ADULT PLACEMENT SERVICES MANUAL

North Carolina Division of Aging and Adult Services

Adult Services Section

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

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Adult Placement Manual
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Placement Manual

I. Introduction

I. Introduction

A. Structure of Manual

A systematic process has been established which county departments shall follow when providing Adult Placement Services. The process begins with establishing an effective procedure for providing Placement Services from opening the case to closure. This manual is arranged accordingly and contains detailed descriptions of the law, administrative code, and recommended social work practice that departments of social services shall use in carrying out their responsibilities. Statutory requirements, administrative codes and recommended social work practices are given for each step in the placement process, as well as for other relevant topics.

Recommended social work practice provides interpretation and guidance to departments in carrying out Placement Services per statutory requirements and administrative code. Links to appendices or recommended forms are located within each section and are evidenced by hyperlinks.

B. Statement of Philosophy and Purpose

Adult Placement Services is a service designed to assist aging and disabled adults who cannot maintain their well-being, safety, or security in an independent setting. These adults need more structure, health care or personal care than their family members and other natural supports can provide, or they do not have able and willing family members to assist them. Adult Placement Services are service options where the social worker helps individuals and their families, determine whether placement can be prevented or if it is the most desirable option as a substitute living arrangement. If placement is chosen, Adult Placement Services assists in making arrangements for the client's relocation to a substitute residence, adjustment to the new location and maintenance of the placement. It is also how social workers help individuals and their families or representatives determine whether individuals living in facilities can return and live safely in more independent settings in their communities.

This service is often provided during a period of crisis or impending crisis in the life of an aging or disabled person and that of their family. Often, the functional abilities of the individual have deteriorated, and the caregiving demands have increased. This creates physical, emotional, and financial challenges for the individual and for their family members and others who are providing care and support to them. Sometimes, a significant life event, such as an illness or change in family structure (death, marriage, birth, relocation) precipitates the consideration of the individual's placement into substitute care. Other triggers include an abusive or neglectful situation. There can also be an improvement in the individual's functioning or in their family's functioning, allowing them to return home.

C. Basic Principles

The social worker's tasks in providing placement services involve attention to the needs of both the individual, their family, and significant other individuals. Assistance during placement services will involve the technical aspects of placement or arranging for other services, as well as attending to the individual's and family's emotional and developmental functioning. It involves providing information to support and enable the individual and family to act and allows more active intervention when the individual and/or family cannot take action. This work should enable positive change for the individual and family to occur. The client and family should be supported, enabled, and empowered to have their needs met through the process. It is likely that the individual and family are in a vulnerable, volatile, or changing situation, so it is critical for the social worker to consider several principles in providing this service:

First, it is a voluntary service. Clients who are able to participate in the decision-making process should be aware of all the long-term in-home and substitute care options (e.g., adult day care, in-home aide, meals, home health, SAIH domiciliary and nursing home) that are available for their health status, and services recommended by their physicians. They should be given the opportunity to make informed choices about whether placement or other services are desired and, if placement is chosen, what type of appropriate substitute living arrangement is preferred. They should be given the opportunity to choose services with an understanding of possible limitations and consequences of their choices. For clients who are unable to fully participate in the decision-making process, placement should be facilitated by the least intrusive measures. Social workers should support and enable clients to express their wishes to the extent they are able.

Second, the assessment of needs and planning with older and disabled adults should be done in the context of their families and other individuals who are significant in their lives. The strengths of clients and their families and support systems should be mobilized to the fullest extent possible. They should be empowered through information, support, and the development of choices to do as much planning and facilitating of services for themselves as possible. At the same time, the social worker's responsibilities entail making sure all involved parties have the information, skills, resources, and emotional stability to take actions. The social worker should take a more active role when these parties are not able to take appropriate action.

Third, within the range of appropriate choices, the settings which are least restrictive to meet the client's needs and those which best suit the client's preferred lifestyle should be pursued. If placement is chosen, consideration should be given to substitute living arrangements which are located in the client's community or near their family, if these aspects are important to them. Should the client (who is already

in a substitute living arrangement) or their family express interest in the individual returning home, to a less restrictive, or to a different setting, the social worker should be prepared to evaluate this option while supporting and enabling the client in working toward this expressed goal.

Fourth, placement in a substitute care residence, or leaving a substitute care residence, is a significant event in the life of an individual and their family and is accompanied by changes in emotional functioning and potential growth. The adult may need support and/or counseling to successfully deal with grief about the loss of independence and their identity. They may grieve over the loss of possessions or their home or may even need support in re-establishing independence that was once lost. The adult will also need help in coping with fear and anxiety about the change, feelings of abandonment, and establishing a routine in a new environment. The family should be supported to resolve feelings of guilt, and conflicts about relinquishing or resuming caregiving responsibilities. There may also be an intensification of earlier unresolved relationship problems, sibling rivalries and symbiotic ties. All involved individuals may need support to maintain a sense of self-esteem and identity in the face of change and may need assistance in maintaining appropriate and supportive family connections.

These state policies and social work practice guidelines adhere to the principles above and are intended to guide social work practice in meeting this same intent. State policies are found in the beginning of sections where they apply, with social work practice guidelines following. State policies are requirements and are bolded. Social work practice guidelines give recommended ways to carry out the requirements, and additional information which may be useful.

Placement Manual

II. Legal Base

II. Legal Base

The rules and regulations for administration of Adult Placement Services have been adopted by the Social Services Commission on the basis of its authority in G.S. 143B-153; and are filed in 71C 0100 and NCAC 13 G. 0701 Admission of Residents under the provisions of the Administrative Procedures Act. Adult Placement Services are mandated through the North Carolina Social Services Block Grant Plan under the provision of G.S. 143B-l0.

10A NCAC 71R. 0919 ADULT PLACEMENT SERVICES

(a) Primary Service. Adult Placement Services are activities necessary to assist aging or disabled individuals and their families or representatives in finding substitute homes or residential health care facilities suitable to their needs when they are unable to remain in their current living situations. Activities include completing an initial screening and assessment while providing counseling to help the individual and his family or representative to determine the need for initial or continued placement; assisting in the process for completing necessary financial applications and medical evaluations; helping to locate and secure placement in a suitable setting and level of care; supporting an individual and his family or representative in the individual's transition from one location to another; and providing counseling and other services to help the individual adjust to the new setting and maintain the placement. Adult Placement Services also include assisting individuals, when requested, to return to more independent settings in the community, or to relocate in more appropriate settings when new levels of care are needed.

Adult Placement Services must be provided by every county department of social services.

(b) Components. None.

(c) Resource Items. None.

(d) Target Population. An individual is in the target population if Adult Placement Services are appropriate and desired based on one of the following client needs:

(1) Adults who are unable to maintain themselves in their own homes independently or with available community or family supports.

(2) Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in relocating due to changes in the level of care needed or other factors indicating that alternative settings may be more appropriate.

(3) Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in returning to more independent living arrangements in the community.

(4) Adults who are living in substitute homes or residential health care facilities, and who need assistance in adjusting to or maintaining their placements due to individual or family problems or a lack of resource.

This target population includes wards for whom the director or assistant director of the county department of social services is the guardian.
(e) Once an individual is determined to be in the target population, Adult Placement Services are provided in the following order of priority:

(1) Adults receiving protective services for whom Adult Placement Services is in their protective services plans.

(2) Adults who are at risk of abuse, neglect, or exploitation because:

(A) they need assistance with activities of daily living, instrumental activities of daily living, or health care and they have no caregiver, or the caregiver is not able, willing, or responsible to provide the amount or type of assistance needed;
or
(B) they were previously abused, neglected or exploited and the conditions leading to that situation continue to exist.

(3) Adults who have problems which place them at risk of losing their current living situations.

(4) Adults who do not meet any of the first three priority groups but whose quality of life would be improved with Adult Placement Services.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 20, 2017.

Applying for Adult Placement Services
State Policies
10 A NCAC 71 C. 0101 Intake and Screening
(a) The initial request or referral must be screened to determine whether

the potential client appears to be in the target population. Documentation must reflect how the criteria in the target population were determined to be met.

(b) When Adult Placement Services are requested, an application must be made in accordance with Requirements for the Provision of Services by County DSS Manual. An application is not required when the only services provided are information regarding placement options and procedures, referral to a more appropriate resource, or consultation with another service provider.

(c) If an application for Adult Placement Services has been made by a responsible party for an individual who then refuses these services, this refusal must be honored. The social worker must offer other services and accept an application or make a referral for other services as requested by the client. If, however, Adult Placement Services or other services are authorized by one of the following legal surrogate decision-makers or by a court order, the service will be provided as requested:

(1) a legally appointed guardian of the person or general guardian;

(2) an attorney-in-fact appointed in a durable Power of Attorney, which grants relevant duties and is in effect; or

(3) a health care agent appointed in a Health Care Power of Attorney, which grants relevant duties and is in effect.

If there is reasonable cause to believe during the intake and screening, assessment, service planning or provision of any services that the individual is an abused, neglected or exploited disabled adult in need of protective services, an Adult Protective Services referral must be made. If there are indications that the individual may be incompetent as defined in G.S. 35A-1101(7) and needs a guardian to facilitate the provision of services, a social worker will explore options with the referral source, family members or within the agency for facilitating incompetency proceedings and the appointment of a guardian.

<u>10A NCAC 71C .0102 ASSESSMENT AND SUPPORTIVE COUNSELING</u>

(a) A thorough assessment must be conducted of the client's situation, including strengths and limitations in the following areas:

(1) Physical Health;

(2) Mental Health;

(3) Social System;

(4) Activities of Daily Living And Instrumental Activities of Daily Living;

(5) Economic and Financial Circumstances; And

(6) Environment.

(b) With the exception of the circumstances listed below the client must be seen personally by the social worker as many times as is necessary to do a thorough assessment in the six areas, but a minimum of one time. The personal contact may be in a setting other than the client's home, if the client or others can provide the necessary information for an assessment of the client's living environment, and, if during the assessment, it does not appear that in-home services will be needed or appropriate as an alternative to placement or as an interim service plan.

(c) For the following situations, an assessment must be done as thoroughly as possible with information and resources available to the social worker, without requiring personal contact with the client to complete the assessment.

(1) a client who is not currently living in the county in which the application is made;

(2) a client who is in an emergency situation, where a placement is needed quickly and personal contact would be a barrier to achieving a quick placement;

(3) a client whose case is being transferred within the agency or referred by another service provider or facility, and an assessment which addresses all six functional areas is available. This assessment must be updated to reflect current information.

(d) Documentation must reflect the reason the client was not seen personally in conducting the assessment.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994;
Amended Eff. March 1, 1995.

Target Population for Adult Placement Services

10A NCAC 71R.0919 (d) (1-4) 10 NCAC 71R .0919

(d) Target Population. An individual is considered to be in the target population if Adult Placement Services are appropriate and desired based on one of the following client needs:

(1) Adults who are unable to maintain themselves in their own homes independently or with available community or family supports.

(2) Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in relocating due to changes in the level of care needed or other factors indicating that alternative settings may be more appropriate.

(3) Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in returning to more independent living arrangements in the community.

(4) Adults who are living in substitute homes or residential health care facilities, and who need assistance in adjusting to or maintaining their placements due to individual or family problems or a lack of resources.

This target population includes wards for whom the director or assistant director of the county department of social services is the guardian.

Priority Order of Service
State Policies

10A NCAC 71R .0919 (e) (1-4)

Once an individual is determined to be in the target population, Adult Placement Services are provided in the following order of priority:

(1) Adults receiving protective services for whom Adult Placement Services is in their protective services plans.

(2) Adults who are at risk of abuse, neglect, or exploitation because:

(A) they need assistance with activities of daily living, instrumental activities of daily living, or health care and they have no caregiver, or the caregiver is not able, willing or responsible to provide the amount or type of assistance needed; or

(B) they were previously abused, neglected or exploited and the conditions leading to that situation continue to exist.

(3) Adults who have problems which place them at risk of losing their current living situations.

(4) Adults who do not meet any of the first three priority groups but whose quality of life would be improved with Adult Placement Services.

History Note: Authority G.S. 143B-153; Eff. March 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 20, 2017

10A NCAC 71C .0103 SERVICE PLANNING

A service plan must be developed which addresses problems identified during the assessment and which takes into account client and family strengths and goals. The client must be involved in the service planning process as much as he is capable of doing so. The service plan must document activities to meet goals.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994.

10A NCAC 0104 PRE-PLACEMENT PROCEDURES

(a) The county department of social services is responsible for facilitating the completion and prior approval of FL-2, and Pre-Admission Screening and Annual Resident Review (PASARR) Level I screening forms for clients receiving Adult Placement Services by following procedures codified in 10A NCAC 13G .0702, 10A NCAC 22A .0101, 10A NCAC 22O .0108 and .0114, 10 NCAC 22B .0201 and .0202, and the regulations for Pre-Admission Screening and Annual Resident Review from the Omnibus Budget Reconciliation Acts (0BRA) of 1987 and 1990 published in the Federal Register, Volume 57, No. 230, pages 56450-56514, November 30, 1992. 10A NCAC 13G .0702, 22A .0101, 22O .0108 and .0114, 22B .0201 and .0202, and the regulations for Pre-Admission Screening and Annual Resident Review are incorporated by reference, including subsequent amendments and editions. Copies of these Rules may be obtained from the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, NC 27699-6714, (919) 733-2678, at a cost of two dollars and fifty cents ($2.50) for up to ten pages and fifteen cents ($.15) for each additional page at the time of the adoption of this Rule. Copies of pages 56450-56514 of Volume 57, No. 230 of the Federal Register may be obtained from the Performance Reporting and Automation Branch, NC Division of Social Services, 325 N. Salisbury Street, 2415 Mail Service Center, Raleigh, NC 27699-2415, (919) 733-4530, at a cost of ten cents ($.10) per page at the time of adoption of this Rule.

(b) The facilitation of FL-2, and PASARR form completion can be accomplished by informing the client, family or other representative of

procedures for getting the forms completed and following up to see that the procedures are followed. If the client is not able to follow the procedures and has no family or representative able or willing to do so, the social worker must work more directly with the physician or other health care provider to get the form(s) completed. This includes assisting the client in locating resources for completion of the form, including transportation and a physician.

(c) A Consent for the Release of Information must be obtained for every client who is receiving Adult Placement Services. The consent must be obtained according to rules codified in 10A NCAC 69, which are incorporated by reference, including subsequent amendments and editions. Copies of these Rules may be obtained from the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, NC 27699-6714, (919) 733-2678, at a cost of two dollars and fifty cents ($2.50) for up to ten pages and fifteen cents ($.15) for each additional page at the time of the adoption of this Rule.

(d) Social work staff must inform applicants for Adult Placement Services of the availability of State/County Special Assistance for Adults or Medicaid to cover the cost of care in a facility, and the procedures for making an application if they are interested and have not already applied.

(e) Local agency procedures must be established to assure that FL-2,and PASARR (Level I Screening or notice of final determination) forms are shared among income maintenance and social work staff when they have mutual clients.

(f) The social worker must coordinate with income maintenance staff regarding the eligibility of clients receiving Adult Placement Services, and must assist the client, family or representative in following procedures to establish eligibility for income maintenance programs as needed to facilitate placement or other services.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994

10A NCAC 71C 0105 LOCATING AND SECURING PLACEMENT

(a) Social workers in the county departments of social services are responsible for assisting clients who are receiving Adult Placement Services and their families or representatives to locate available beds in substitute homes, residential health care facilities, or independent housing in the community with services and charges suitable to their needs.

(1) County departments are not allowed to make referrals to or participate in plans for placing individuals in domiciliary homes,

nursing facilities, or any other facility placement arrangements which do not comply with the Civil Rights Act of 1964, or to provide Adult Placement Services to individuals residing in those homes or facilities.

(A) A list of all licensed domiciliary homes, and group homes operated by or under contract with area mental health authorities which have signed a Civil Rights Compliance Statement are published quarterly by the Adult and Family Services Section of the Division of Social Services. This list may be obtained at no cost by contacting the Adult and Family Services Section at (919) 733-7145 or 325 N. Salisbury Street, 2405 Mail Service Center, Raleigh, NC, 27699-2405.

(B) A list of licensed health care facilities which are Medicaid or Medicare certified, and therefore have signed a statement of compliance with the Civil Rights Act of 1964, is available from the Certification Section of the Division of Health Service Regulation by request. This list may be obtained at no cost by contacting the Licensure and Certification Section at (919) 733-7461 or 2711 Mail Service Center, Raleigh, NC, 27699-2711.

(C) In addition to procedures in Parts (a)(1)(A) and (B) of this Rule, the inclusion of a statement of compliance with the Civil Rights Act of 1964 in the home or facility's admissions policies, or the posting of a Medicaid or Medicare certification in a nursing home, will indicate compliance.

(2) If the social worker cannot determine compliance with the Civil Rights Act of 1964 according to Parts (a)(1)(A), (B), or (C) of this Rule, referrals, planning for placement, and services to individuals in those homes or facilities must not be provided.

(b) When an available and appropriate placement for a client has been located, the social worker will assist the client and his family or representative in planning for and facilitating the admissions process. If the client, family or representative is not able or willing to follow admissions procedures, the social worker will provide more direct assistance as needed to facilitate the placement.

(c) The social worker must coordinate with income maintenance staff (if applicable) to assure that eligibility for State/County Special Assistance for Adults or Medicaid is established, assure that there is an understanding between the facility and client about how payment will be made, or assist the client in making alternate arrangements prior to the date of placement.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 20, 2017.

10A NCAC 71C 0106 POST PLACEMENT ADJUSTMENT

(a) County departments of social services are responsible for providing or facilitating services to assist clients receiving Adult Placement Services to adjust to their placements or independent settings. This includes clients for whom the county department has facilitated placement arrangements as well as clients already living in facilities who request or are referred for services.

(b) Adjustment services include psychosocial adjustment as well as assuring that supportive services and financial arrangements are in place.

(c) These services may be facilitated by assuring that another agency, facility staff member, family member or other representative is assisting the client with adjustment. If another agency, facility staff member, family member or representative is not assisting the client, the social worker will provide these services until a satisfactory adjustment has been made or until alternate services are in place for the client. The county department must provide or facilitate adjustment services a minimum of 30 days after the client's admission or relocation to a facility or other living arrangement.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994.

10A NCAC 71C. 0107 TERMINATION OF ADULT PLACEMENT SERVICES

(a) Prior to Adult Placement Services being terminated, the social worker must review available information and make contacts with significant persons to determine whether services need to be continued, and to reach closure with the client and involved parties. If there are no identifiable client needs that can be addressed by the agency, or those needs are being met by another party, Adult Placement Services may be terminated in accordance with policies codified in 10A NCAC 71R .0600, which is incorporated by reference, including subsequent amendments and editions. If Adult Placement Services have been ordered by the court under Adult Protective Services, services will terminate when the order expires.

(b) Contacts may be made in person, by telephone, or by letter but must allow for sufficient information to be obtained to make a determination about the need for services.

(c) Documentation must reflect the contacts which were made to make the determination.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994.

10A NCAC 71C 0108 COORDINATION WITH OTHER SERVICE PROVIDERS

Documentation in the client's case record must include information about other agencies or service providers who are known to be involved with the client. If any of those parties are involved in placement, adjustment, or relocation services with the client, documentation must reflect how these services are being coordinated so as not to duplicate efforts. If the placement social worker in the department of social services is the most appropriate or only source of assistance, and the client meets the criteria in the target population in 10A NCAC 71R .0919, an application must be made in accordance with 10A NCAC 71R .0400 and Adult Placement Services provided. 10A NCAC 71R .0919 and .0400 are incorporated by reference, including subsequent amendments and editions.

History Note: Authority G.S. 143B-153;
Eff. March 1, 1994.

Placement Manual
III. Definitions

III. Definitions

Adult – an individual 18 years of age or over, or an emancipated minor, who, because of a temporary or chronic physical condition or mental disability needs a substitute living arrangement, and may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator, the services and accommodations of the home will meet their needs.

Adult Placement Services - Adult Placement Services are activities necessary to assist aging or disabled individuals and their families or representatives in finding substitute homes or residential health care facilities suitable to their needs when they are unable to remain in their current living situations. Activities include completing an initial screening and assessment while providing counseling to help the individual and their family or representative to determine the need for initial or continued placement; assisting in the process for completing necessary financial applications and medical evaluations; helping to locate and secure placement in a suitable setting and level of care; supporting an individual and their family or representative in the individual's transition from one location to another; and providing counseling and other services to help the individual adjust to the new setting and maintain the placement. Adult Placement Services also include assisting individuals, when requested, to return to more independent settings in the community, or to relocate to more appropriate settings when new levels of care are needed.

Adult Services Functional Assessment – Comprehensive assessment that covers six functional domains considered essential to assessing the well-being and overall needs of a client and their family.

Assisted Living Residence – Any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies.

Division of Health Service Regulation - Oversees medical, mental health and adult care facilities, emergency medical services, and local jails.

Facility- an adult care home licensed under G.S. 131D-2.4.

Family Care Home - An adult care home having two to six unrelated residents.

FL-2 - Medical form that lists the physician's recommended level of care as well as medical diagnoses, care needs, and medications.

Group Home - A supervised living group home is required to be licensed if it serves two or more adult residents and provides for the care, habilitation or rehabilitation of adults who have a mental illness, developmental disability and/or substance use disorder. Facilities usually serve a maximum of six residents.

Medicaid - A federal and state program that provides health coverage for certain people with limited income and assets.

Nursing Facility - A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital.

Preadmission Screening and Resident Review (PASRR) – A Screening tool guided by federal regulations that requires all individuals being considered for admission to a Medicaid-certified nursing facility (NF) be screened prior to admission, to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition.

Ombudsmen – An individual who assists residents of long-term care facilities in exercising their rights and attempts to resolve grievances between residents, families, and facilities.

State/County Special Assistance - A cash supplement to low-income individuals to help pay for room and board in residential facilities.

Placement Manual

IV. Screening and Application Process

IV. Screening and Application Process

Administrative Code Related to:

10A NCAC 71C .0101 INTAKE AND SCREENING

(a) The initial request or referral must be screened to determine whether the potential client appears to be in the target population. Documentation must reflect how the criteria in the target population were determined to be met.

(b) When Adult Placement Services are requested, an application must be made in accordance with Requirements for the Provision of Services by County DSS Manual. An application is not required when the only services provided are information regarding placement options and procedures, referral to a more appropriate resource, or consultation with another service provider.

(c) If an application for Adult Placement Services has been made by a responsible party for an individual who then refuses these services, this refusal must be honored. The social worker must offer other services and accept an application or make a referral for other services as requested by the client. If, however, Adult Placement Services or other services are authorized by one of the following legal surrogate decision-makers or by a court order, the service will be provided as requested:

(1) a legally appointed guardian of the person or general guardian;

(2) an attorney-in-fact appointed in a durable Power of Attorney, which grants relevant duties and is in effect; or

(3) a health care agent appointed in a Health Care Power of Attorney, which grants relevant duties and is in effect.

If there is reasonable cause to believe during the intake and screening, assessment, service planning or provision of any services that the individual is an abused, neglected or exploited disabled adult in need of protective services, an Adult Protective Services referral must be made. If there are indications that the individual may be incompetent as defined in G.S. 35A-1101(7) and needs a guardian to facilitate the provision of services, a social worker will explore options with the referral source, family members or within the agency for facilitating incompetency proceedings and the appointment of a guardian.

Social Work Practice Related to Intake and Screening

Depending on the circumstances, the application (DSS-5027 Client Entry Form) can be made at the intake setting or at the time the social worker makes personal contact with the client.

Screening to determine whether an individual falls within the target population for Adult Placement Services includes a review of at least two criteria: the individual's needs and the resources available to the individual to meet those needs. When Adult Placement Services are being requested, there is usually an indication that the individual's needs have become greater than they can manage and/or that their caregivers can manage. In some cases, it may be determined that an adult currently in placement has improved and that their needs have lessened, and they are ready for a living situation where less assistance is provided. This adult may need assistance transitioning back to an independent setting.

It is important to establish processes for securing screening information during intake for Placement services. The DAAS-6218- Adult Services Intake/Inquiry Form, or an agency intake form can be utilized to gather this information. This information leads to initial decisions about what service options the client and family initially want to explore and whether and where the client will be entered into the service delivery system. For Adult Placement Services, it is especially critical, since these decisions may lead to inappropriate placements of clients who might be maintained in their current settings with services. Lack of appropriate placements or other services also risks the health and safety of clients. The client's needs, and the caregiver's ability to meet those needs, should be briefly screened, to determine what type of service is most likely needed.

For individuals living at home who request, or who are referred for initial placement, the following questions will be of assistance in making the screening decision:

- Are the individual's needs for assistance short-term or intermittent, or are they long-term and constant?
- Does the individual have a primary caregiver or others who provide assistance?
- Does the individual have several needs which are not being met, placing that person at risk?
- What specific needs does the individual have?
- Has the need for assistance on a day-to-day basis increased?
- Is another person required to provide on-going, direct personal care for the individual?

- What are the impacts on the caregiver's time, space, finances, psychological health, and physical health?

- Has there been a recent crisis, such as deterioration in the individual's health or that of their caregiver, or a loss in informal supports?

- Does the individual require total supervision due to disorientation or wandering?

- What interventions have already been attempted and what was the outcome?

These types of questions will help the social worker and client or referral source to determine the amount of assistance needed versus the caregiver's ability to assist, which indicates whether substitute living, and care arrangement may be needed.

However, further assessment may indicate more appropriate or desired service options than placement. The screening is meant to give an indication of an initial potential service option and is not meant to replace a thorough assessment of the client and their situation.

Inherent in the screening process is the opportunity to present information to the client or referral source about alternative care and service options. Some options can be screened in or out as potential services, based on client preferences. This process continues with the assessment and service planning.

Residency Requirements

Generally, individuals who apply for services are residents of North Carolina. However, there may be instances in which a person living in another state intends to move to North Carolina and applies for Adult Placement Services. A possible scenario is when a person who needs placement intends to move to North Carolina to live near family members. If the individual meets the criteria in one of the target populations, the social worker may accept the application DSS-5027 Client Entry Form. The circumstances, however, should allow for services to be provided on a timely basis, according to the Requirements for the Provision of Services by County Departments of Social Services or the application should be denied. If the client intends to apply for State-County Special Assistance for Adults or for NC Medicaid to cover the cost of care, the social worker should work closely with income maintenance staff around residency issues.

If a person with the status of documented citizen, refugee or if an undocumented individual needs placement services, social workers should refer to the Alien

Requirements. For further assistance, supervisory staff may reach out to the DAAS Adult Services Listserv.

When a Client Refuses Services or is Incapacitated

1. State Policies

If an application for Adult Placement Services has been made by a responsible party for an individual who then refuses these services, this refusal must be honored. The social worker must offer other services and accept an application or make a referral for other services as requested by the client. If, however, Adult Placement Services or other services are authorized by one of the following legal surrogate decision-makers or by a court order, the service will be provided as requested:

a. A legally appointed guardian of the person or general guardian;

b. An attorney-in-fact appointed in a Durable Power of Attorney, which grants relevant duties and is in effect; or

c. A health care agent appointed in a Health Care Power of Attorney, which grants relevant duties and is in effect.

If there is reasonable cause to believe, at any point during the placement process, that a disabled adult is being abused, neglected, or exploited, then an Adult Protective Services referral must be made. If there are indications that the individual may be incompetent as defined in NCGS 35A - 1101(7) and needs a guardian to facilitate the provision of services, the social worker will explore options with the referral source, family members or within the agency to facilitate incompetency proceedings and the possible appointment of a guardian.

Social Work Practice Related to the Application Process

It is preferable for the client to sign their application but, since many individuals in need of placement services are unable to apply, another responsible person may apply on the client's behalf. In order of preference, those other individuals are:

- a legal guardian (if applicable),
- attorney-in-fact appointed in a power of attorney.
- Health care agent appointed in a health care power of attorney (if applicable and depending on responsibilities granted),
- a relative or other responsible person

When another person applies on behalf of a client, that person should be encouraged to make the client aware of the application, if this has not been done already.

Sometimes clients are initially reluctant to accept placement services, and this is understandable given the lifestyle changes and loss of independence which usually accompany placement in a facility. An application for Adult Placement Services should be viewed by the social worker as an opportunity for further exploration of long-term or substitute care with the client and not, in and of itself, a final decision regarding placement.

Approaching the application from this framework may help an initially reluctant client to accept an assessment of needs and discussion of service options more readily and may help the client and family to feel more comfortable in exploring their feelings regarding placement as a substitute care option.

A client's refusal of services must be honored unless there is a legal surrogate decision-maker or a court order authorizing the service. However, the social worker should try to determine the nature of the refusal, in a sensitive way, so as not to intrude on the person's rights to privacy and self-determination. Even when a client does not allow for a thorough assessment to be done, there may be an opportunity to determine whether the client is just refusing placement in a facility or is refusing all services, and the reasons for the refusal. It is important for the client to be advised if there are potential consequences which may result from the refusal of services, such as having personal and medical needs go unattended, so an informed decision can be made. A sensitive approach to the client will often allow for further assessment and relationship building, so that they are able to accept placement or other appropriate services.

If a referral source indicates at intake that the client may be incompetent, there may be other measures that need to be taken before a service plan can be implemented. An "incompetent adult" in NCGS 35A-1101 means an adult or emancipated minor who lacks sufficient capacity to manage their own affairs or to make or communicate important decisions concerning their person, family, or property whether such lack of capacity is due to mental illness, intellectual disability, epilepsy, cerebral palsy, autism, inebriety, senility, disease, injury, or a similar cause or condition. The client's mental status should be assessed closely to determine whether a guardian or other legal measures may be needed to facilitate services.

Placement Manual

V. Eligibility for Adult Placement Services

V. Eligibility for Adult Placement Services

State Policies
10A NCAC 71R. 0919 ADULT PLACEMENT SERVICES

Eligibility Criteria
If an individual meets the criteria in the target population below, they are determined to be eligible for Adult Placement Services. Since this service is provided without regard to income, income is not a factor of eligibility for the service and no fees are charged.

Adult Placement Services are mandated and must be provided by every county department of social services.

Target Population for Adult Placement Services
10A NCAC 71R.0919 (d) (1-4); 10 NCAC 71R .0919

(d) Target Population. An individual is considered to be in the target population if Adult Placement Services are appropriate and desired based on one of the following client needs:

(1) Adults who are unable to maintain themselves in their own homes independently or with available community or family supports.

(2) Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in relocating due to changes in the level of care needed or other factors indicating that alternative settings may be more appropriate.

(3) Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in returning to more independent living arrangements in the community.

(4) Adults who are living in substitute homes or residential health care facilities, and who need assistance in adjusting to or maintaining their placements due to individual or family problems or a lack of resources.

This target population includes wards for whom the director or assistant director of the county department of social services is the guardian.

Priority Order of Service
State Policies
10A NCAC 71R .0919 (e) (1-4)

(e) Once an individual is determined to be in the target population, Adult Placement Services are provided in the following order of priority:

(1) Adults receiving protective services for whom Adult Placement Services is in their protective services plans.

(2) Adults who are at risk of abuse, neglect, or exploitation because:

(A) they need assistance with activities of daily living, instrumental activities of daily living, or health care and they have no caregiver, or the caregiver is not able, willing or responsible to provide the amount or type of assistance needed; or

(B) they were previously abused, neglected or exploited and the conditions leading to that situation continue to exist.

(3) Adults who have problems which place them at risk of losing their current living situations.

(4) Adults who do not meet any of the first three priority groups but whose quality of life would be improved with Adult Placement Services.

Social Work Practice Related to Priority of Service

According to the Requirements for the Provision of Services by County Departments of Social Services, in situations where there is reasonable certainty that the agency will not be able to provide a service, the agency may establish a waiting list. Otherwise, if a requested service cannot be provided promptly, the application for services must be denied. Local policies and procedures governing the agency's use of a waiting list must be in writing and approved by the county board of social services.

Adult Placement Services must be provided promptly unless a policy governing a waiting list for the service is established. If a waiting list is established, the service must be made available in accordance with the priority order of service listed in Section VI above.

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VI. Assessment and Supportive Counseling

VI. Assessment and Supportive Counseling

State Policies

10A NCAC 71C .0102 ASSESSMENT AND SUPPORTIVE COUNSELING

(a) A thorough assessment must be conducted of the client's situation, including strengths and limitations in the following areas:

(1) physical health;

(2) mental health;

(3) social system;

(4) activities of daily living and instrumental activities of daily living;

(5) economic and financial circumstances; and

(6) environment.

(b) With the exception of the circumstances listed below the client must be seen personally by the social worker as many times as is necessary to do a thorough assessment in the six areas, but a minimum of one time. The personal contact may be in a setting other than the client's home, if the client or others can provide the necessary information for an assessment of the client's living environment, and, if during the course of the assessment, it does not appear that in-home services will be needed or appropriate as an alternative to placement or as an interim service plan.

(c) For the following situations, an assessment must be done as thoroughly as possible with information and resources available to the social worker, without requiring personal contact with the client to complete the assessment.

(1) a client who is not currently living in the county in which the application is made;

(2) a client who is in an emergency situation, where a placement is needed quickly and personal contact would be a barrier to achieving a quick placement;

(3) a client whose case is being transferred within the agency or referred by another service provider or facility, and an assessment

which addresses all six functional areas is available. This assessment must be updated to reflect current information.

(d) Documentation must reflect the reason the client was not seen personally in conducting the assessment.

Social Work Practice Related to the Assessment

These six functional areas overlap, and assessment in one area usually yields information pertinent to another area. The object in assessing all six areas is to get a well-rounded perspective on the client and their situation so appropriate goal setting and service planning can be accomplished. It is important for the assessment to include the client's perspective, as well as that of their caregiver(s) and significant others, and to include observation as well as written materials and discussion.

Consistent with the philosophy of enabling and empowering the client and their family, assessment for strengths should be included. Strengths in any of these areas should be built upon in the service planning process, and this may make the difference in whether the client can remain in their current setting, and how the client will adjust to a new setting. For instance, a client with a strong, independent family system may be able to mobilize the family to provide sufficient caregiving so that they can remain at home; and a client with good social skills may adjust really well in a facility by making friends with other residents and relating well to the staff.

Assessment of the Six Functional Domains (Adult Services Functional Assessment - DAAS-6220**).**
The following are points to consider in assessing the six functional domains for Adult Placement Services.

Social
The individual's social system and supports often make the difference in whether a person will need to change living arrangements or can be maintained in the current setting. The social system should be viewed broadly to include family, friends, informal and formal caregivers, or helpers, as well as any person or activity which is of significance to the client.

The social worker should:

- determine the client's current lifestyle and what type of activities and atmosphere are important to them. This will help in determining which type of placement arrangement may meet their social needs.When the client is in a domiciliary or nursing home, it includes roommates and significant staff as well.

- assess the social system not only for assistance given to the client, but also for the dynamics of the system, relationships between family members and

others, gaps in the system, social stressors, and significant recent changes in the system.

- be aware of social supports which could be strengthened or new supports which could be developed to improve the client's functioning, either independently or in a facility placement setting.

- determine if family members or others are acting formally or informally as decision-makers for the client, particularly when there are disagreements about appropriate care or service planning for the client.

- determine if there are concerns in family functioning that will need to be addressed for the client to benefit from services.

- determine how much the family and others can help in arranging placements.

- determine if the family/other supports can help the adult with adjusting to the new living environment.

- determine the dynamics present in a facility placement setting or in an independent living arrangement that may affect the client and assess how to intervene when there are adjustment problems.

Environment
Environment includes the home in which the client is living, as well as the outside grounds and neighborhood.

The social worker should:

- assess the environment for access to rooms, equipment, and facilities within the home and outside.

- assess the environment for sanitation, fire safety, and hazards, as well as neighborhood safety.

- assess the setting for potential hazards, particularly if the client is disoriented or confused. The assessment should consider problems in the environment and whether they can be corrected or not.

- assess the facility environment to determine if environmental constraints or hazards are contributing to adjustment difficulties.

Economic
The economic status of the client will determine if the client is eligible for any forms of public assistance, which in some circumstances will be a determining factor in whether placement is a service option, what level of care can be covered

financially, and whether Special Assistance In-Home or other Community supportive services are an option.

The social worker should assess to determine:

- sources of income (Social Security, SSI, Pension, Retirement, Employment, Child Support, SAIH, in-kind support, and financial accounts/assets (property, savings or banking accounts, stocks, bonds, CD's).

- expenses (mortgage/rent, utilities, taxes, food, medications, insurance) and money management (representative payee, POA).

- if the client may need assistance in disposing of assets before placement can be achieved.

Mental Health

The client's mental health status not only helps determine whether a facility placement is the most viable option as well as the recommended level of care, it also determines whether counseling, medications, other resources, or behavior management may be needed during the adjustment phase. For clients who are already residing in facilities, mental health status may be a strong factor in the precipitation or exacerbation of adjustment problems and may indicate whether a return to a more independent setting is possible.

The social worker should:

- assess cognitive as well as emotional functioning.

- assess any progressive dementing illness (Alzheimer, dementia, Parkinson, etc.).

- assess the adult's judgment and the ability to solve problems.

- assess the mental health status to determine if guardianship or another legal measure will be needed to facilitate services.

- administer some screening tests for mental status and spread the assessment over several visits to obtain an accurate picture of mental status.

- assess the effect of time of day, nutrition, and medications on the client's mental state.

- determine if there is any question about the client's mental status, or when there is a diagnosed mental illness present, if a mental health professional should be consulted and/or a mental health evaluation secured.

The FL2 and PASRR forms also contain some information on mental status which should be compared to the social worker's assessment. (See Pre-Placement Procedures FL2, and PASRR Procedures.)

Activities of Daily Living and Instrumental Activities of Daily Living
The capacity of the client to function independently, as well as the social support available to assist them, has major implications for whether maintenance in the current living situation is possible. The less able the client is to manage their activities of daily living and instrumental activities of daily living, and the more tenuous or unstable their social support is, the more likely it is that they will need placement. For a client who is already in a facility, the need for greater assistance will help determine if they can remain in the current level of care or in the current facility or return to an independent living arrangement. It is also important to discern whether functioning capacities are likely to increase or decrease in the future; if rehabilitation and regaining capacities is possible, or if capacities will remain stable, in-home services or a short-term placement may be a service option rather than long-term care placement.

The social worker should assess to determine:

- the adult's level of independence or dependence on others to assist with ADLs (bathing, dressing, eating, toileting, transferring) and IADL (money management, telephone, household chores) needs.

- the need for assistance and the source of assistance with ADLs/IADLs.

- whether functioning capacities are likely to increase or decrease in the future; if rehabilitation and regaining capacities is possible, or if functioning capacities will remain stable.

- whether in-home services or a short-term placement may be a service option rather than long-term care placement.

Some of the activities of daily living are addressed on the FL-2, which should be compared and elaborated upon in the social worker's assessment.

Physical Health
An assessment of the client's physical health is critical when placement or relocation is being considered, since physical health is a strong factor used in determining the appropriate level of care.

The social worker should:

- assess the client's strengths and deficits related to physical health.

- identify the client's medical professionals and service providers.

- assess to determine any diagnosis or disabilities and their impact upon functioning.

- work in coordination with the client, IMC and/or others to obtain the FL-2 form with the recommended level of care, which is completed by the physician.

- determine if the client has more than one physician, as they may have different perspectives on their illnesses, limitations, and treatments. It is important for any discrepancies to be noted and brought to the attention of the physician, with the appropriate consent.

- assess to determine the potential progression of illnesses impacts and need for other/additional service options.

- gather information from a variety of sources to complete a physical health assessment. For example, the adult's physician may have limited knowledge of the disabled adult's health regimen in their home but may be a good source of information through physical assessments and medical tests.

If the client is to be placed, a well-rounded assessment can be used to help the client/representative determine appropriate or preferred placement setting(s). This assessment can give the social worker and facility staff information to help the client in adjusting to the placement and obtaining needed resources.

Assessment When a Personal Contact is Not Required
Although a direct personal contact in the three circumstances is not required, as described in 10A NCAC 71C .0102 Assessment and Supportive Counseling, the social worker is encouraged to do so when possible, particularly if a thorough assessment has not been done recently. If the client is currently in another county, that county department of social services may initiate or do a complete assessment upon mutual agreement of the two counties. Other options for obtaining the required assessment information are:

- Contacts with the client by telephone or mail;

- Contacts with family members or friends of the client by telephone, mail or personally;

- Written information collected from another facility, hospital, agency, etc. (such as social histories, psychological or physical examination reports, FL2);

- Contacts with other social workers or providers by telephone, mail, or personally.

Because client-specific assessment information is normally requested from sources other than the client or person acting responsibly for the client, Consent for the Release of Information will need to be obtained.

If the client cannot be seen personally during the assessment phase, it is important for the social worker to make every attempt to see the client during the service planning phase or in providing other services. The social worker will want to pay special attention to assure that the relocation and adjustment proceed smoothly. The lack of personal contacts with a client should be an exception in delivery of Adult Placement Services and not the rule.

Social Work Practice related to Supportive Counseling

Supportive counseling is inherent in the assessment process and continues throughout service planning, locating, and securing a placement (or relocation to independent arrangements in the community), and the adjustment phase. As the social worker gathers information during the assessment process, the client's and family's problems are uncovered, creating opportunities for the social worker to provide counseling or refer the client or family to another professional for counseling. The social worker should not allow the information gathering process to shortcut opportunities for dealing with the client's and family's emotional issues, which are sometimes presented in subtle or non-verbal ways.

Because the assessment process includes counseling, it may take more than one contact with the client to complete the assessment and develop a relationship which is conducive to service planning.

The assessment process itself can also create anxiety and fears with the client and their family about a potential placement or relocation and can elicit unresolved issues which create difficulty for the client. It is important for the social worker to conduct the assessment in a way that does not feel intrusive to the client and family, and that supports and enables them to share information and feelings.

Placement Manual
VII. Service Planning

VII. Service Planning

10A NCAC 71C. 0103 SERVICE PLANNING

A service plan must be developed which addresses problems identified during the assessment and which takes into account client and family strengths and goals. The client must be involved in the service planning process as much as he is capable of doing so. The service plan must document activities to meet goals.

DAAS-0011 Adult and Family Service Plan

Social Work Practice Related to Service Planning Counseling Goals and Service Options

Once the assessment is complete and the client's and family's strengths and problems have been identified, sometimes more information is needed about the placement and in-home options that are available, including information about care provided and daily routines in facilities. This also includes potential financial eligibility for services. The client and family can enter the problem-solving process and become more capable of making a decision when fully informed. With more information they can become empowered to cope more effectively with beliefs and emotions which may interfere with their abilities to consider placement as an option.

Alternately, clients who are living in facilities may need more information about other service options in communities before they can determine whether returning to a more independent setting is possible.

Counseling around service options may need to be done over a period. The client and/or family may not be able to make decisions immediately because of a need to continue gathering information, think more fully about the options, or deal with emotional, financial, or family issues. The social worker should be sensitive to this need and assist with this process as needed.

The discussion of service options should consider the client's goals. Goals should not be confused with services. For instance, placement is not a goal but a service which may accomplish several different goals, such as improving nutritional status, taking medications regularly, increasing opportunities for socialization, etc. Often there are several different ways goals can be accomplished. The goals of improving nutritional status, taking medications regularly, and increasing opportunities for socialization might also be met by home health or in-home aides, meals-on-wheels, and transportation, or by adult day care, depending on the specific circumstances and preferences.

There may also be short-term and long-term goals, leading to short and long-term service planning. Goals flow from the problems identified in the assessment. The identification of goals gives the social worker and client a clearer picture of which services are appropriate, what the services are meant to accomplish and a framework for identifying when they are successfully accomplished.

Advance Planning and Legal Measures
Counseling with the client and family may also need to include discussion of how to get the client's needs met if they are incompetent or become incompetent in the future. This includes planning for health care as well as financial management. If the client seems to be incompetent, a decision should be made about whether incompetency and guardianship procedures should be pursued and if so, what type of guardian is needed. This will depend on factors such as whether there are family members who can arrange for meeting the client's needs, the client's financial situation and medical or legal opinions. If the family and the medical, service, and legal communities agree about the client's needs and how to meet them, there may be less intrusive measures that can be taken, such as having a representative payee appointed to manage finances and having the family to facilitate services. If, on the other hand, there is disagreement among family members or the medical, service, or legal communities, it may be necessary for guardianship to be pursued to assure that the authority lines are clear and that the client's best interest and/or desires are served. This may also be true if it is anticipated that complex decisions or planning will need to be done for the client, or if there is a complex financial situation. If the client is not incompetent, it may be helpful to initiate discussions with the client about how and what decisions they would want to be made in the future. Discussion can include information on establishing Advance Directives, such as a Living Will or Health Care Power of Attorney, as well as a durable Power of Attorney. If the client is interested in these options, the social worker can help facilitate these options. The social worker should advise the adult and/or family to look into completing an Advanced Directive - Advanced Directives -NC

Client Involvement in Service Planning
The client should be involved as much as possible in the service planning process. If the client is involved with service planning and believes the plan will help them achieve personal goals, they are more likely to successfully adjust, particularly if they enter a placement arrangement. The social worker should look for opportunities to create choices for the client, even when options appear limited. For instance, if the client's service option seems limited to placement, they still may have choices about which facility to enter, when to move, what belongings to take, what activities will help in adjustment, etc. It is important for the plan to build on client strengths and help them maintain a sense of self-esteem and independence.

Family Involvement in Service Planning
The family is often instrumental in service planning, sometimes acting as a surrogate decision-maker for the client, and sometimes facilitating service provision for the client. A decision which personally affects the client also affects the entire family system. The social worker's role is to support the family system in maintaining or strengthening its identity and integrity in the face of change. Caution should be taken not to assume what are familial roles (which may be different in each family).

Sometimes family dynamics interfere with the facilitation of service planning. Family members may disagree on an appropriate service plan for the client, and if the client is somewhat confused or is not able to separate their needs and goals from that of family members, the service planning process becomes difficult. The social worker may need to counsel with the family to resolve the disagreement before service planning with the client can proceed.

The social worker may need to help the family set limits about what kind and how much assistance they can provide to the client. The social worker may need to help the family understand how to communicate their limits to the client, so the client is more fully informed about the possible consequences of their decisions.

The Involvement of Surrogate Decision Makers in Service Planning

When the client has a legal surrogate decision maker, such as a legal guardian or attorney-in-fact appointed in a Power of Attorney, that person is instrumental in planning and facilitation. Depending on the responsibilities granted to the surrogate, a service plan may not be able to be implemented without that person's involvement. Therefore, it is important to involve this person early in the process. If there is more than one surrogate decision maker such as a guardian of the person and guardian of the estate, both individuals need to be involved.

Even when there is a legal decision maker, the client still may be able to express their wishes and have input into some aspects of the plan. Finding a way to do this (when the client is able) will help the client to maintain a feeling of control and self-determination. This is also true if the director or assistant director of the county department of social services is the guardian. If the surrogate decision maker is not a family member, the social worker should also try to be sensitive to the family's feelings and wishes, while helping the legal surrogate to fulfill their responsibilities to the client.

Identifying Activities to be Taken and Responsible Parties

When the general direction of the service plan is decided, activities can then be assigned to parties to be implemented, and time frames can be established. This should again involve the client and family as much as possible, to continue the process of enabling and empowering them. They should be allowed to determine what they are able to do and what they need help in doing. With more information and facilitation, they may be able to do much of what is needed. If the service plan has moved in the direction of in-home or community-based services, other social workers or providers should be involved as appropriate in developing the service plan. In some agencies, this may mean transfer of the case to another social worker, which should be done with the knowledge of the client and family.

Placement Manual

VIII. Pre-Placement Procedures

VIII. Pre-Placement Procedures

10A NCAC 71C .0104 PRE-PLACEMENT PROCEDURES

(a) The county department of social services is responsible for facilitating the completion and prior approval of FL-2, RSVP, or Pre--Admission Screening and Resident Review (PASRR) Level I screening forms for clients receiving Adult Placement Services by following procedures in the 10A NCAC 13G .0701 Admission of Residents; the Aged, Blind and Disabled Manual MA 2260; and the Pre-Admission Screening and Annual Resident review (PASRR).

(b) The facilitation of FL2, RSVP and PASRR Level I form completion can be accomplished by informing the client, family or other representative of procedures for getting the forms completed and following up to see that the procedures are followed. If the client is not able to follow the procedures and has no family or representative able or willing to do so, the social worker must work more directly with the physician or other health care provider to get the form(s) completed. This includes assisting the client in locating resources for completion of the form, including transportation and a physician.

(c) A Consent for the Release of Information must be obtained for every client who is receiving Adult Placement Services. The consent must be obtained according to rules codified in Chapter 69 and Access to Client Records, which are incorporated by reference, including subsequent amendments and editions.

(d) Social work staff must inform applicants for Adult Placement Services of the availability of State/County Special Assistance for Adults or Medicaid to cover the cost of care in a facility, and the procedures for making an application if they are interested and have not already applied.

(e) Local agency procedures must be established to assure that FL2, and PASRR (Level I screening or notice of final determination) forms are shared among income maintenance and social work staff when they have mutual clients.

(f) The social worker must coordinate with income maintenance staff regarding the eligibility of clients receiving Adult Placement Services, and must assist the client, family, or representative in following procedures to establish eligibility for income maintenance programs as needed to facilitate placement or other services.

Social Work Practice Related to Prior Approval

The completion of FL2, RSVP, and PASRR Level I form and prior approval of the cost of care for Medicaid are critical when placements are being made.

The FL2 or the RSVP are needed for clients when placement in a domiciliary facility is being planned.

FL2 forms must be completed, and prior approval received for clients when placement in a Medicaid-certified nursing facility is being planned and Medicaid will be the source of payment.

PASRR Level I screening forms are required to be completed for clients when placement in a Medicaid-certified facility is being planned. When Medicaid will be the source of payment, the PASRR Level I form must be approved along with the FL2. The forms may be initiated at intake if screening information indicates placement will likely be needed, in order to expedite the process. However, for situations in which the service plan is less clear, initiation of the FL2 , RSVP and PASRR process too soon can cause unnecessary effort on the part of the social worker, client or family/representative; and the forms may expire before the service plan is set and ready to be implemented. The forms may have been given to the client family or representative by income maintenance staff. In this case, the social worker's responsibility is to assure that the procedures are being followed to get the forms completed. Advocacy, education, and consultation are often appropriate roles for the social worker in facilitating this process. The client, family members or representative may need assistance in understanding the forms, their purpose, and how to get them completed. Some physicians also need assistance in understanding the levels of care and need reinforcement in completing the forms with sufficient medical data to justify the recommended level of care. The social worker often must work with the physician to ensure all required information is included on the form. Any amendments to the FL2 must be amended by the physician. Complete information about the requirements and the process for getting the Pre-Admission Screening can be found at this link; PASRR.

It is important for the agency to set up a system for processing these forms. The system should address roles of services, income maintenance, and clerical staff, with attention to obtaining telephone prior approval; routing, stamping and mailing forms to NC TRACKS and assuring that Adult Services and Income Maintenance staff coordinate information and are distributed copies of the forms. Particular attention should be paid to due dates and expiration dates.

Nursing Home - Preadmission Screening Resident Review Process

A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the NC Medicaid program as a swing-bed provider of nursing facility services), that is licensed and certified by the North Carolina Department of Health and Human Services Division of Health Service Regulation and enrolled with Medicaid to provide nursing facility level of care services.

A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under

the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.

Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility.

PASRR Level I

Federal law (42 CFR 483.128) mandates that states provide a Level I screen for all applicants to Medicaid-certified nursing facilities to identify residents with serious mental illness (SMI), Intellectual or Developmental Disabilities (IDD), or a related condition (RC). For residents with no evidence or diagnosis of SMI, IDD, or RC, the initial Level I screen remains valid unless there is a significant change in status.

ADULT CARE HOME – PRE-ADMISSION SCREENING PROCESS

Adult Care Home. - An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

Admission of Residents

(a) Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator the services and accommodations of the home will meet his particular needs.

(b) People shall not be admitted:

(1) for treatment of mental illness, or alcohol or drug abuse;

(2) for maternity care;

(3) for professional nursing care under continuous medical supervision;

(4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or

(5) who pose a direct threat to the health or safety of others.

Tuberculosis Test, Medical Examinations and Immunizations

(a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 amendments and editions.

(b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter.

(c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:

(1) The examining date recorded on the FL-2 shall be no more than 90 days prior to the person's admission to the home.

(2) The FL-2 and RSVP shall be in the facility before admission or accompany the resident upon admission and be reviewed by the facility before admission except for emergency admissions.

(3) In the case of an emergency admission, the medical examination and completion of the FL-2 as required by this rule shall be within 72 hours of admission as long as current medication and treatment orders are available upon admission or there has been an emergency medical evaluation, including any orders for medications and treatments, upon admission.

(4) If the information on the FL-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.

(5) The completed FL-2 shall be filed in the resident's record in the home.

(6) If a resident has been hospitalized, the facility shall have a completed FL-2 or a transfer form or discharge summary with signed prescribing practitioner orders upon the resident's return to the facility from the hospital.

(d) Each resident shall be immunized against pneumococcal disease and annually against influenza virus according to NCGS 131D-9 except as otherwise indicated in this law.

(e) The facility shall make arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated.

Consent for the Release of Information

A consent for the Release of Information must be obtained for every client who is receiving Adult Placement Services. The consent must be obtained according to rules contained in the NCGS 131D 2.14 Confidentiality and Chapter 69 Confidentiality and Access to Clients Record.

Social Work Practice Related to Confidentiality and Release of Information
Adult Placement Services cannot be facilitated without securing client-specific information from medical forms, patient charts, and other sources to do a thorough assessment and determine the services which are needed. The service also cannot be facilitated without releasing client-specific information to facilities where placement is being considered, and sometimes to other service providers when adjustment services, an interim in-home services plan, or plan to return from a facility to an independent setting is being pursued.

As with the application, it is preferable for the person who will receive the services to sign their own consent form. If he/she cannot, it is preferable for a legal guardian, an attorney-in-fact delegated in a Power of Attorney or health care agent appointed in a Health Care Power of Attorney (depending on responsibilities granted), to sign the consent. NCGS 131D 2.14 Confidentiality and Chapter 69 Confidentiality and Access to Clients Records also allows for someone who is acting responsibly for the client to sign the consent. However, the social worker should be careful when accepting a signature other than the client's signature on the consent form and be reasonably sure the person is acting responsibly for the client. If there is any doubt, the social worker should err on the side of getting the client's signature or pursuing some legal means to facilitate service provision. One option is to give consideration to whether the client is incompetent as defined in NCGS 35A-1101 and will need a guardian to facilitate a placement and/or other services. A consent form is not required when information is released or secured pursuant to a court order.

Presuming a person acting responsibly for the client applies for Adult Placement Services at intake, the consent may be signed at that time as well, or the social worker may wait until a personal contact is made with the client. In any case, the consent must be obtained before any information is released or secured.

Coordination with Income Maintenance State Policies
Social work staff must inform applicants for Adult Placement Services of the availability of State/County Special Assistance for Adults or Medicaid to cover the cost of care in a facility, and the procedures for making an application if they are interested and have not already applied.

Local agency procedures must be established to assure that FL2, RSVP, and PASRR forms (Level I screening or notice of final determination) are shared among income maintenance and social work staff when they have mutual clients.

The social worker must coordinate with income maintenance staff regarding the eligibility of clients receiving Adult Placement Services, and must assist the client, family, or representative in following procedures to establish eligibility for income maintenance programs as needed to facilitate placement or other services.

Social Work Practice Related to Coordination with Income Maintenance
The establishment of eligibility for State/County Special Assistance for Adults or Medicaid is an integral part of service provision for clients who are entering placements and who need assistance to cover the cost of care.

Although the income maintenance caseworker is responsible for establishing eligibility, it is sometimes necessary for the social worker to help the client or family understand and carry out steps to get eligibility established. This might be as simple as facilitating FL-2 completion or gathering required documents, or as complex as assistance with financial planning.

The social worker should not attempt to interpret eligibility policies to the client and family but should refer them back to the appropriate income maintenance staff. The social worker can, however, work directly with income maintenance staff to see if there are specific areas where the client needs assistance, and can then work with the client on those areas. This should be coordinated carefully to assure that nothing is done which would create a problem in determining eligibility.

When Medicaid applicant/beneficiaries are being placed in nursing facilities, it is critical to the county's Medicaid determination process that the FL2 and RSVP process and the placement be accomplished as soon as possible, and that the income maintenance caseworker be kept advised of the person's status. Some Medicaid determinations cannot be completed until the person has been placed and prior approval granted, so it is important to advise the income maintenance caseworker immediately when prior approval is granted and when the client is placed so the Medicaid determination can be made. Failure to inform the income maintenance caseworker could result in the application/change in circumstance for an ongoing case, pending unnecessarily and delay issuing benefits timely.

Placement Manual

IX. Locating a Bed and Securing Placement

IX. Locating a Bed and Securing Placement

10A NCAC 71C .0105 LOCATING A BED AND SECURING PLACEMENT

(a) Social workers in the county departments of social services are responsible for assisting clients who are receiving Adult Placement Services and their families or representatives to locate available beds in substitute homes, residential health care facilities, or independent housing in the community with services and charges suitable to their needs.

(1) County departments are not allowed to make referrals to or participate in plans for placing individuals in domiciliary homes, nursing facilities, or any other facility placement arrangements which do not comply with the Civil Rights Act of 1964, or to provide Adult Placement Services to individuals residing in those homes or facilities.

(A) A list of all licensed domiciliary homes, and group homes operated by or under contract with area mental health authorities which have signed a Civil Rights Compliance Statement are published quarterly by the Adult and Family Services Section of the Division of Social Services.

(B) A list of licensed health care facilities which are Medicaid or Medicare certified, and therefore have signed a statement of compliance with the Civil Rights Act of 1964, is available from the Certification Section of the Division of Health Service Regulation.

(C) In addition to procedures in Parts (a)(1)(A) and (B) of this Rule, the inclusion of a statement of compliance with the Civil Rights Act of 1964 in the home or facility's admissions policies, or the posting of a Medicaid or Medicare certification in a nursing home, will indicate compliance.

(2) If the social worker cannot determine compliance with the Civil Rights Act of 1964 according to Parts (a)(1)(A), (B), or (C) of this Rule, referrals, planning for placement, and services to individuals in those homes or facilities must not be provided.

(b) When an available and appropriate placement for a client has been located, the social worker will assist the client and his family or representative in planning for and facilitating the admissions process. If the client, family, or representative is not able or willing to follow admissions procedures, the social

worker will provide more direct assistance as needed to facilitate the placement.

(c) The social worker must coordinate with income maintenance staff (if applicable) to assure that eligibility for State/County Special Assistance for Adults or Medicaid is established, assure that there is an understanding between the facility and client about how payment will be made, or assist the client in making alternate arrangements prior to the date of placement.

Social Work Practice

Further Assessment of Client/Family Preference

Upon deciding that placement is an appropriate service, further assessment is needed to determine which substitute living arrangements can accommodate the client's needs and preferences. This process can and usually does begin at intake and continues throughout the service delivery process. It is important that the search for a bed in an appropriate facility does not hamper the assessment and service planning process and does not inadvertently imply that a decision regarding placement has been made when a decision may not have been made.

The FL2 will indicate the appropriate level of care. Beyond that, the client and family may also have preferences regarding accommodations. Assessment should be done regarding the client's lifestyle, the things that are important for the client to feel significant and safe, how the family intends to be involved in the client's care once placed, and resources that may be needed to support a placement. One decision which will also affect preference is whether this is a short-term or long-term placement arrangement. Another issue might be the client's preferences regarding medical treatment and whether there are Advance Directives in place since some facilities' philosophies and admissions criteria will not allow for refraining from active medical treatment.

Providing Information Regarding Facilities

Some clients and their families may already know the facilities where they are interested in pursuing available beds. In this case, their preferences should be documented, and the social worker should assist them in facilitating a placement arrangement in a facility of their choice. In other cases, the client and family may need more information to make a decision.

At a minimum, it is useful for the social worker to compile a list of the local facilities to share so the client and family will be well-informed about all the available options. Another method of sharing information about facilities is to collect photographs, house rules, brochures, etc. about the facilities to share, with the agreement of the administration of the facilities. These materials help to personalize the facilities, and

give information which may be important to clients such as smoking and visitation policies, services offered, access to resources and activities, etc. It is important to give information and avoid favoritism among facilities.

Clients and their families should be encouraged to visit facilities, review their policies, and license, and ask questions of facility staff and residents about issues that are important to them. The social worker may need to assist the client and family in knowing the types of things to observe and what to ask, and to assist in weighing the pros and cons of facilities in relation to the client's needs and preferences. The social worker may also need to facilitate clients' and families' visits to facilities, serving as liaison and arranging for transportation when needed. The client and family should be assisted in whatever ways seem appropriate to make fully informed choices. In situations where the client does not have family or other natural supports the social worker should provide more intensive support during the decision making process. The social worker needs to remain fully informed about available facilities. In order to be able to fully assist a client and family to know the various options, social workers should keep in contact with their peers in surrounding counties, communicating about available beds in facilities. The Division of Health Service Regulation maintains a list of facilities that the Adult Care Licensure Section licenses or registers. The facility list is updated annually and can be accessed at: https://info.ncdhhs.gov/dhsr/acls/faclistings.html. The Recipient and Provider Services Section of the Division of Health Benefits Section also keeps a Central Bed Registry for nursing facilities to voluntarily call when they have vacancies.

Providing Client-Specific Information to Facilities

Upon determining client and family preferences regarding facilities, it may be necessary for the social worker to actively make referrals to those facilities. Consent for the Release of Information is needed in order to do so.

The FL2 and PASRR, when necessary, are usually primary information sources for facilities to consider accepting a client. In addition, the social worker may want to add to the medical information by including portions of the assessment or other information which may be available, such as a social history. Staff in potential facilities should be given all factual information about the client which may affect a successful placement, such as lifestyle preferences, mental health status, family involvement, and habits. It is counterproductive not to inform potential facility staff of challenging behaviors the client may have; the behaviors should be described factually without any judgment on the part of the social worker. If there are behaviors which may cause difficulty for facility staff, the social worker should be proactive about offering post-placement adjustment services or helping to determine other resources which may help facilitate a successful adjustment.

Civil Rights Compliance by Facilities

County departments of social services are not able to make referrals or plan for clients' placements in facilities which are not in compliance with the Civil Rights Act of 1964 They are also not able to provide other Adult Placement Services, such as adjustment services, to clients living in those facilities, since the facilities would benefit indirectly

through service to those clients. Most domiciliary and nursing homes do comply; however, there are a few which do not choose to do so. Normally income maintenance and/or social work staff in the county department of social services know which facilities are in compliance because they are certified to accept Medicaid or are able to accept Special Assistance. If staff is unsure, they should utilize the following resources:

- The NC Division of Health Services Regulation compiles a list of domiciliary homes and mental health facilities which have signed the Civil Rights Statement of Compliance and keeps copies of the signed statements. if there is any question about whether a domiciliary home or mental health facility is in compliance contact the NC Division of Health Services Regulation. The Adult Homes Specialist is also a resource, as the Civil Rights Statement of Compliance is collected routinely as part of the licensing and monitoring process, although compliance is not required for licensure.

- Nursing homes which are Medicaid-certified or Medicare-certified must comply with the Civil Rights Act of 1964 in order to be certified. Their certification should be posted in the facility with the license. The NC Division of Health Services Regulation Adult Care Licensure Section also has a listing of certified facilities and may be contacted for this information.

- In addition to the procedures above, the inclusion of a statement of compliance with the Civil Rights Act of 1964 in the home or facility's admissions policies will indicate compliance.

- When an available and appropriate placement for a client has been located, the social worker will assist the client and their family or representative in planning for and facilitating the admissions process. If the client, family, or representative is not able or willing to follow admissions procedures, the social worker will provide more direct assistance as needed to facilitate the placement.

- The social worker must coordinate with income maintenance staff (if applicable) to assure that eligibility for State/County Special Assistance for Adults or Medicaid is established, assure that there is an understanding between the facility and client about how payment will be made, or assist the client in making alternate arrangements prior to the date of placement.

Social Work Practice Guidelines Admissions Planning and Counseling
Depending on the client's circumstances and the involvement of family members or others, the social worker may need to assist the client in making final preparations to move. This can include when to move (depending on the facility's flexibility), what belongings to take, how or whether to dispose of other belongings, and payment arrangements. The social worker may need to help plan or arrange for transportation for

the actual move, and to more directly assist or arrange for someone to help in packing. This is an important time for the social worker to help the client see where they have choices, and to help them maintain a sense of self-esteem and independence. If family members are involved, one of the tasks may be to help the family recognize ways in which the client can remain independent. The client may also want or need more information at this time about daily routines in the facility and house rules, in addition to needing reassurance and counseling around feelings of fear, anxiety or abandonment. If there has been a delay in finding a placement the social worker may need to remind the client of how and why the decision was made for the client to enter a placement arrangement.

When the actual placement is being planned, unresolved problems among family members may be reactivated, creating a need for the social worker to provide assistance to the entire family so the client can make a successful move. The social worker should recognize the family's efforts to provide care for the client and help to frame the placement in a way that it can be seen as a positive change for the client's and family's well-being. The social worker will also want to help the family determine ways in which they can remain actively and appropriately involved with the client in their new home.

The Admissions Process

The social worker should assure that the client has someone to help with the actual move and with signing the necessary admissions documents if they are unable to do so. This should also include helping the client to understand what the documents mean. If the family or representative cannot help the client read or understand the documents, the social worker should do so.

Staff of county Departments of Social Services should not co-sign admission agreements without legal authorization to do so. Even when the agency has legal authorization (such as the client's guardianship or power of attorney), the social worker should exercise caution in signing admissions documents to ensure that the agency is not obligated to any terms that are not to the client's benefit or would create financial or other obligations that are not agreeable to the agency. The first option to consider when a co-signature is requested is to see if there is a family member, guardian, attorney-in-fact named in a Power of Attorney, or health care agent named in a Health Care Power of Attorney, who can co-sign the agreement. In negotiating placement arrangements for an adult who has not been adjudicated incompetent and who has no other person to co-sign the agreement, the following guidelines may also be used within the limits of local agency policies.

- Ask that the facility accept the competent adult on their own signature. Explain that the agency has been advised not to co-sign admission agreements, and that the facility has potential liability in acting on the basis of decisions by a party which co-signs agreements without legal authority to do so.

- If the facility staff are concerned about financial responsibility for the client's expenses, and if the adult is eligible for Medicaid or State-County Special Assistance for Adults (whichever is appropriate), confirm that the agency will assume financial responsibility to the extent that Medicaid or Special Assistance will cover the cost of care. If the adult is ineligible, discuss with the facility the arrangements that have been made for payment.
- If the facility staff is concerned about the availability of someone to assume responsibility for decisions about the adult's care in the event that they become incapable of making such decisions:
    - Assist the adult in establishing a Durable Power of Attorney or Health Care Power of Attorney which would go into effect if the adult becomes incompetent. If the adult has no responsible party who is willing or able to serve as an attorney-in-fact or health care agent, the agency might consider being designated to act in this capacity, being authorized to make decisions about care and treatment on their behalf; or
    - Confirm (in writing if necessary) that the agency will be available to assist with protective services and/or a guardianship proceeding if appropriate.

Placement Manual

X. Post Placement

X. Post-Placement Adjustment

10A NCAC 71C 0106 POST-PLACEMENT ADJUSTMENT

(a) County departments of social services are responsible for providing or facilitating services to assist clients receiving Adult Placement Services to adjust to their placements or independent settings. This includes clients for whom the county department has facilitated placement arrangements as well as clients already living in facilities who request or are referred for services.

(b) Adjustment services include psychosocial adjustment as well as assuring that supportive services and financial arrangements are in place.

(c) These services may be facilitated by assuring that another agency, facility staff member, family member or other representative is assisting the client with adjustment. If another agency, facility staff member, family member or representative is not assisting the client, the social worker will provide these services until a satisfactory adjustment has been made or until alternate services are in place for the client. The county department must provide or facilitate adjustment services a minimum of 30 days after the client's admission or relocation to a facility or other living arrangement.

Social Work Practice Related to Post Placement

All clients who move to substitute living arrangements, including a move from a facility back to an independent setting, undergo a transitional period when adjustment is being made to the new setting. Clients who have been involved in the decision-making and planning process and who have been prepared for what to expect may make a rapid adjustment. Other clients may have more difficulty in adjusting and need more intense or longer assistance. Still others may need services on a long-term basis to help them maintain an adequate adjustment and prevent disruption of a placement.

Components of Adjustment Services

Services which may be needed are varied, including counseling, advocacy, dispute resolution, and arranging for resources or supportive services. These components also include helping the family and other significant individuals to remain appropriately and actively involved in the client's life.

Counseling

Counseling may be needed to help the client work through the grieving process related to change and losses associated with a placement and to establish a maximum level of emotional and physical independence within a placement setting. The client may need help in framing placement as a positive change and in making linkages from the past to

the present. They also will need to enhance their coping skills or learn new ones to get their needs met within the setting.

The social worker should be alert for cues of depression, agitation disorientation, or inappropriate behaviors exhibited in an attempt to adjust. If there is a pattern of any of these behaviors prior to placement or if the client has been involved in a series of disrupted placement arrangements, it is especially important to be alert for them and to have facility staff be alert for them after placement. Counseling may be needed to help the client understand how their own behaviors contribute to placement disruption, and how they can change those behaviors. The family may also need counseling to deal with changes in their lives as a result of a client's placement, and to cope with associated feelings of guilt and loss. If some family members disagree with this decision, they may need help in coming to terms with the decision for placement, so they do not hamper the client's adjustment. One symptom a family member may show which might indicate unresolved feelings about a client's placement may be a series of complaints about the placement setting which are unfounded or which a client does not have. These situations need to be looked at closely to ensure that the client's needs are, in fact, being met and that the client is satisfied. If this is so, the social worker needs to determine whether a counseling intervention is needed with the family member.
If the client has returned from a facility to an independent living arrangement, counseling may be needed to help the client establish routines and activities and get personal needs met without the structure of a facility. The family may also need help in re-establishing or establishing appropriate caregiving responsibilities while allowing for the client's independence. They may need to deal with anger or other feelings related to the restriction that caregiving places on their own lives and determine how to prevent or relieve caregiver stress.

Advocacy
The social worker may need to advocate on behalf of the client when the client and their family cannot do so. Advocacy may be needed with facility staff when the client's needs are not being met or their rights are being violated, or with other service providers to obtain resources and services which would be of benefit to the client or their family. Advocacy might be particularly important when the client is being discharged from a facility in order to stop the discharge process or delay the discharge until other plans can be made. Sometimes, the social worker will need to enlist others to assist in advocacy, such as the Community Advisory Committee, regulatory agencies, or the ombudsman. Ultimately, the social worker should attempt to help the client and family become empowered and learn to advocate for themselves.

Dispute Resolution
Sometimes the client's adjustment is hampered by disagreements with facility staff members, with other residents in the facility, or with family members. Tension and misunderstandings can occur when a client who is accustomed to living independently is requested to cope with restrictions, lifestyles, and behaviors different from their own in

a placement setting. If in an independent setting, they may have disputes with caregivers or service providers about the amounts or types of care being provided. The disputes may involve the client's attempts to regain more control over their life and/or others' attempts to control the situation. Sometimes the social worker can negotiate settlements in disputes, helping the parties to see the other points of view and reframe their positions to achieve resolution. Another option is for the social worker to involve a long-term care ombudsman if the client is residing in a facility. Again, ultimately the goal is for the client or family to be able to settle these differences, so in dispute resolution, the social worker should educate the client and/or family and model behaviors conducive to dispute resolution.

Arranging for Resources

Sometimes, even with appropriate planning and preparation, the placement or independent living arrangement does not totally meet the client's needs. The client may have an illness or impairment or may exhibit behaviors which would be better managed in another setting if available. When services which are needed by the client are lacking, it may be necessary for the social worker to help the client obtain them. Health care or in-home aide services, supplies, day placements activities, mental health treatment or other personal needs may need to be arranged through the DSS or other community agencies, such as Local Mental Health Entity/Managed Care Organization (LME/MCO) or developmental day programs, etc. Some needs may not be met with the personal funds of the client, in which case the social worker may need to search for resources from the facility, agency, family, or other community organizations. Some clients may also need guardians, attorneys-in-fact appointed in Powers of Attorney, health care agents, or representative payees to assist with their ongoing decision-making or financial arrangements.

Most of these needs should have been identified prior to the placement or move to an independent setting and arranged to be met. However, sometimes this is an ongoing process, particularly if the relocation was done quickly.

Adjustment Services Provided by another Agency or Person

If another person or agency is involved in helping the client to adjust, the social worker may only need to be minimally involved in the transition period. This person may be staff of a facility, such as a social worker in a nursing home, or a family member or other significant person who is involved with the client. It may also be staff of another county department of social services if a placement or other living arrangement has been made out of the county and that county department has agreed to provide the services. In these situations, the social worker will want to keep in contact with this person or individuals to assure that services are being given and the adjustment process is going smoothly.

Depending on the relationship the social worker has developed with the client, the social worker may still need to remain involved with the client for continuity of care and to work toward case termination.

The social worker should also be prepared to more directly intervene when problems arise, or when it appears that adequate services are not being provided.

Adjustment Services for Clients Returning to an Independent Setting
When a client is placed in a temporary arrangement (for rehabilitation, respite care, when a client requests assistance in leaving a facility, or during an interim when other housing and services are unavailable, etc.), adjustment services should be viewed broadly to include not only the placement but also the services which will be needed when the client leaves the placement. In other words, if the client will be returning home or to another community setting, the client and family will need to be emotionally and physically prepared for it. If the client will be going to another facility, they will need preparation just as one does with an initial placement to make a change in routines and grieve the change and learn how to cope.

Sometimes a client will want to leave a facility when the social worker, physician, family members or others do not believe it is in his/her best interest. In this case, the social worker should determine, with the client, what will need to happen for the client to live independently. This may be for client behaviors to change, for health to improve, for housing to be obtained, for the financial situation to change, for a family situation to improve, or for services to become available. Upon determining what needs to happen, goals and activities can be set which will help the client progress toward leaving the facility. There may be transitional services, such as adult day care, which would help the client transition to more independent living. Alternately, the client may then be able to see that their long-range goal of leaving may not be possible, and counseling around adjustment issues can then take place if the client's return home or to a more independent setting is planned, the social worker may need to arrange in-home, day care, or other services to support this plan. Depending on local agency policies and procedures, the development of the discharge plan may need to be coordinated with another social worker within the agency or another service provider.

Distinguishing Between Adult Placement and Other Services
Sometimes placement services overlap with or are provided in conjunction with other services, such as Adult Protective Services 204 (when placement is needed as a part of a protective services plan), Guardianship, or the Representative Payee a component of Individual and Family Adjustment Services. A guardian or representative payee may be needed for ongoing support to the client in a placement setting.

Developing a service plan which includes Guardianship or Payee services is part of the responsibility in Adult Placement Services for assuring that adjustment to a placement setting is achieved and maintained. However, the requirements of establishing Guardianship through the court, planning for services after Guardianship is established, and the decision making and documentation requirements related to Guardianship are

all part of the Guardianship service; similarly, making financial arrangements after appointment are part of Individual and Family Adjustment - Representative Payee services. Unless the social worker is actively continuing to work with the client around psychosocial adjustment to placement or working with the client to relocate. Adult Placement Services can usually be terminated, and Guardianship or Representative Payee services provided on an ongoing basis, if psychosocial adjustment or relocation services are being provided. Adult Placement Services should continue as well as Guardianship or Representative Payee, whichever is appropriate.

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XI. Adult Care Home Discharge

XI. Adult Care Home Discharge

Discharge of a Resident
House Bill 677 (Session Law 2011-145) was enacted to provide adult care homes with greater flexibility in the transfer and discharge of residents and to enact appeal rights for adult care home residents and adult care homes with respect to discharge decisions. This Bill also created Adult Care Homes Resident Discharge Teams (ACH-RDT) within every county which contains an Adult Care Home licensed under Chapter 131D of the General Statutes.

It is expected that the ACH/FCH will understand and follow the requirements of House Bill 677 (Session Law 2011-145). The ACH/FCH retains responsibility for the resident/consumer until the discharge is completed. The discharge still must occur in a safe and orderly manner in accordance with the North Carolina General Statutes and adult care home licensure rules. The adult care home licensure rules can be found at: Chapter 131 D Inspection and Licensing of Facilities.

Reasons for Initiating a Discharge
An ACH/FCH may initiate discharge of a resident/consumer based on any of the following reasons:

- The discharge is necessary to protect the welfare of the resident and the adult care home cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner.
- The health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the adult care home, as documented by the resident's physician, physician assistant, or nurse practitioner.
- The safety of the resident or other individuals in the adult care home is endangered.
- The health of the resident or other individuals in the adult care home is endangered, as documented by a physician, physician assistant, or nurse practitioner.
- The resident has failed to pay the costs of services and accommodations by the payment due date specified in the resident's contract with the adult care home, after receiving written notice of warning of discharge for failure to pay.
- The discharge is mandated under this Article, Article 3 of this Chapter 131D, or rules adopted by the Medical Care Commission.

Adult Care Home Resident Discharge Team Procedures Manual

Departments of Social Services (DSS) are required to have an Adult Care Home Resident Discharge Team (ACHRDT) as outlined in House Bill 677. The purpose of the Discharge Team is to provide a mechanism for Adult Care Homes licensed under Chapter 131 D of the General statutes greater flexibility when discharging or transferring a resident. It also allows for the resident of an Adult Care Home or Family Care home the ability to enact their appeal rights when issued a discharge notice. An ACH-RDT must include at least one member of the DSS and one member of a Local Management Entity (LME). The Local Management Entities shall take the lead role for the discharge destination for those residents whose primary unmet needs are related to mental health, developmental disabilities, or substance abuse and who meet the criteria for the target population established by the Division of Mental Health, Developmental Disabilities, and Substance Use Services. Local Departments of Social Services shall take the lead role for those residents whose primary unmet needs are related to health, including Alzheimer's disease and other forms of dementia, welfare, abuse, or neglect.

The ACHRDT Manual outlines the process DSS, or the LME should follow when there is a request from the ACH staff or Resident to convene the Adult Care Home Resident Discharge Team (ACHRDT Manual).

Placement Manual

XII. Termination of Adult Placement

XII. Termination of Adult Placement

10A NCAC 71C .0107 TERMINATION OF ADULT PLACEMENT SERVICES

Prior to Adult Placement Services being terminated, the social worker must review available information and make contacts with significant persons to determine whether services need to be continued, and to reach closure with the client and involved parties If there are no identifiable client needs that can be addressed by the agency, or those needs are being met by another party, Adult Placement Services may be terminated in accordance with policies in the Requirements for the Provision of Services by County Departments of Social Services Manual Section C. Basic for Denial, Modification and/or Termination. If Adult Placement Services have been ordered by the court under Adult Protective Services, services will terminate when the order expires.

(b) Contacts may be made in person, by telephone, or by letter but must allow for sufficient information to be obtained to make a determination about the need for services.

(c) Documentation must reflect the contacts which were made to make the determination.

Social Work Practice Related to Termination Routine Termination of Adult Placement Services

Termination of Adult Placement Services should be done in a planned way in order to meet two purposes. First, a determination should be made regarding the need for continued services. Second, the client and family should have an opportunity to reach closure with the social worker.

In reviewing available information and in making contacts prior to termination, the social worker, client, and others should determine if the client's problems and goals reflected in the service plan have been met. The contacts should be meaningful, revealing how the client is functioning in the physical, mental, social, ADL/IADL, economic, and environmental realms, and an overall picture of the progress which has been made if the client and family have adjusted, or if the adjustment process has begun and someone else is facilitating the process, the client is probably no longer in need of the service.

If the social worker and client or family have developed a relationship which is significant, the termination process should include attention to emotional content. Ideally the client and family will have been informed from the beginning that involvement with the social worker will be time-limited, and that when goals are met, the involvement will end. If this has happened, everyone will have been preparing for this outcome and it will not be a surprise. If this is not the case, the social worker may need to make several contacts with the client or family for closure. During these contacts, a review can be done of what has happened, how goals have (or have not) been met, and how the client and/or family is now better able to meet their own needs.

If there are new problems or goals, it should be decided whether the client or others can work toward meeting them or whether the social worker needs to remain involved. This should involve a decision about whether the client continues to meet the target population for the service. This will help determine whether it is feasible for the client to continue receiving services.

Termination When the Client Does Not Benefit from Adult Placement Services
There are some clients who are not able to benefit from Adult Placement Services because they are not able to develop or carry out activities in a viable service plan. Sometimes, a client at intake and assessment appears to meet one of the target populations, but during work and ongoing assessment with the client, it becomes apparent that they are not part of a target population and/or have decided not to proceed with placement.

Sometimes, there are factors which would indicate that another agency is a more appropriate service provider, or the client, for whatever reason, is not able to cooperate in the delivery of the service. If the service plan does not seem to be working, the social worker should assess the reasons with the client and perhaps try some alternate strategies.

There are a number of different strategies which should be considered:

- Reassesses the goals with the client and make a determination about whether the current service plan enables the client to achieve those goals.

- Review the service plan with the client, modifying it as needed and contracting with them about the plan.

- More thoroughly assess the client's family system (interpreting "family system' broadly) to determine if there are factors which are contributing to the failure of the service plan and enlist assistance and support from this system.

- Conduct a multi-disciplinary/multi-agency staffing to get other ideas and to assure that involved parties or agencies are not inadvertently confusing the goals and service plan.

- Obtain a physical or mental examination from a physician or mental health professional to determine if the client has physical or mental illnesses or drug reactions which are having an effect on their ability to follow through with the service plan.

- Work with facility staff, mental health professionals or others to manipulate the environment or set up a behavior management program or different form of counseling for the client.

- Refer the client to another unit within the agency or another service provider, if indicated. All techniques that are tried should be documented thoroughly.

- The social worker needs to be thorough and careful in a determination to terminate services when the client does not seem to be benefiting from services.

A decision should be made about whether there is a basis for termination according to the Requirements for the Provision of Services by County Departments of Social Services Manual, Section C, Basis for Denial, Modification and/or Termination. The social worker should get the support of their supervisor to terminate the case when all appropriate strategies have been tried and be able to document and explain the reasons for termination.

Placement Manual

XIII. Coordination with Other Service Providers

XIII. Coordination with Other Service Providers

10A NCAC 71C .0108 COORDINATION WITH OTHER SERVICE PROVIDERS
Documentation in the client's case record must include information about other agencies or service providers who are known to be involved with the client. If any of those parties are involved in placement, adjustment, or relocation services with the client, documentation must reflect how these services are being coordinated so as not to duplicate efforts. If the placement social worker in the department of social services is the most appropriate or only source of assistance, and the client meets the criteria in the target population in 10A NCAC 71R .0919, an application must be made in accordance with Requirements for the Provision of Services by County DSS Manual Section II, Application for Social Services.

Social Work Practice Guidelines
When Adult Placement Services are requested, the screening should include information about other involved parties delivering services and, if there are other involved parties the reason the social worker in the county department of social services is the most appropriate source for service delivery. In a domiciliary or nursing home, it should be determined whether licensure or Bill of Rights issues are the primary problem, in which case, the Adult Home Specialist, staff of the Division of Health Services Regulation, or long-term care ombudsman may be a more appropriate source of assistance. In continuing care retirement centers or multi-unit housing, there may be a case manager or housing manager who can arrange for resources. Clients who are involved with area mental health programs may have case managers or social workers in that service system that can provide services. Licensure rules require nursing homes to provide social work services, and each patient's plan of care is to contain a plan for meeting their social needs.

Generally, social workers in nursing homes should be able to provide most social work services that the county Department of Social Services can provide, including adjustment services, referrals for other resources, financial services, and discharge or transfer. However, those rules also allow for referrals to the county Department of Social Services to be made. Similarly, hospital discharge planners normally provide placement services as part of their discharge planning, but licensure and accreditation rules are not specific about how those services should be provided.

Depending on the nature of the problem, and time and resources available, it may be appropriate for the DSS placement social worker to offer consultation to the involved social worker or case manager in another setting who will then provide the direct services. In these situations, a case should not be opened for services.

However, there may also be circumstances in which the placement social worker from the county DSS is the most appropriate source of direct assistance to the client. Examples of this might be when the person is already a client of the DSS, the DSS has

access to information and/or relatives of the client, the DSS social worker has greater access to the needed resources, or the DSS social worker has greater skills or expertise in a particular area than does the other involved party. These situations can be explored on a case-by-case basis. The social worker should determine what services have already been offered or provided by the other involved social worker, case manager or other professional and why the DSS is the most appropriate service provider before becoming directly involved, while being careful to be sure individuals who need assistance are served. Services should not be duplicative.

Another option is to develop formal or informal memoranda with local service providers and agencies who might be involved in the delivery of placement services. The memoranda would reflect a shared understanding of the circumstances under which each agency would become involved in placement services to clients, and how communication and coordination would take place. These memoranda would help to prevent misunderstanding and duplication of efforts among local agencies.

The DSS is also sometimes represented on interagency teams, where cases are staffed, and agencies determine who will take various responsibilities in serving the clients. This is sometimes an efficient way to plan services and service provision and to avoid duplication of efforts by agencies.

Placement Manual

XIV. Coordination with Other Departments of Social Services

XIV. Coordination with Other Departments of Social Services

No applicable Adult Placement Service policy.

Social Work Practice Related to Coordinating with other county Department of Social Services

The Requirements for the Provision of Services by County Departments of Social Services Manual determines which county is responsible for providing public assistance for eligible individuals as well as other social services. Generally, a person has legal residence in the county in which he resides. However, a person who is in a hospital mental institution, nursing home, boarding home, confinement facility or similar institution or facility does not, solely because of that fact, have legal residence in the county in which the institution or facility is located. It is usually presumed that a person in a facility or institution retains legal residence in the county where he lived in a private living arrangement prior to entering a facility.

Consistent with this legal framework, and with guidance found in the Requirements for the Provision of Services by County DSS Manual, the county of legal residence is responsible for providing Adult Placement Services for adults who are residing in facilities and institutions and who need services to help relocate or adjust to their placements. This also includes services to enable these adults to return to more independent living arrangements. Services may be provided directly to these adults by the county of legal residence or may be provided by the county where the adult resides upon agreement by both counties. If the county where the adult resides provides services at the request of the county of legal residence, either the county of legal residence can maintain case responsibility or close the case, whereby the county where the adult resides would open the case and assume responsibility.

Again, this would be decided by mutual agreement of the counties. Should the county where the adult resides assume case responsibility, it is important for information to continue to be coordinated with the appropriate income maintenance staff in the county of legal residence, since the county of legal residence will maintain responsibility for any form of public assistance the adult receives. To determine which county will provide services, the following questions may be helpful:

- Which county can provide the most efficient and effective services to the client?
- Which county, if either, has greater access to the client's family or significant others?
- Does one of the counties have greater access to resources or placement arrangements the client needs?

- What is the client's and family's preference regarding who will provide services?

If the county where the adult resides does not agree to provide services, it will be necessary for the county of legal residence to provide services directly to the client. The county of legal residence may work directly with a client or facility staff in another county without contacting that county DSS. However, it would be courteous for the social worker to advise the county DSS where a placement is being made if there is potential for the client to have adjustment problems which that county may need to address.

Placement Manual

XV. Service Codes

XV. Service Codes

Service Codes and Definitions - Appendix B

For the purposes of statistical and fiscal reporting, all activities provided as a part of Adult Placement Services are to be reported with the code 095. Prior to opening a client for Placement Services, the Adult Services Case Manager must determine the client meets the eligibility criteria for that service and program code(s). This can be documented in case narrative or on the Adult Services Functional Assessment.

095 – Adult Placement Services: Activities necessary to assist aging or disabled individuals and their families or representatives in finding substitute homes or residential health care facilities suitable to their needs when they are unable to remain in their current living situations. Activities include:

- completing an initial screening and assessment while providing counseling to help the individual and their family or representative to determine the need for initial or continued placement.

- assisting in the process for completing necessary financial application and medical evaluations.

- helping to locate and secure placement in a suitable setting and level of care.

- supporting an individual and their family or representative in the individual's transition from one location to another.

- providing counseling and other services to help the individual adjust to the new setting and maintain the placement.

Adult Placement Services also include assisting individuals, when requested, to return to more independent settings in the community, or to relocate in more appropriate settings when new levels of care are needed.

Placement Manual

XVI. Documentation, Record Keeping and Monitoring

XVI. Documentation, Record Keeping and Monitoring

The Adult Services Case Manager must document services and keep records according to the requirements outlined in this section. Specific case management programs may have additional documentation requirements that need to be followed.

A. How Long Records Must Be Kept

The records must be maintained by the DSS according to the guidelines in the DHHS Record Retention Schedule based upon the program code used by the Adult Services Social Worker.

B. What Case Information Must Be Kept

The agency maintains client records that contain:

1. All FL-2's, 5027's, Adult Services Functional Assessments and Adult Services Annual Reassessments (DAAS- 6224 Adult Services Annual Assessment), Service Plans (DAAS-0011 Adult and Family Service Plan), Quarterly Reviews DAAS-6223 Interim or Quarterly Review), IMC/Case Manager communications and case related correspondence;

2. Case management documentation as required in C. below;

3. Other correspondence related to the client.

C. Service Documentation

The minimum service documentation requirements for Case Management are as follows:

1. Case Management Documentation

The agency maintains case narrative by the Adult Services Case Manager that documents client assessment and ongoing case management activities to plan, coordinate and monitor services. The narrative may be electronic or handwritten. Case management notes should include all contacts and activities related to the client's care and services.

2. **Case management documentation should include the following:**
   a. The date of the case management activity

   b. The time (in minutes) involved in the activity either documented in the narrative notes or on the day sheet

   c. A description of the activity

   d. Each entry must contain sufficient detail to support a claim for reimbursement.

Example: If the activity involved a telephone call, the entry must briefly describe the purpose of the call.

e. The Adult Services Case Manager should sign and date narrative that is maintained in hard copy. If the county has a case management system, the narrative should have an electronic signature.

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XVII. Funding Sources for Adult Placement Services

XVII. Funding Sources for Adult Placement Services Division of Social Services

Social Services block Grant (SSBG)--primarily federal funds which may be used to provide Adult Placement Services to any adult determined to be in need of the service.

Placement Manual

XVIII. Appendices

XVIII. Appendices

A. FL- 2/NC DHB

B. Referral Screening Verification Process FAQ (RSVP)

C. Pre-Admission Screening and Annual Residency Review (PASRR)

D. Requirements for the Provision of Services by County Department of Social Services Manual

E. Aged, Blind And Disabled Manual MA 2260

F. NC Medicaid Manual 2300 (Application)

G. NC Medicaid Intermediate Care Facilities for Individuals with ICF/IID

H. NC Medicaid-Nursing Facility Services - Medicaid and Health Choice: Clinical Coverage Policy No: 2B-1, Amended Date: January 10, 2020

I. NC Tracks Prior Approval FAQ

J. 10 NCAC 13 G. 0701 Admission of Residents

K. SA Manual 3100 Eligibility

L. NC Medicaid Division of Health Benefits- Alien Requirements

M. NCGS 131D 2.14 Confidentiality and Chapter 69 Confidentiality and Access to Clients Records

N. Civil Rights Act of 1964

O. ACH Residents' Bill of Rights

P. NCGS 131E 117 Declaration of Patient's Rights

Q. Chapter 32 A - Powers of Attorney

R. NC Advance Directive (Living Will)

S. ACH Domiciliary Community Advisory Committee

T. LTC Ombudsman Program Policies and Procedures Manual

U. Funding Source for Adult Placement Services (MAC)

V. Requirements for the Provision of Services to County Departments of Social Services ..... (SSBG)

W. Adult Care Home Resident Discharge Policy