Home Help Services

Home Help Services (ILS)

ADULT COMMUNITY PLACEMENT (ACP)

WHAT IS HOME HELP SERVICES

- **The Home Help program is administered by the Michigan Department of Health and Human Services (MDHHS). The program provides personal care services to individuals who need hands-on assistance with Activities of Daily Living (ADL's) and assistance with Instrumental Activities (IADL's). MDHHS is responsible for approving Home Help providers for participation in the program.**
- **The Home Help Program provides funding for qualified individuals to hire someone to assist them with their daily activities. It is designed to support individuals who wish to live independently in their home rather than live in an adult foster care home, home for the aged or nursing facility.**
- **You can contact your local DHHS office or view the website at www.michigan.gov/homehelp**

Adult Community Placement

- **DHHS provides personal care supplement payments to the Adult Foster Care homes. A client must have active Medicaid. A review is completed by the client and the worker every 6 months.**

Eligibility/Requirements for Home Help

- To receive Home Help Services, an individual must:
- Have active and qualifying Medicaid
- Certification of medical need by Medicaid enrolled provider/physician
- Hands-on need of in-home care and/or use adaptive equipment
- Need for services, based on a complete comprehensive assessment indicating a functional limitation of level 3 or greater.
  - ASSESSMENT MUST BE COMPLETED BY AN ADULT SERVICES WORKER TO CONDUCT A COMPREHENSIVE ASSESSMENT. THIS ASSESSMENT IS TO DETERMINE WHAT SERVICES ARE NEEDED AND THE AMOUNT OF TIME IT WILL TAKE TO COMPLETE EACH TASK. ONCE APPROVED, A HOME VISIT WILL BE COMPLETED EVERY SIX MONTHS TO MAINTAIN SERVICES.

How to Apply for Home Help Services

- Please call your county Intake number:
- Ingham County- 517-887-9652
- Eaton County- 517-543-0860
- Clinton County- 517-775-8876

- You may also find the required Medical Needs form and Adult Services Home Help Application on-line at: **<u>www.michigan.gov/homehelp</u>**

WHAT HOME HELP SERVICES ARE COVERED

- **Eating**
- **Bathing**
- **Dressing**
- **Grooming**
- **Mobility**
- **Transferring**
- **Toileting**
- **Medications**
- **Light Housework**
- **Laundry**

- ***Shopping***
- **Complex Care**
- **Meal Preparation**

WHAT HOME HELP SERVICES ARE NOT COVERED

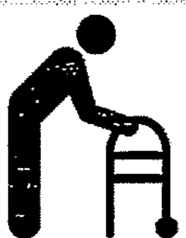
- **Heavy Housework**
- **Transportation**
- **Medical transportation or assistance to office/Dr. visits**
- **Home repairs**
- **Supervision**
- **Yard Work**
- **Prompting or reminding someone to complete a task**

Home Help Services for Hands-On Need of Care

You must qualify for assistance with at least one of these tasks: (ADL'S)

-Mobility -Bathing -Toileting -Transferring

-Eating -Grooming -Dressing



Requirements Before Initial Assessment

Medical Needs Form- must be completed, signed and dated by a medical professional certifying a medical need for personal care services. The medical professional MUST BE an enrolled MEDICAID provider and hold one of the following professional licenses:

- Physician
- Nurse Practitioner
- Occupational Therapist
- Physical Therapist
- Physician's Assistance

Must be signed and dated by client or guardian only

MEDICAL NEEDS
State of Michigan
Department of Human Services

INSTRUCTIONS: To be completed annually by a physician, nurse practitioner, physical or occupation therapist. Please print or type.

Case Name				
Case Number		Recipient ID Number		
Patient's Name				Patient's Birth Date
County	District	Section	Unit	Specialist
Specialist		Specialist Phone Number ( )		

Medical Provider:
We would appreciate your cooperation in completing the spaces checked below. In addition to a physician, Box A may be completed by a physician's assistant, certified nurse-midwife, ob-gyn nurse practitioner or ob-gyn clinical nurse specialist. Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Department of Human Services.

Patient's or Representative's Signature	Patient's Name	Signature Date
Authorized Specialist's Signature	Signature Date	Local DHS Office

- ☐ A — Pregnancy Delivery (Expected) Date | Number of medically verified unborn children
- ☐ B — Diagnosis(es) / Treatment plan for this patient
- ☐ C — Chronic ongoing illness ▶ ☐ YES ☐ NO
- ☐ D — Estimated number of office or clinic visits ______ times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify) | Will this change? ☐ YES, When ______ (Date) ☐ NO
- ☐ E — Give estimated number of months for the diagnosis in B that medical treatment will be required ☐ Lifetime
- ☐ F — Is the patient non-ambulatory? ☐ YES ☐ NO | If Yes, explain:
- ☐ G — Does patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ YES ☐ NO ▶
- ☐ H — Does someone need to accompany the patient to the medical appointment? ☐ YES ☐ NO ▶ | If yes, who / why?
- ☐ I — Do you certify the patient has a medical need for assistance with any of the personal care activities listed below? ▶ ☐ YES ☐ NO
  - Eating, Toileting, Bathing, Grooming, Dressing, Transferring, Mobility, Taking Medications, Meal Preparation, Shopping, Laundry, Housework
  - Check any complex care services needed: ☐ Specialized Feeding ☐ Catheters or Leg Bags ☐ Colostomy Care ☐ Bowel Program ☐ Suctioning ☐ Bedsore Prevention ☐ Range of Motion ☐ Other ______
- ☐ J — Can patient work at usual occupation? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long):
  - Can Patient work at any job? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long):
- ☐ K — Other (Explain)
- ☐ L — Is the spouse or parent of the above disabled individual? ☐ Yes ☐ No (Needed in the home to provide care) ☐ Yes ☐ No (Cannot engage in work due to the extent of care required.)

Date patient was last seen	Are you a Medicaid enrolled provider? ☐ YES ☐ NO	
Name and title (Print or type)	MA enrolled Provider Signature	
National Provider Identifier (NPI) Number	Signature Date	Telephone Number

AUTHORITY: Federal 45 CFR of 233.20, CFR 440.10 and CFR 440.20
COMPLETION: Voluntary
PENALTY: Benefits may be affected.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Requirements Before Initial Assessment

Home Help Application- must be signed by client or guardian only

TWO return envelopes will be provided to have both forms mailed back to DHHS once completed.

ADULT SERVICES APPLICATION
Michigan Department of Human Services

FOR DEPARTMENTAL USE ONLY

1. Case Name					
2. Case Number				3. Recipient	3. Number
4. County	District	Section	Unit	Specialist	Date

NOTE: If you need help to complete this application please indicate what kind of help you need.

☒ Bi-Lingual Interpreter ☐ Sign-language interpreter for the deaf
☐ Other (Specify):

5. Your Full Name (of person needing or requesting services)	6. Date of Birth (mm/dd/yyyy)	7. Social Security Number
8. Your address (No., Street, City, State, Zip Code)	9. Telephone Number	10. TTD No. (teletype for the deaf)

SECTION A. DEPARTMENT PROGRAMS. Below is a brief description of the services provided by the Department.
Instructions: Check the box or boxes which describe the services you need or problems where you desire help.

1. ☐ Services to help adults stay in their own homes. Include such things as help in finding or using health and housing resources, referral to other services in the community (such as a senior citizen center) and counseling for a personal or health problem.
2. ☐ Services to help in paying for someone to assist with personal care and housekeeping services.
3. ☐ Services for adults who can no longer remain in their own homes. Includes help in finding an adult foster home, home for the aged, or nursing home and services for people living there.
4. ☐ Services for adults who are in danger and who need protection.
5. ☐ Other services: If none of the above descriptions seem to fit your situation, please state here what you need.

SECTION B. CURRENT SITUATION: Instructions: X the boxes which apply to you.

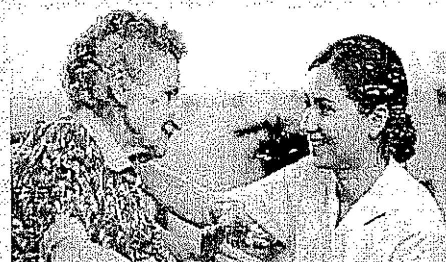
1. Your Status as a Recipient
   - a. ☐ Medicaid (MA) recipient
   - b. ☐ Supplemental Security Income (SSI) recipient
   - c. ☐ Financial Independence Program (FIP recipient)
   - d. ☐ Applied for SSI but did not meet income requirements
   - e. ☐ Food Assistance recipient
   - f. ☐ State Disability Assistance (SDA) recipient
   - g. ☐ State Family Assistance (SFA) recipient
   - h. ☐ Member of migrant family
   - i. ☐ Other

FOR DEPARTMENTAL USE ONLY — How recipient status is verified

2. Living Arrangement (Mark X in the proper boxes, and answer related questions)
   - a. ☐ Alone
   - b. ☐ With spouse Is spouse disabled? ☐ Yes ☐ No
   - c. ☐ With children under age 18. How many?
   - d. ☐ With others (relatives and non-relatives) How many?
   - e. ☐ Live in adult foster care facility, home for the aged, or nursing home.

Initial Home Visit Assessment and Reviews

- An initial home assessment visit must be conducted in the client's residence. If the client has a guardian, the Guardian must be present or available by phone.
- Medications will be reviewed at the initial visit and every 6 months for review visits.
- Home visit assessments must be completed every 6 months with the client in the home. Contact with the provider is also required every 6 months, however, one in-person contact is required per year. The other 6 month contact can be made by phone.
- If there is a change in Home Help Care, the client or guardian must contact the case worker to schedule a new home visit review to determine if there is a change in home help care.



Home Help Service Providers

The Recipient/Client of the Home Help program is responsible in hiring a provider and/or agency of their choice. The recipient/client is the employer, not DHHS. Providers must be 18 years old and pass a criminal history background check. A provider can be a relative, friend or neighbor.

Assistance with Individual Provider Enrollment into CHAMPS

- **ASSISTANCE IS ONLY FOR INDIVIDUAL PROVIDERS NOT AGENCY PROVIDERS**

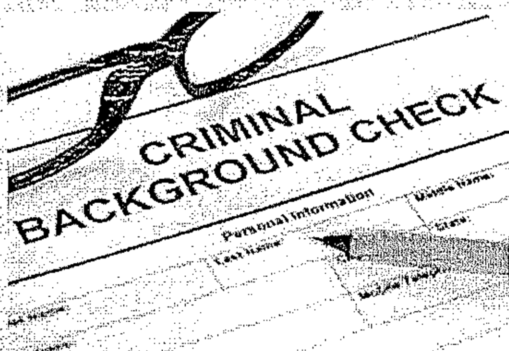
- CHAMPS- Community Health Automated Medicaid Processing System (for documentation of provided home help care/time and tasks)
- Ingham County offers enrollment assistance during the following:
- Wednesdays from 10:00 a.m. to 12:00 p.m.
- Please visit DHHS at 5303 S. Cedar Street, Lansing, MI
- Come through Building 4 in front
- Please sign in on the sheet for "provider enrollment"
- Please fill out form for enrollment

Assistance with Individual Provider Enrollment Into CHAMPS

- The provider will be called back into a room, individually, to be assisted with enrollment into the CHAMPS program by an Adult Services Worker
- Please have photo identification and social security card available during this time
- You can also call the Provider Hotline at 1-800-979-4662 for on-line assistance.

Provider Selection

- A criminal background check must be completed before the provider's start date of employment for each client.



Provider Criteria

- The provider must have the ability to meet the following minimum criteria:
- Ability:
  - Able to follow instructions and Home Help program procedures
  - Able to perform the services required
- Personal Qualities:
  - Dependable
  - Approach tasks as a job
  - Adhere to agree upon schedule
  - Protect confidentiality of case/client information

Employment Process

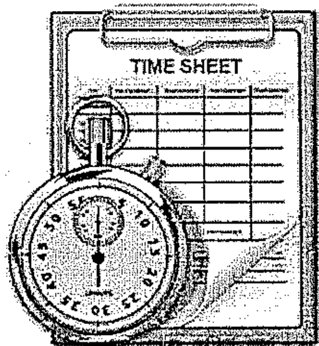
- Providers must complete a new provider enrollment on the CHAMPS system and receive criminal background clearance prior to beginning work for each client.
- At each case opening, the provider must meet with the Adult Services Worker and complete a 4676 Statement of Employment and present picture ID.
- Sub-Contracting: NO SUB-CONTRACTING ALLOWED. Payments must be issued to the person performing the work.
- For further questions, contact the Adult Services Worker assigned to the client whom you are performing care.

Provider Requirements

- The provider is employed by the client, NOT the Department of Health and Human Services or the Department of Community Health.
- A provider who receives public assistance must report all income received from the Home Help Program wherever applicable, i.e., DHHS FAP/Medicaid Caseworker.
- The client and provider are responsible for notifying the Adult Services Worker of any change in provider or hours of care before the end of the month the change occurs, i.e. hospitalization, physical therapy out of the home, vacation, respite care. Failure to do so may result in a payment recoupment.

Provider Requirements

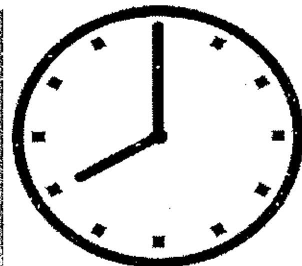
- The provider must complete electronic service verification (ESV) of services provided in the CHAMPS system and submit it on a monthly basis. ESV verifies completed home help work and must be submitted after the last day of the month. Payments will be suspended or stopped if the ESV is not submitted timely.



Provider Requirements

- After the care needs assessment is completed, the Adult Services Worker will inform the provider and client what tasks are approved.
- A time and task schedule will be drafted including the frequency, amount and type of services that are approved. This must be reviewed with provider before care can begin.

TIME FRAME FOR PENDING HOME HELP ASSESSMENT



- THE DATE OF WHEN THE HOME HELP REFERRAL IS MADE, A MEDICAL NEEDS FORM AND APPLICATION WILL BE MAILED TO CLIENT'S HOME.
- THE CLIENT HAS 21 DAYS, FROM THE REFERRAL DATE, TO HAVE THE FORMS COMPLETED AND SENT BACK TO CASEWORKER TO SCHEDULE INITIAL HOME VISIT.
- COMMUNICATION IS IMPORTANT. IF YOU ARE UNABLE TO HAVE THE FORMS COMPLETED BY DEADLINE DATE, PLEASE CONTACT YOUR ASSIGNED CASEWORKER. ADULT HOME HELP WILL WORK WITH YOU.
- IF YOUR CASE IS DENIED, YOU MAY RE-APPLY BY CALLING YOUR COUNTY INTAKE NUMBER.