personal care services payment rate to the department in a format that the department requires. The district must not implement any proposed personal care services payment rate until the department and the Director of the Budget approve the rate. The department will send the social services district written notice of the approval or disapproval of the proposed rate.

(7) This paragraph sets forth the methodology by which the department will determine MA payment rates for personal care services providers that have contracts with social services districts for any rate year that begins on or after January 1, 1994.

(i) Providers' submission of required cost reports.

(a) Providers with cost experience.

(1) This clause applies to providers with cost experience. A provider with cost experience is defined as any provider of personal care services that can report its actual operating costs for the full rate year specified in the required cost report.

(2) Each provider must complete and submit to the department such cost report as the department may require. Each provider must complete the cost report by reporting such of the provider's actual operating costs of providing personal care services as the cost report may require for the full rate year specified in the cost report.



(3) The department will furnish each provider with the cost report form. The cost report form will specify the date by which the provider must submit the completed report to the department; however, no provider will have fewer than 90 calendar days to submit the report after its receipt. The department may grant a provider an additional 30 calendar days to submit the cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date the report is due for reasons beyond the provider's control.

(4)

(i) If the department determines that the cost report submitted by a provider is inaccurate or incomplete, the department will notify the provider in writing. The notice will advise the provider of the corrected or additional information that the provider must submit.

(ii) The provider must submit the corrected or additional information within 30 calendar days from the date the provider receives the department's notice. The department may grant the provider an additional 30 calendar days to submit the corrected or additional information when the provider, prior to the date that the corrected or additional information is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the corrected or additional information by the date the information is due for reasons beyond the provider's control.

(5) If the provider determines that the cost report that it has submitted to the department is inaccurate or incomplete, the provider must submit corrected or additional information. The provider must submit such corrected or additional information to the department within 45 calendar days from the date the provider submitted the original cost report to the department.

(6)

(i) In the event a provider fails to file the required cost report on or before the due date, or as the same may be extended pursuant to subclause (3) of this clause, the State Commissioner of Health shall reduce the current rate paid by state governmental agencies by two percent for a period beginning on the first day of the calendar month following the original due date of the required report and continuing until the last day of the calendar month in which the required report is filed.

(ii) Failure to timely file the corrected or additional data as required pursuant to subclause (4) of this clause will result in application of item (i) of this subclause. Lack of certification by the operator or by the accountant, as required pursuant to subclauses (8) and (9) of this clause, shall render a cost report incomplete.

(7) The provider must complete the cost report in accordance with generally accepted accounting principles as applied to the provider, unless the department specifies otherwise on the cost report form.

(8) The cost report must be certified by the owner or administrator of a proprietary personal care services provider, the chief executive officer or administrator of a voluntary personal care services provider, or the public official responsible for the operation of a publicly operated personal care services provider. The cost report form will include a certification form, which will specify who must certify the report.

(9) The provider must submit an opinion of an independent certified public accountant that the provider's cost report, or such portions of the cost report as the department may specify, has been examined and determined to comply with generally accepted accounting principles and with the allowable costs and recoveries of expenses requirements specified in subclauses (ii)( a)(3) and (4), respectively, of this paragraph. The provider must submit such independent certified public accountant's opinion on a form as the department may require.

(b) New providers.

(1) This clause applies to new providers of personal care services. A new provider of personal care services is defined as any provider of personal care services that cannot report its actual operating costs for the full rate year specified in the required cost report.

(2) Each new provider must complete and submit to the department such cost reports as the department may require. Each new provider must complete the cost report by reporting such of the provider's estimated operating costs of providing personal care services as the cost report may require for the full rate year specified in the cost report.

(3) The department will furnish each new provider with the cost report form. The cost report form will specify the date by which the provider must submit the completed report to the department; however, no provider will have fewer than 90 calendar days to submit the report after its receipt. The department may grant a provider an additional 30 calendar days to submit the cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date the report is due for reasons beyond the provider's control.

(4)

(i) If the department determines that the cost report that a new provider has submitted is inaccurate or incomplete, the department will notify the provider in writing. The notice will advise the provider of the corrected or additional information that the provider must submit.

(ii) The new provider must submit the corrected or additional information within 30 calendar days from the date the provider receives the department's notice. The department may grant the provider an additional 30 calendar days to submit the corrected or additional information when the provider, prior to the date that the corrected or additional information is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the corrected or additional information by the date the information is due for reasons beyond the provider's control.

(5) If the new provider determines that the cost report that it has submitted to the department is inaccurate or incomplete, the provider must submit corrected or additional information. The provider must submit such corrected or additional information to the department within 45 calendar days from the date the provider submitted the original cost report to the department.

(6) If a new provider fails to submit the cost report or any corrected or additional information regarding the cost report by the original or extended date on which such report or such corrected or additional information is due, the provider's existing approved payment rate, if any, will remain in effect until such time as the provider submits such cost report or such corrected or additional information and otherwise complies with the requirements of this clause, and the department is able to determine a rate for the provider. The rate will be effective for the full rate year regardless of the date on which the provider submitted such cost report or such corrected or additional information and otherwise complied with the requirements of this clause.

(7) The new provider must complete the cost report in accordance with generally accepted accounting principles as applied to the provider, unless the report specifies otherwise.

(8) The cost report must be certified by the owner or administrator of a proprietary personal care services provider, the chief executive officer or administrator of a voluntary personal care services provider, or the public official responsible for the operation of a publicly operated personal care services provider. The cost report form will include a certification form, which will specify who must certify the report.

(9) When a new provider has contracted with a social services district for the provision of personal care services for one year and can report its actual operating costs for such year, the provider must report its actual operating costs for such year to the department by completing a new cost report and submitting such report to the department in accordance with the requirements for providers with cost experience as set

forth in clause (a) of this subparagraph.

(ii) Determination of payment rate.

(a) Providers with cost experience.

(1) Medical assistance payments to personal care services providers for any rate year beginning on or after January 1, 1994, are made at the lower of the following rates:

(i) the rate the provider charges the general public for personal care services; or

(ii) the rate determined by the department in accordance with subclauses (2) through (7) of this clause.

(2) The department will determine a provider's payment rate based on the cost report the provider submits. Each provider must report its personnel and nonpersonnel operating costs as specified in the cost report. The department will consider only the provider's operating costs that are allowable costs, as defined in subclause (3) of this clause and as adjusted by the provider in accordance with subclause (4) of this clause. The department will adjust the provider's allowable costs by trend factors, as determined in accordance with subclause (5) of this clause. The department will determine whether the provider's allowable costs exceed the ceilings that the department has established for such costs in accordance with subclause (6) of this clause and, if so, consider only such of the provider's allowable costs that do not exceed such ceilings. The department will calculate an amount for profit, for proprietary providers, or surplus, for voluntary providers, as determined in accordance with subclause (7) of this clause. The resulting rate will be payment-in-full for all personal care services provided to MA recipients during the applicable rate year, subject to any revisions the department may make in accordance with the rate revision or audit processes authorized by subparagraphs (iii) or (iv) of this paragraph.

(3) Allowable costs.

(i) *Allowable costs* are defined as a provider's documented costs that are necessary for the provider's operation, are directly or indirectly related to recipients' care, and are not expressly declared nonallowable by Federal or State law or regulations.

(ii) Allowable costs will be determined in accordance with reimbursement principles developed for determining payments under title XVIII of the federal Social Security Act (Medicare). These reimbursement principles are set forth in the *Medicare Provider Reimbursement Manual*, Part 1, entitled "HCFAPub. 15-1 thru T. 365," which is published by the Health Care Financing Administration of the United States Department of Health and Human Services. The department has incorporated by reference Chapters 1-14, 21-23 and 26 of such manual, as revised effective January 1, 1992. A copy of such manual is available for public use and inspection at the Department of Social Services, 40 North Pearl St., Albany, NY 12243.

(iii) Allowable costs include the following:

(A) a monetary value assigned to services provided by religious orders and for services rendered by an owner or operator of a provider;

(B) only that portion of the dues the provider pays to any professional association that has been demonstrated, to the department's satisfaction, to be allocable to expenditures other than for public relations, advertising or political contributions;

(C) costs allocated to the provider from a related organization when the costs are reasonably related to the efficient provision of personal care services and the bases of allocation of such costs are consistent with regulations applicable to the cost reporting of the related organization. An organization is related to the provider when the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities or supplies. *To a significant extent* means that:

(i) the provider or an officer, director or partner of such provider has an ownership interest, as defined in section 505.2(i) of this Part, in such organization equal to five percent or more; has an indirect ownership interest, as defined in section 505.2(g) of this Part, in such organization equal to five percent or more; has a combination of an ownership interest and an indirect ownership interest in such organization equal to five percent or more; has an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by such organization if that interest equals at least five percent of the value of the organization's property or assets; or is an officer, director or partner of such organization or otherwise has the power, directly or indirectly, significantly to influence or direct the actions or policies of such organization; or

(ii) the organization furnishing the services, facilities or supplies to the provider, or an officer, director or partner of such organization has an ownership interest, as defined in section 505.2(i) of this Part, in the provider equal to five percent or more; has an indirect ownership interest, as defined in section 505.2(g) of this Part, in the provider equal to five percent or more; has a combination of an ownership interest and an indirect ownership interest in the provider equal to five percent or more; has an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by the provider if that interest equals at least five percent of the value of the provider's property or assets; or is an officer, director or partner of the provider or otherwise has the power, directly or indirectly, significantly to influence or direct the actions or policies of the provider;

(D) reasonable compensation for owners or operators, their employees and their relatives for services actually performed and required to be performed. A *relative* is defined in accordance with section 902.5 of the *Medicare Provider Reimbursement Manual* as follows: the spouse; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law; and grandparent and grandchild of an owner or operator. The amount of allowable costs for reasonable compensation is equal to the amount of compensation normally required to be paid for the same services provided by a nonrelated employee, as determined by the department. Allowable costs do not include compensation for any services which owners or operators and their employees and relatives are not authorized to perform under State law or regulation;

(E) costs of advertising, public relations or promotion when such costs are specifically related to the provision of personal care services and are not for the purpose of attracting patients; and

(F) such other costs as are determined allowable in accordance with reimbursement principles specified in the *Medicare Provider Reimbursement Manual*.

(iv) Allowable costs do not include the following:

(A) amounts in excess of reasonable or maximum costs authorized under title XVIII of the federal Social Security Act or in excess of customary charges to the general public. This provision does not apply to services furnished by public providers free of charge or at a nominal fee;

(B) expenses or portions of expenses reported by providers that the department determines are not reasonably related to the efficient provision of personal care services because of either the nature or the amount of the particular item;

(C) costs that are not properly related to patient care and that principally afford diversion, entertainment or amusement to owners, operators, their employees or relatives;

(D) any interest paid by the provider that is related to a rate determination or penalties imposed by governmental agencies or courts except tax penalties that are imposed through no fault of the provider and the costs of insurance policies that the provider obtains solely to insure against the imposition of such penalties;

(E) costs of contributions or other payments to political parties, political candidates or political organizations;

(F) any element of cost as determined by the department to have been created by the sale of a provider;

(G) the amount of the personal care services provider assessment required by [section 367-i of the Social Services Law](#) or [section 3614-b of the Public Health Law](#); or

(H) such other costs as are determined to be unallowable in accordance with reimbursement principles specified in the *Medicare Provider Reimbursement Manual*.

(4) Recoveries of expense. The provider must reduce its reported operating costs by the costs of services or activities that are not properly chargeable to patient care. When the department determines that it is not practical to establish the costs of such services or activities, the provider will reduce its reported operating costs by the income that the provider receives from such services or activities. Examples of such income include, but are not limited to, the following:

(i) any amount the provider receives as a discount on purchases;

(ii) any amount the provider receives from tuition payments or from other payments made to the provider for educational services or other services not directly related to personal care services;

(iii) any amount the provider receives from a lease of office or other space to concessionaires that provide services not related to personal care services; and

(iv) any amount the provider charges for the use of telephone, telefax or telegraph services.

(5) Trend factors.

(i) The department will establish annual trend factors to be applied to providers' reported allowable costs for the provision of personal care services other than nursing supervision or nursing assessment. The department will also establish annual trend factors to be applied to providers' reported allowable costs for the provision of nursing supervision and nursing assessment when providers have contracts with social services districts for the provision of nursing supervision and nursing assessment.

(ii) The department has designated an external price indicator for the aide/nurse direct care component, the administrative component and the training component of the costs of personal care services and the costs of nursing supervision and nursing assessment.

(A) The external price indicators that the department has designated for the costs of personal care services are as follows: for the aide direct care component, the external price indicator is the *Employment Cost Index for Compensation* for December of each year, as published by the United States Department of Labor, Bureau of Labor Statistics; for the administrative component, the external price indicator is the *Consumer Price Index for All Urban Consumers*, as published for December of each year by the United States Department of Labor, Bureau of Labor Statistics; and for the training component, the external price indicator is the trend factor established by the Department of Health for certified home health agencies in upstate urban areas.

(B) The external price indicators that the department has designated for the costs of nursing supervision and nursing assessment are as follows: for the nurse direct care and the training components, the external price indicator is the trend factor established by the Department of Health for certified home health agencies in upstate urban areas; and for the administrative component, the trend factor is the *Consumer Price Index for All Urban Consumers*, as published for December of each year by the United States Department of Labor, Bureau of Labor Statistics.

(iii) The department will determine the average percentage of all providers' total reported costs for personal care services and for nursing supervision and nursing assessment that each component represents as of June 30th of the year prior to the year for which the department is establishing a rate; and the department will weigh each component's average percentage of total personal care services costs and nursing supervision and nursing assessment costs by the external price indicator for that component.

(iv) The department will multiply each provider's reported allowable costs for personal care services and, if

applicable, for nursing supervision and nursing assessment, for the year specified in the required cost report by two annual projected trend factors: a projected trend factor that the department has estimated for the year that immediately follows the year for which the provider has reported its costs and a projected trend factor that the department has estimated for the year for which the department is determining a rate.

(v) The department will revise trend factors as specified in this item. Such revisions, if they occur, will occur after the department has determined providers' rates for a particular rate year and is determining providers' rates for the subsequent rate year. When the department determines, based upon the external price indicators, that the actual trend factor for the previous rate year deviated by one-half of one percent or more from the department's projected trend factor for such rate year, the department will revise the projected trend factor for the year immediately following such rate year by the amount of the deviation.

(6) Ceilings on payment for allowable costs.

(i) The department will establish ceilings on payment for providers' allowable costs. The department will determine the ceilings as set forth in this item:

(A) The department will assign providers to one of the following five regional groups:

(i) the Metropolitan Downstate Group, which includes providers located in Nassau, Rockland, Suffolk or Westchester County;

(ii) the Metropolitan Upstate Group, which includes providers located in Albany, Broome, Dutchess, Erie, Monroe, Niagara, Oneida, Onondaga or Orange County;(iii) the Suburban Group, which includes providers located in Cayuga, Fulton, Genesee, Madison, Montgomery, Ontario, Oswego, Rensselaer, Saratoga, Schenectady or Wayne County;(iv) the New York City Group, which includes providers located in the five boroughs of New York City; and(v) the Rural County Group, which includes providers located in any of the remaining 33 social services districts not included in the Metropolitan Downstate, Metropolitan Upstate, Suburban or New York City group.

(B) The department will use providers' reported allowable costs for the 1990 calendar year as the base from which it will determine the ceilings for the rate year that begins on or after January 1, 1994. The department will use providers' reported allowable costs for the 1992 calendar year as the base from which it will determine the ceilings for each rate year that begins on or after January 1, 1995.

(C) For each regional group of providers, the department will calculate the centered means of the appropriate base year costs, other than costs attributable to the administrative component, that the providers in the regional group have reported on the cost reports required by the department.

(D) The department will apply an annual trend factor, as determined in accordance with subclause (5) of this clause, to the centered means of the appropriate base year costs. The department will apply such an annual trend factor for each of the following years: the year that immediately follows the appropriate base year and each subsequent year up to and including but not exceeding the year for which the department will be determining providers' rates.

(E) The department will determine regional ceilings for allowable costs within the combined aide/nurse direct care and the training components of the costs of personal care services and nursing supervision and nursing assessment. The ceiling will be expressed as a percentage of the applicable centered mean, as adjusted by annual trend factors, for each such allowable cost.

(F) The department will establish the following ceilings:

(I) Within the combined aide/nurse direct care and the training components, the ceiling for allowable costs will be 115 percent of the applicable trended regional centered mean; however, any costs providers may incur under their contracts with social services districts to determine whether prospective personal care aides or nurses have Federal or state criminal records or to fingerprint personal care aides will not be subject to such ceiling;

(II) (Effective January 1, 1994, to December 31, 1994) Payment for a provider's administrative and general expenses, excluding capital costs, will not exceed 28 percent of the provider's total allowable costs, as reported by the provider in its cost report. The department will reduce payment for a provider's administrative and general expenses in accordance with the following schedule: when a provider's reported administrative and general expenses, expressed as a percentage of the provider's total allowable costs, are greater than 26 percent, but do not exceed 31 percent, of the provider's total allowable costs, the department will reduce payment for the provider's administrative and general expenses by four percent; when a provider's reported administrative and general expenses, expressed as a percentage of the provider's total allowable costs, are greater than 22 percent, but do not exceed 26 percent, of the provider's total allowable costs, the department will reduce payment for the provider's administrative and general expenses by three percentage points; and when a provider's reported administrative and general expenses, expressed as a percentage of the provider's total allowable costs, are greater than 20 percent, but do not exceed 22 percent, of the provider's total allowable costs, the department will reduce payment for the provider's administrative and general expenses by two percentage points; however, no provider's administrative and general expenses will be reduced to less than 20 percent of the provider's total allowable costs.

(III) (Effective January 1, 1995) Payment for a provider's administrative and general expenses, excluding capital costs, will not exceed 28 percent of the provider's total allowable costs, as reported by the provider in its cost report.

(ii) The department will apply the ceilings as follows: when a provider's reported allowable costs are equal to or less than the ceiling that the department has established, the provider will receive full payment for its reported allowable costs. When a provider's reported allowable costs exceed the ceiling that the department has established, the provider will receive payment for such reported allowable costs in an amount not to exceed the ceiling.

(7) Adjustments for profit or surplus.

(i) The department will include an adjustment for profit, for proprietary providers, or surplus, for voluntary providers. The department will determine the amount of the adjustment by calculating the ratio of the provider's allowable costs for aide wages and benefits to the provider's total allowable personal care services costs; multiplying such ratio by the 26 week United States Treasury Bill rate ("treasury bill rate"), as published by the United States Department of the Treasury in the last week of September of the year preceding the year for which the department is determining the rate; and multiplying the provider's rate, as determined in accordance with subclauses (2)-(6) of this clause, by the product of such multiplication. The result is an amount which the department will add to the provider's rate, subject to items (ii) and (iii) of this subclause.

(ii) When the treasury bill rate used for purposes of this subclause has increased or decreased from the previous applicable treasury bill rate by more than two percent, the department will consider only a two percent increase or decrease in the treasury bill rate when determining providers' adjustments for profit or surplus for a particular year.

(iii) The amount that the department will add to the provider's rate as an adjustment for profit or surplus will in no event exceed an amount equal to five percent of the provider's rate absent such adjustment for profit or surplus.

(b) New providers.

(1) Medical assistance payments to new personal care services providers for any rate year beginning on or after January 1, 1994, will be made at the lower of the following rates:

(i) the rate the provider charges the general public for personal care services; or

(ii) the rate determined by the department in accordance with subclause (2) of this clause.

(2)

(i) The department will determine a new provider's payment rate based on the cost report the provider submits. Each provider must report its estimated personnel and non-personnel operating costs as specified in the cost report.

(ii) The department will consider only the provider's estimated operating costs that are allowable costs, as determined in accordance with subclause (a)(3) of this subparagraph and as adjusted by the provider in accordance with subclause (a)(4) of this subparagraph.

(iii) The department will determine whether the provider's estimated allowable costs exceed the ceilings that the department will establish for such costs in accordance with subclause (a)(6) of this subparagraph, except that the limitation on providers' administrative and general expenses that is set forth in phrases (a)(6)(i)(F)(II) and (III) of this subparagraph will not apply to new providers in the first year of operation, and if the provider's estimated allowable costs otherwise exceed such ceilings, the department will consider only such of the provider's estimated allowable costs that do not exceed such ceilings.

(iv) The department will calculate an amount for profit, for proprietary providers, or surplus, for voluntary providers, as determined in accordance with subclause (a)(7) of this subparagraph.

(v) The resulting rate will be payment-in-full for all personal care services provided to MA recipients during the applicable rate year, subject to any revisions the department may make in accordance with the rate revision or audit processes authorized by subparagraph (iii) or (iv) of this paragraph.

(iii) Revisions to rates.

(a) The department will notify each provider of its approved rates of payment at least 30 days prior to the beginning of an established rate period for which the rate is to become effective. In the case of payments to be made by State governmental agencies notification shall be made only after approval of rate schedules by the State Director of the Budget. The advance notification of rates shall not apply to prospective or retroactive adjustments to rates that are based on rate appeals filed by the provider, audits, corrections of errors or omission of data or errors in the computation of such rates or the submission of cost report data from providers without an estimated cost basis.

(b)

(1) Within 90 calendar days after the provider receives the written notification of its rate, the provider must notify the department of any errors in the rate resulting either from the provider's submission of erroneous information in its cost report or the department's erroneous computation of the rate and of the provider's request for a revised rate.

(2) The provider must submit its notice and request for a revised rate on forms as may be required by the department. The request for a revised rate must specify the basis for the revision, as specified in clause (c) of this subparagraph, and contain documentation supporting the request. The department may request such additional documentation as determined necessary.

(c) The department will consider only those requests for rate revisions that are based on one or more of the following:

(1) the provider's claim that the rate contains mathematical, statistical, fiscal or clerical errors;

(2) the provider's claim that it has incurred new or unanticipated costs for programs or services mandated or approved by the department and that the cost report that the provider submitted to the department does not reflect the provider's actual costs for reasons beyond the provider's control; or

(3) the provider's desire to obtain a rate that is lower than the rate promulgated by the department.

(d) When the department determines that a provider's request for a revised rate does not meet one or more



requirements of clause (c) of this subparagraph, the department will notify the provider in writing within 30 calendar days of such determination.

(e) When the department determines that a provider's request for a revised rate meets one or more requirements of clause (c) of this subparagraph, the department will determine whether the provider's rate should be revised. The department will notify the provider in writing of the results of its determination and, if the department determines that the provider's rate should be revised, of the revised rate. Within six months after the date the department receives the provider's request for a revised rate, the department will submit its determination regarding the revised rate to the Division of the Budget for its review and approval.

(f) Within 30 calendar days after the provider receives the written notification of its revised rate, the provider must notify the department in writing of any errors in the revised rate.

(iv) Audits, hearings and recoveries of overpayments. Parts 517, 518, and 519 of this Title, which concern provider audits, recoveries of overpayments and provider hearings respectively, apply to audits of, recoveries of overpayments from, and hearings granted to providers subject to the requirements of this paragraph.

(v) Exemptions.

(a) A social services district may request an exemption from the application of the methodology, as set forth in subparagraphs (i) through (iii) of this paragraph, to providers with which the district has contracts for the provision of personal care services. A social services district that seeks an exemption must submit a written exemption request to the department. The exemption request must describe the alternative rate methodology that the district has developed and will use to determine payments to personal care services providers and such other information as the department may require.

(b) The department may grant a social services district's exemption request when it determines that the alternative rate methodology that the district will use is based on providers' costs of providing personal care services; includes an adjustment for inflationary increases in the providers' costs of doing business; and contains provisions comparable, as determined by the department, to the rate methodology and other provisions set forth in this paragraph.

(i) *Reimbursement.* State reimbursement shall be available pursuant to [section 368-a of the Social Services Law](#) for expenditures for services provided in accordance with the provisions of this section.

(j) *Annual plan.* The local social services department shall submit annually to the New York State Department of Social Services a plan for provision of personal care services on forms required by the department.

(k) *Shared aide plans.*

(1) Except as provided in paragraph (2) of this subdivision, each social services district must implement a shared aide plan approved by the department.

(i) Prior to implementing a shared aide plan, a social services district must develop a proposed shared aide plan and submit the proposed plan to the department for its review and approval or disapproval. The social services district must submit its proposed shared aide plan to the department on forms the department requires and within 60 business days after the department issues an administrative directive to all social services districts regarding the districts' development and implementation of shared aide plans.

(ii) In its proposed shared aide plan, the social services district must document the following information to the department's satisfaction:

(a) the number of shared aide sites the social services district plans to establish and the projected implementation date at each site;

(b) the number of nurse supervisors, case managers, provider agency coordinators, and other personnel who will serve personal care services recipients under the district's shared aide plan;

(c) the methods the social services district will use to inform personal care services recipients and providers regarding the district's shared aide plan;

(d) the methods the social services district will use to select the personal care services providers that will participate in the district's shared aide plan;

(e) the differences, if any, between the provision of nursing assessments, nursing supervision, and case management to personal care services recipients under the district's shared aide plan and the district's existing method of delivering personal care services; and

(f) the methods the social services district will use to monitor and evaluate the district's shared aide plan, including how the district will evaluate personal care services recipients' satisfaction with the district's shared aide plan.

(iii) The department will approve proposed shared aide plans that comply with the requirements set forth in this paragraph. The department will notify the social services district in writing of its approval or disapproval of the district's proposed plan within 45 business days after receipt of the plan. If the department disapproves the social services district's proposed plan, the district must submit a revised plan within 30 business days after receipt of the department's disapproval notice. The department will notify the social services district in writing of its approval or disapproval of the district's revised plan within 45 business days after receipt of the revised plan.

(iv) Each social services district with an approved shared aide plan must submit to the department such reports or information relating to the plan's implementation as the department may require. Personal care services providers must furnish such reports or information relating to the social services district's implementation of its shared aide plan as the district or the department may require.

(v) Except as otherwise provided in this subdivision, personal care services provided under a shared aide plan must conform to the standards specified in this section.

(vi) A social services district may delegate to another agency or entity the responsibility for developing and implementing a shared aide plan provided that the department has approved the delegation, and the social services district and such other agency or entity have a written agreement or contract specifying each entity's responsibilities.

(2) A social services district is not required to develop and implement a shared aide plan if the district has requested an exemption from the shared aide plan requirement and the department has approved the district's exemption request.

(i) A social services district that seeks an exemption from the shared aide plan requirement must submit an exemption request to the department for its review and approval or disapproval. The social services district must submit its exemption request to the department on forms the department requires and within 60 business days after the department issues an administrative directive to all social services districts regarding the districts' development and implementation of shared aide plans.

(ii) In its exemption request, the social services district must satisfactorily document that the district's existing method of delivering personal care services adequately meets, and can continue to meet, recipients' personal care services needs and that a sufficient supply of personal care services providers is available, and is reasonably expected to continue to be available, to provide personal care services to recipients in the district. A social services district's exemption request must also satisfactorily document that at least one of the following exemption criteria exists in the district:

(a) the number of personal care services recipients is either too few to support a shared aide plan or so

geographically dispersed that the district cannot identify a group of recipients for which a shared aide plan would be appropriate;

(b) the annual costs of delivering personal care services under a shared aide plan would be equal to, or greater than, the annual costs of delivering personal care services under the district's existing method; or

(c) the district has another cost-effective method to improve the efficiency of the delivery of personal care services.

(iii) The department will approve exemption requests that comply with the requirements set forth in this paragraph. The department will notify the social services district in writing of its approval or disapproval of the district's exemption request within 45 business days after receipt of the exemption request.

(a) If the department disapproves the district's exemption request, the district must submit either a revised exemption request or a proposed shared aide plan within 30 business days after receipt of the disapproval notice. The department will notify the social services district in writing of its approval or disapproval of the district's revised exemption request or proposed shared aide plan within 45 business days after receipt of the revised exemption request or proposed shared aide plan.

(1) If the social services district submits a revised exemption request and the department disapproves the revised exemption request, the district must submit a proposed shared aide plan within 30 business days after receipt of the disapproval notice. The social services district's proposed shared aide plan, and the department's review and approval or disapproval of the proposed shared aide plan, must otherwise meet the requirements of paragraph (1) of this subdivision.

(2) If the social services district submits a proposed shared aide plan and the department disapproves the proposed shared aide plan, the district must submit a revised shared aide plan within 30 business days after receipt of the disapproval notice. The social services district's revised shared aide plan, and the department's review and approval or disapproval of the revised shared aide plan must otherwise meet the requirements of paragraph (1) of this subdivision.

(iv) An approved exemption request is effective only for the year covered by the social services district's current approved annual plan for the provision of personal care services, as required by subdivision (j) of this section. A social services district that has been exempted from the shared aide plan requirement must submit a new exemption request or a proposed shared aide plan when the district submits a new annual plan for the provision of personal care services or before the day that the district's approved exemption request expires.

## **APPENDIX E**

### **9 NYCRR 6654.17**

#### **Section 6654.17. EISEP in-home services**

(a) For purposes of this section the words “client” and “consumer” are interchangeable except where noted otherwise.

(b) Each area agency receiving EISEP service funds shall ensure provision of both Personal Care Level I (may appear as housekeeping/chore in other sections of the regulations) and Personal Care Level II (may appear as homemaking/personal care in other sections of the regulations) services as needed by EISEP participants as determined in compliance with the assessment procedures prescribed in section 6654.16 of this Part.

(c) An in-home service provided as a respite service as described in section 6654.18 of this Part shall be so documented in the client case record.

(d) An in-home services agency or area agency directly providing the services shall have and ensure that all in-home services workers are familiar with written procedures for responding to emergency situations.

(e) Some and total assistance as referenced in subdivisions (f) and (g) of this section is defined as follows:

(1) some assistance means that a task or function is performed and completed by the client with assistance from another individual; and

(2) total assistance means that a task or function is performed and completed for the client.

(f) Personal Care Level I services include some or total assistance with only the following tasks on behalf of or to assist a client:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the client uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the client if no other arrangements are possible;

(7) the client’s laundering including necessary ironing and mending;

(8) meal preparation, including simple modified diets;

(9) payment of bills and other essential errands; and

(10) escort to appointments and community activities may also be included under EISEP.

(g) Personal Care Level II services include only:

(1) some or total assistance with the tasks listed in subdivision (f) of this section; and

(2) some or total assistance with:

(i) bathing of client in the bed, tub or shower;

- (ii) dressing;
- (iii) grooming, including care of hair, shaving, and ordinary care of nails, teeth and mouth;
- (iv) toileting, including assisting the client on and off the bedpan, commode or toilet;
- (v) walking, beyond that provided by durable medical equipment, within and outside the home;
- (vi) transferring from bed to chair or wheelchair;
- (vii) preparation of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
- (viii) feeding;
- (ix) administration of medication by the client, including prompting client of time, identifying the medication for the client, bringing the medication and any necessary supplies or equipment to the client, opening the container for the client, positioning the client for medication and administration, disposing of used supplies and materials and storing the medication properly;
- (x) routine skin care;
- (xi) using medical supplies and equipment such as walkers and wheelchairs; and
- (xii) changing simple dressings.

(h) To the extent feasible, the same worker should be assigned to a client whenever possible. An in-home services agency or area agency directly providing the services shall have a back-up system for worker substitution when the regular worker is not available. Under consumer directed in-home services, the consumer or consumer representative shall have a back-up system for worker substitution when the regular worker is not available.

(i) Except under consumer directed in-home services, an in-home services worker shall be able to read and write; understand and carry out directions and instructions; record messages and keep simple records; and communicate with clients, their families and others involved in caregiving. Under consumer directed in-home services, the consumer or the consumer representative shall determine the abilities they will require the in-home services worker to possess.

(j) An in-home services agency, area agency directly providing the services or, under consumer directed in-home services, the consumer or consumer representative shall ensure that in-home services workers perform tasks as specified in a client's care plan and service schedule.

(k) Requirements for criminal background checks.

(1) An in-home services agency that is a licensed home care services agency or a certified home health agency providing in-home services shall comply with SDOH requirements for a criminal history check to the extent required by 10 NYCRR Part 402.

(2) Agencies providing in-home services other than licensed home care services agencies or certified home health agencies, including area agencies directly providing in-home services, shall complete a criminal history check on all in-home services workers and applicants.

(3) Under consumer directed in-home services, the consumer or the consumer representative must be informed by the case manager or fiscal intermediary as designated by the area agency of the option(s) to require a prospective in-home services worker to complete a criminal history check.

(l) An in-home services agency, area agency directly providing the services or, under consumer directed in-home services, the consumer or consumer representative in conjunction with the fiscal intermediary shall comply with SDOH health requirements for in-home services workers pursuant to [10 NYCRR section 766.11 \(c\) and \(d\)](#) or any successor regulation.

(m) Each in-home services worker shall receive an annual assessment of his or her performance and effectiveness except under consumer directed in-home services no such assessment is required.

(n) The in-home services agency or area agency directly providing the services shall have liability or other insurance coverage in an amount sufficient to protect the area agency from any potential liability claims resulting from acts, omissions, or negligence of in-home services agency or area agency personnel. An area agency on aging sponsored by a county or other unit of general purpose local government may satisfy the insurance coverage requirement through self-insurance. The in-home services agency shall maintain such insurance coverage while its contract with the area agency is in effect and the area agency directly providing the services shall maintain such coverage while it is providing the services.

(o) Except under consumer directed in-home services, each person providing Personal Care Level I services shall:

(1) be instructed, prior to delivering any in-home services, on how to work with the elderly;

(2) receive an orientation, prior to delivering any in-home services to:

(i) the housekeeping/chore tasks which the worker may perform;

(ii) the policies and procedures of the provider agency; and

(iii) the rights of clients as set forth in section 6654.16(ai) of this Part;

(3) receive on-the-job training as needed to instruct the Personal Care Level I worker in a particular skill or technique or to assist in resolving problems in individual care situations.

(p) Except under consumer directed in-home services, each person performing Personal Care Level II services shall participate successfully in a training program that meets the requirements described in [18 NYCRR section 505.14\(e\)\(1\)-\(4\) and \(7\)](#); or meets the training requirements as described in [10 NYCRR section 700.2\(b\)\(14\)\(i\) or \(ii\)](#).

(q) Under consumer directed in-home services, responsibilities for training, which includes orientation and instruction, are as follows:

(1) the consumer or consumer representative is responsible for determining the need for, and providing and/or arranging for any training of the in-home services worker pertaining to the performance of tasks in the consumer's care plan;

(2) the fiscal intermediary is responsible for training the consumer or the consumer representative and the in-home services worker on the following:

(i) the roles and responsibilities of the fiscal intermediary; and

(ii) the respective roles and responsibilities of the consumer or the consumer representative and the in-home services worker as they relate to the roles and responsibilities of the fiscal intermediary.

(r) At the request of the consumer or consumer representative additional training may be provided. If such training is available, the case manager or fiscal intermediary as designated by the area agency will inform the consumer or consumer representative what additional training is available to the consumer or consumer representative and the in-home services worker, and the entity(ies) responsible for providing it.

(s) Except under consumer directed in-home services, each in-home services worker shall:

(1) have or be designated a supervisor who shall:

(i) be a registered professional nurse who is licensed and currently certified to practice as a registered professional nurse in New York State, meets the health requirements specified in subdivision (l) of this section and either has at least two years satisfactory recent home health care experience or has a combination of education and experience equivalent to at least two years of satisfactory experience with at least one year of home health care experience, or acts under the direction of a registered professional nurse who has at least two years satisfactory recent home health care experience or has a combination of education and experience equivalent to at least two years of satisfactory experience with at least one year of home health care experience; or possess a bachelors degree with a major in social work, psychology, counseling or related field and one year of experience in the health or social services field; or have five years of related experience; and

(ii) have received an orientation from the area agency on EISEP's design, objectives, local administration, standards, policies and procedures;

(2) receive the first supervisory visit in the home of each client to whom he or she is regularly assigned within five working days of the first time he or she is to provide services to the client. If the visit does not take place the first time the worker is to provide services to the client, the supervisor shall contact the client by phone or letter, prior to service delivery, to inform the client of who the worker will be. The first in-home supervisory visit shall include:

(i) demonstration and instruction to the worker and the client concerning specific tasks to be performed;

(ii) orientation to the client and worker; and

(iii) clarification of the roles and responsibilities of the worker, the client and the supervisor in relation to the service plan;

(3) receive regular supervision by the designated supervisor in each client's home at least every six months during which the supervisor shall:

(i) evaluate the skills and performance of the in-home services worker;

(ii) provide to the in-home services worker information, consultation, instruction, and demonstration as needed;

(iii) determine the extent to which client needs are appropriately and adequately being met;

(iv) follow up, as specified by the case management agency, with the client's case manager to report the findings of the supervisory visit; and

(v) provide the client and his or her authorized representative an opportunity to discuss in privacy with the supervisor the service being provided;

(4) receive administrative supervision on a regular basis.

(t) Under consumer directed in-home services, the consumer or consumer representative shall supervise the in-home services worker.

(1) Supervision shall include, but is not limited to, assuring that each in-home services worker competently and safely performs services that are within the worker's scope of services and that are included in the consumer's care plan.

(u) Records of an in-home services agency, area agency directly providing the services or the fiscal intermediary under consumer directed in-home services are subject to review only by the client, his or her authorized representative, case manager, case manager supervisor, area agency, the office, other authorized staff, and authorized program or fiscal monitoring agents.

(v) An in-home services agency or area agency directly providing the services shall maintain a case record for each client receiving in-home services:

(1) containing:

(i) current and past care plan summaries;

(ii) a copy of the current and past authorizations for service;

(iii) a list of names and dates of workers who provide the in-home services;

(iv) dated verifications of service provision, signed by the client or his or her authorized representative;

(v) accident or incident reports;

(vi) on-going narrative notes of a substantive nature that include but are not limited to:

(a) observations;

(b) problems;

(c) plans of action;

(d) records of telephone contacts; and

(e) records of in-home supervisory visits;

(2) updated in a timely manner; and

(3) maintained for six years from the end of the State fiscal year in which the client last received services.

(w) Under consumer directed in-home services, the fiscal intermediary shall maintain a record for each consumer receiving in-home services for whom it serves as the fiscal intermediary:

(1) containing at a minimum:

(i) consumer or consumer representative contact information;

(ii) current and past authorization for services, during the fiscal intermediary's tenure;

(iii) name and other pertinent information of the consumer representative, if applicable;

(iv) name(s) and contact information of in-home services worker(s);

(v) name and contact information of back-up in-home services worker(s);

(vi) a log of contacts between the fiscal intermediary and the case manager and between the fiscal intermediary and the consumer or consumer representative that includes date, who contact was with, summary of contact and follow up;



(vii) documentation of training provided by the fiscal intermediary to the consumer or consumer representative; and

(viii) copies of any consumer specific reports requested by the area agency, case manager, consumer or consumer representative;

(2) updated in a timely manner; and

(3) maintained for six years from the end of the State fiscal year in which the consumer last received services.

(x) Under consumer directed in-home services, the fiscal intermediary shall maintain a record for each in-home services worker:

(1) containing at a minimum:

(i) enrollment form(s) for an in-home services worker;

(ii) contact information;

(iii) documentation of meeting eligibility requirements to be an in-home services worker as referenced in section 6654.15(d)(7) of this Part;

(iv) documentation of compliance with subdivision (l) of this section;

(v) documentation of compliance with subdivision (k) of this section, if applicable;

(vi) copies of any agreements signed by the in-home services worker;

(vii) required payroll and other benefits documents;

(viii) copy of time sheets or electronic time keeping records;

(ix) documentation of any training requests to the fiscal intermediary by the consumer or consumer representative for the in-home services worker; and

(x) a log of contacts between the fiscal intermediary and the in-home services worker that includes date, who contact was with, summary of contact and follow up;

(2) updated in a timely manner; and

(3) maintained for six years from the end of the State fiscal year in which the consumer last received services.

(y) An in-home services agency or area agency directly providing the services shall maintain a personnel record for each in-home services worker containing evidence of compliance with this section. No reimbursement shall be available for services provided by individuals who are not trained and supervised in accordance with this section.