Sec. 17b-342-1. Connecticut home care program for elders; standards for access agencies and requirements for assisted living service agencies

(a) **Scope**

The purpose of sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies is to describe non-financial program requirements, services available and limitations under the Connecticut Home Care Program for Elders. This program provides home health services, community based services and assisted living services funded under a waiver to the Medicaid program and under a program funded with an appropriation by the General Assembly. The financial eligibility requirements for these three parts of the program differ and are specified under sections 2540.92 and 8040 to 8040.50, inclusive, of the Uniform Policy Manual of the Department of Social Services. This program includes all clients transferred from the following programs as of July 1, 1992: Promotion of Independent Living for the Elderly, Department on Aging Home Care Demonstration Project and Long Term Care Preadmission Screening and Community Based Services Program. Sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies also establish standards and requirements for access agencies and assisted living service agencies which operate under the Connecticut Home Care Program for Elders and the Connecticut Partnership for Long Term-Care.

(b) **Definitions**

As used in sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies the following definitions apply:

(1) “Access Agency” means an organization which assists individuals in receiving home and community based services by conducting assessments and developing plans of care tailored to the needs of the individuals and making arrangements with service providers. If needed by the individuals the access agency shall also coordinate services and monitor the quality of the services over an extended period, but the access agency shall not be a provider of services, other than to provide care management to department clients that are approved for program participation. An access agency shall have a governing body which assumes all financial and programmatic responsibility for the agency’s activities and shall meet the requirements pursuant to section 17b-342-1(h) of the Regulations of Connecticut State Agencies and the provisions set forth in a legal contractual provider agreement;

(2) “Applicant” means an elderly person who directly or through any representative, including but not limited to, a guardian, conservator, family member, physician, social worker or discharge planner completes a Home Care Request Form and submits it to the department or indicates to the department a desire to be considered for services under the Connecticut Home Care Program;

(3) “Assisted Living Services Agency” or “ALSA” means an agency authorized to provide and arrange for the delivery of assisted living services to clients. The participating ALSA shall be licensed with the Department of Public Health and shall enter into a contract with a managed residential care facility that has been approved for participation and be an enrolled service provider with the Department of Social Services. The ALSA shall comply with the standards and requirements in section 19-13-D105 of the Regulations of Connecticut State Agencies;

(4) “Assisted living services” means a special combination of housing, supportive

services, personalized assistance and health care designed to respond to the individual needs of clients who need help with activities of daily living and instrumental activities of daily living in managed residential care facilities approved for participation. Services are delivered in a service package model within a specific service cost package level;

(5) "Assessment" means a comprehensive written evaluation of an individual's medical, psychosocial and economic status, degree of functional impairment and related service needs. For the purposes of the Connecticut Home Care Program, this assessment shall include a face-to-face interview and shall utilize a standard assessment tool approved by the department;

(6) "Average nursing facility cost" means a weighted average calculated by multiplying the nursing facility Medicaid rates in effect on July 1 of that calendar year for each facility by their respective number of days, adding the products and then dividing that total by the total patient days, and reducing the result by the average applied income for nursing facility patients. This figure shall be used when calculating the cost limits for fee-for-service;

(7) "Client" means a person who has met the requirements for eligibility and enrolled as an active participant in the program;

(8) "Commissioner" means the Commissioner of Social Services or his or her designee;

(9) "Community based services" includes but is not limited to care management, adult day services, assisted living services, chore services, companion services, elderly foster care, home delivered meals, homemaker services, laundry services, mental health counseling, minor home modification services, respite care, transportation and personal emergency response systems;

(10) "Connecticut Home Care Program" or "the Program" means the program operated for elders pursuant to section 17b-342 of the Connecticut General Statutes. This program was formerly known as the Long Term Care Facility Preadmission Screening and Community Based Services Program and includes all home care clients who were transferred from the former Department on Aging and the department's Fairfield pilot program clients;

(11) "Cost of home care services" means the total amount of direct costs in state administered public funds expended to provide the home health and community based services set forth in sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies;

(12) "Day" means calendar day;

(13) "Department" or "DSS" means the Department of Social Services, its employees and agents;

(14) "Elder" or "elderly person" means an individual 65 years of age or older and a resident in the State of Connecticut;

(15) "Emergency admission" means that an individual has been determined by the department to be in need of protective services and is referred to a nursing facility for admission by an appropriate state agency pursuant to the provisions of section 17b-450 to 17b-460,inclusive, of the Connecticut General Statutes. This does not include nursing home placements from the community in which the family desires to make the placement as soon as possible because of an applicant's deteriorating health condition;

(16) "Fee-for-service" means a service delivery system which a cost-and-payment

methodology is used for services rendered to care-managed and self-directed clients who receive benefits under the Medicaid waiver or state- funded portions of the program, except those services rendered to clients participating in the assisted living services component of the program;

(17) “Health care professional” means a Connecticut licensed physician, Connect-icut licensed nurse, social worker or hospital discharge planning personnel;

(18) “Health screen form” means a department form used to determine whether an individual is at risk of institutionalization and if the individual meets the functional criteria for the program. This form includes information regarding the person’s physical (functional and medical) and psycho-social status;

(19) “Home care request form” means a department form used to indicate if an applicant appears to be financially eligible and wishes to apply for the Connecticut Home Care Program;

(20) “Home care services” means any combination of community based services and home health services as defined in sections 17b-342-1(b)(9) and (21) of the Regulations of the State Agencies which enable elders to live in noninstitutional settings. Such services may be provided to elders living in private homes, congregate housing, assisted living demonstration project facilities, housing and urban development facilities, private facilities and homes for the aged and other community living situations as long as the services needed are not considered a regular component of the services of the community living situation;

(21) “Home health services” for the purposes of the Connecticut Home Care Program means those medical procedures included in the definition of home health services under the Medicaid program. Home health services provided under the Connecticut Home Care Program shall be defined in the same way and covered to the same extent as they are under the Medicaid program;

(22) “Hospital” means a general short term or chronic disease hospital licensed by the Department of Public Health pursuant to section 19a-490(b) of the Connecticut General Statutes;

(23) “Medicaid recipient” means an individual who has been determined eligible for Medicaid benefits;

(24) “Nursing facility” means a facility licensed by the Department of Public Health pursuant to section 19a-490(c) of the Connecticut General Statutes as a chronic and convalescent nursing home or rest home with nursing supervision and certified to participate in the Medicaid program as a nursing facility as evidenced by a Medicaid provider agreement between the department and the facility. For purposes of this section, the term “nursing facility” does not include an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or any other residential or inpatient health care facility;

(25) “Person” means an individual applicant or elder client enrolled in the Connecticut Home Care Program and a representative authorized to act on the applicant or client’s behalf including guardians, conservators or other legally authorized representatives;

(26) “Plan of care” means a written individualized plan of home care services which specifies the type and frequency of all services and funding sources required to maintain the individual in the community, the names of the service providers and the cost of services, regardless of whether or not there is an actual charge for the service. The plan of care shall

include any in-kind services and any services paid for by the client or the client's representative;

(27) "Re-evaluation" means a review of the functional and financial status of an applicant or client for the purpose of establishing functional and financial eligibility and determination of needs for consideration for program participation;

(28) "Related party" means an entity which is associated with another by common ownership or control. Control of or by another entity exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider or organization serving the provider;

(29) "Relative" means spouse, natural parent, child, sibling, adoptive child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, grandparent and grandchild;

(30) "Risk of institutionalization" means that the individual is in danger of hospitalization or nursing facility placement due to his or her medical, functional or cognitive status but would be able to remain at home, without the creation of an unacceptable risk to the safety of the individual or others, if home care services were provided. This definition includes individuals who are currently institutionalized and who are at risk of continued institutionalization unless home care services are provided;

(31) "Self-directed care" means the ability of the client to be responsible for the self-direction, coordination and arrangement of his or her plan of care under the fee-for-service delivery option of the program;

(32) "Standard assessment tool" means a department form used to conduct an initial assessment and re-evaluation of applicants and clients for the purpose of establishing functional eligibility and determination of needs for consideration for program participation;

(33) "Status review" means a review of the functional and cognitive status of a client enrolled in the program based on a face-to-face interview in order to reevaluate the plan of care and program participation when the individual is not receiving ongoing monitoring by an access agency or services through any program component;

(34) "State administered public funds" means direct payments of state or federal funds allocated by a state agency to an individual or to an agency to pay for medical or social services required to be provided under an individual's plan of care;

(35) "Unacceptable risk" means a situation which places an individual's life or health in immediate jeopardy. In determining whether an unacceptable risk exists, the department shall take into account the provider's professional standards, the client's needs and the client's informed viewpoint with regard to the potential risk;

(36) "Waiting list" means a record maintained by the department for the Connecticut Home Care Program that includes the names of the applicants seeking to be screened for program participation and specifies the date the contact was made. The department may maintain separate waiting lists, regional or statewide, depending on the program component and type of service.

(c) **General**

(1) The purposes of the Connecticut Home Care Program are to:

(A) Assess whether cost-effective home care services can be offered to elders who are at risk of institutionalization;

(B) determine, prior to admission to a nursing facility whether the elder does or does not need nursing facility services;

(C) authorize department payment for elders for nursing facility care or home care services if appropriate; and

(D) provide a full range of community based services, home care services and assisted living services to eligible individuals who choose to remain in the community, if such services are appropriate, available and cost effective.

(2) The program application process shall consist of:

(A) A financial eligibility determination in accordance with section 17b-10-1 of the Regulations of Connecticut State Agencies and the department's Uniform Policy Manual sections 8040 and 2540.

(B) an initial determination as to the elder's needs, which shall include the category of services needed, the elder's functional eligibility and potential service options under the program. The initial determination shall be conducted by department staff based on completion or review of the health screen form.

(i) As a result of a review of the health screen form, the department shall determine:

(aa) Whether the elderly person meets the functional level for admission to the program;

(bb) whether the elderly person needs care that would otherwise be provided in a nursing facility;

(cc) which program component and category of services may be appropriate and authorized for the person in the community;

(dd) whether an initial assessment is deemed appropriate. The assessment shall be conducted only after the elder or the elder's representative gives written consent. The assessment shall include, but not be limited to: Explaining Program participation to the elder or the elder's representative; explaining client's rights and responsibilities; explaining the state's recovery policy; confirming client's functional eligibility and financial information; determining if the elder can be offered a cost-effective plan of care to enable the elder to remain in the community without creating an unacceptable risk to the elder or others;

(ee) whether the elderly person should be admitted to a nursing facility without an assessment; and

(ff) whether the elderly person requires assistance in the completion of the financial application or other assistance to establish program eligibility and participation. This does not relinquish the elderly person's responsibility to comply with all program requirements necessary to determine eligibility and program participation.

(ii) Initial determination as to the elder's needs, the category of services and functional level based on the health screen form shall be valid for sixty (60) days unless the department receives information which indicates that a person's condition has changed significantly.

(iii) The health screen form shall also be used to verify recommendations for short term placement. For purposes of this section, a short term placement means a maximum stay of ninety (90) days for rehabilitative or recuperative care which is expected to result in the person's return to the community.

(C) a referral to other sources of assistance, including authorization for admission to a nursing facility without an assessment, if appropriate.

(D) The department shall send a screening outcome letter to the applicant to provide notice of the initial functional and financial screening determination issued and to advise the applicant of their rights.

(3) Determination of Need

(A) The determination as to whether the elder is at risk of institutionalization or needs services that would otherwise require institutionalization shall be made by the department based upon an evaluation of the completed health screen and an assessment, if deemed appropriate.

(B) The basis for determining the level, type, frequency and cost of services and funding source that an elder may receive under the program shall be determined by their financial and functional eligibility and need for services.

(C) Functional eligibility means the elder must be at risk of institutionalization and needs assistance with at least one critical need. For the purposes of eligibility, critical needs are defined as "activities of daily living" which are hands-on-activities or tasks that are essential for a client's health and safety. These include, but are not limited to; bathing, dressing, transferring, toileting (bowel or bladder), feeding, meal preparation, administration of medication or ambulation.

(4) Category types

The following three category types define the funding sources which pay for the client's community based services and home health services. The category types apply to care managed cases, self directed cases and the assisted living service program component.

(A) Category Type 1:

This category applies to elders who are at risk of institutionalization but who might not immediately enter a hospital or nursing facility in the absence of the program. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in section 17b-10-1 of the Regulations of Connecticut State Agencies and the department's Uniform Policy Manual section 8040. Some clients under Category Type 1 may be Medicaid recipients because they do not meet the functional criteria for the Medicaid waiver portion of the program.

(B) Category Type 2:

This category applies to elders who would otherwise require admission to a nursing facility on a short or long term basis. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in the department's Uniform Policy Manual section 8040.

(C) Category Type 3:

This category applies to elders who, but for the provision of home care services, would require nursing facility care funded by Medicaid. This category type is available to elders who meet the financial and functional eligibility criteria for Medicaid under the federal waiver as defined in the department's Uniform Policy Manual section 2540.92.

(D) The program category type identifies the maximum funding level available for all program clients. The access agencies, department staff and assisted living service agencies shall specify the category type on the client's plan of care in the funding source section.

(5) The determination of services for the program's fee-for-service and assisted living services option consists of:

(A) Completion of an initial assessment by the access agency or the department;

(B) a determination if program participation is feasible;

(C) a determination of what service options under the program are appropriate;

(D) development of a plan of care for care managed cases by the access agency or the department. For clients participating in the assisted living service option, the assisted living service agency shall develop the plan of care;

(E) a determination as to the feasibility and cost-effectiveness of home care services, if deemed appropriate; and

(F) authorization for community based services and home health services in the community.

(d) **Initial Assessment and Plan of Care**

(1) A person who is determined by the department to appear to meet the financial and functional eligibility criteria of the Connecticut Home Care Program shall be referred by the department to an access agency or the department's staff for an initial assessment as defined in section 17b-342-1 (b)(5) of the Regulations of Connecticut State Agencies. The results of the initial assessment shall be used to:

(A) Determine or verify the following:

(i) Whether program participation is feasible;

(ii) whether the elderly person's financial information;

(iii) whether the elderly person's functional eligibility;

(iv) whether the assisted living services option is appropriate; if appropriate the access agency, department staff or department designee will complete an initial assessment and forward the paperwork to the department for review and processing;

(v) whether the fee–for-service option is appropriate; if appropriate, verify the elderly person's category of services for fee-for-service;

(vi) the individualized plan of care based on the cost limits for care-managed or self-directed care cases under fee-for-service; and

(vii) if the elder resides in an assisted living facility, develop an individualized plan of care based on the service package levels under the program's assisted living services option; and

(B) develop an individual plan of care. The access agencies, department, assisted living service agencies or department designee, when developing a plan of care, shall verify the elderly person's category type, category of services, level of service and financial information according to the following provisions:

(i) Determine the feasibility and cost-effectiveness of meeting the elderly person's care needs with home care services, pursuant to section 17b-342-3(b) of the Regulations of Connecticut State Agencies;

(ii) include a thorough exploration of all available services and funding resources;

(iii) establish an appropriate service delivery mix and arrangement which is non-duplicative and not overlapping (i.e. two similar services being provided at the same time);

(iv) clients shall only receive home care services through one of the following program service options: Fee-for-service (care-managed or self-directed) or assisted living services,

if appropriate; and

(v) applicants or clients shall receive home care services through only one department program or state agency.

(2) Such person shall be given the opportunity to participate, to the extent possible, in the development of his or her plan of care.

(3) When carrying out its responsibilities for the initial assessment and development of the plan of care under the Connecticut Home Care Program, the department, the access agency, department staff or department designee may collaborate with other health care professionals providing services to the person to avoid the duplication of services. The access agencies, assisted living service agencies, department staff or department designee may, to the extent permitted by section 17b-342 of the Connecticut General Statutes, involve other service providers in the completion of the assessment and care plan development.

(4) Written notice of the outcome of the assessment shall be provided to the applicant and to hospital discharge planning personnel in the case of hospitalized patients. The applicant shall also be notified of appeal rights and procedures, in accordance with the department's Uniform Policy Manual sections 8040 and 1570.

(5) If the person refuses to participate in the assessment, or does not agree to accept a plan of care approved by the department, services shall not be available under the Connecticut Home Care Program.

(6) If the department determines that a plan of care is feasible and cost-effective under the program, the elderly person may remain in the community with assistance provided under the Connecticut Home Care Program. If home care is desired, the plan of care shall be authorized by the department.

(7) For the Connecticut Home Care Program, all home care services shall be included as part of a written plan of care developed initially and updated regularly by the access agency, the assisted living service agency, department staff or department designee. The plan of care shall specify the start date of services, services to be provided, category type of services, frequency, cost, funding source and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person's needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement. For any services where the client would be at risk if the schedule of the service varied, a back-up plan shall be identified in the total plan of care. Services not included as part of the approved plan of care or not covered by sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies are not eligible for reimbursement from the Connecticut Home Care Program.

(8) The client's individualized plan of care must be signed by the client or the client's representative and the access agency staff, assisted living agency staff, department staff or department designee.

(9) Services that shall be covered by another payer, including but not limited to, any covered services through Medicare, private insurance or long-term care insurance, shall be included in the plan of care.

(10) In-kind services performed by family members, volunteer groups, community action agencies or any other person or entity shall be included as part of the client's plan of care.

(e) **Status Reviews**

(1) Status reviews shall be provided for clients enrolled in the program in order to re-evaluate the client's status and the plan of care. Status reviews may be conducted by the access agencies, assisted living service agencies (only when authorized by the department), department staff, department designee or agencies which provide home health services or adult day health services as described in sections 17b-342-2(b) and (h) of the Regulations of Connecticut State Agencies. The staff who conduct the status reviews shall be either registered nurses or social services workers who meet the requirements pursuant to subsections (h)(1)(A) and (B)of this section.

(2) For each client there shall be no more than one agency at any time, designated by the department, which shall be responsible for status reviews. When care management services by an access agency have been temporarily interrupted due to an institutional stay, a status review may be conducted by the access agency, department staff or department designee. When ongoing care management services have been suspended, the department shall determine in advance which agency may conduct any necessary status reviews taking into consideration the needs and preferences of the client, if deemed feasible and allowed under the program.

(3) Status reviews shall be provided only when care management services by the access agency are not authorized, when deemed appropriate by the department and are limited to the following situations:

(A) No more than one time during a hospital stay which is less than or equal to 45 days;

(B) No more than one time during a nursing facility stay which is less than or equal to 45 days;

(C) No more than one time every twelve months for annual reassessment of a person not receiving care management from an access agency; and

(D) In other circumstances, when there is prior authorization by the department, such as when an elder is being reevaluated to consider having the care management from the access agency, department staff, or department designee reinstated after a lapse of more than two months in this service or when an elder is being reevaluated by the access agency, department staff or department's designee for reinstatement of program services following a nursing facility or hospital stay of more than 45 days.

(f) **Forms**

(1) The department shall promulgate a uniform assessment tool and all required program-related forms, including a home care request form, financial application form, a health screen form and client notices.

(2) Program information and forms shall be distributed by the department to all nursing facilities and hospitals in the State and to other providers that have contact with the elderly. Other providers may receive program information and forms upon request.

(g) **Information Submission**

Persons seeking home care services may initiate a screening for program participation by submitting a Home Care Request Form or by calling the department. Individuals or client representatives are responsible for assuring that all information necessary for determining eligibility including,but not be limited to, completing and submitting a program financial application and providing any required verifications, is submitted on their behalf to the

department. Authorization for home care services shall not be granted, nor a plan of care implemented, until complete information has been provided and a financial and functional eligibility determination has been issued by the department. Failure to provide required information and non-cooperation with any of the program requirements shall be grounds for denial or discontinuance from the Connecticut Home Care Program.

(h) **Requirements of an access agency**

(1) An access agency shall ensure the selection of qualified staff.

(A) The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

(B) Care managers shall have the following additional qualifications:

(i) Demonstrated interviewing skills which include the professional judgment to probe as necessary uncover underlying concerns of the applicant;

(ii) demonstrated ability to establish and empathic relationships;

(iii) experience in conducting social and health assessments;

(iv) knowledge of human behavior, family/caregiver dynamics, human development and disabilities;

(v) awareness of community resources and services;

(vi) the ability to understand and apply complex service reimbursement issues; and

(vii) the ability to evaluate, negotiate and plan for the costs of care options.

(C) Care management supervisors shall meet all the qualifications of a care manager plus have demonstrated supervisory ability, and at least one year of specific experience in conducting assessments, developing care plans and monitoring home and community based services.

(2) An access agency shall ensure that care managers are appropriately trained and supervised.

(A) An access agency shall provide or arrange for orientation and initial and ongoing training for care managers and care management supervisors, including training in the use of the assessment tool, required program forms, program requirements and in all aspects of program operation.

(B) An access agency shall provide or arrange for appropriate supervision and clinical consultation for care managers. For care managers with a social service background, the access agency shall have nursing staff available for consultation during normal business hours; for care managers with a nursing background, the access agency shall have a social services staff available for consultation during normal business hours.

(3) An access agency shall have the following additional responsibilities:

(A) Establish working relationships with existing service providers and provide community education regarding the care management role;

(B) Establish a quality assurance process subject to approval by the department or the Office of Policy and Management, which includes at a minimum review of client records

(without client identifiers) by professionals not employed by the agency and annual evaluation of client satisfaction;

(C) Maintain client records and administrative records to support agency activities and data collection activities;

(D) Under the Connecticut Home Care Program, subcontract with vendors to provide services needed in the plan of care;

(E) Under the Connecticut Home Care Program, submit claims through the department's claims processing agent; and

(F) Under the Connecticut Home Care Program, reimburse subcontractors when appropriate.

(4) An access agency shall establish a written client bill of rights and responsibilities to be provided to the client or the client's representative at the time of admission to the program. At a minimum, the bill of rights shall state that the clients have the following rights:

(A) To be treated as an adult with respect and dignity;

(B) to be fully informed about all services, charges and choices available through the access agency;

(C) to participate in and have control over the plan of care to the greatest extent possible;

(D) to be treated fairly by the department regardless of client's race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, physical disability, learning disability or source of payment;

(E) to have any problems or questions addressed and resolved in a timely manner;

(F) to have all personal, financial and medical information treated in a confidential manner and released only as necessary to authorized persons;

(G) to choose among all qualified and available service providers;

(H) to file a grievance with the access agency or the department without fear of discrimination or reprisal; and

(I) to achieve maximum self-direction and choice in lifestyle as long as this does not create an unacceptable risk.

(5) All access agency offices serving participants in the Connecticut Home Care Program shall be located within the State of Connecticut and be accessible to the public.

(6) The access agency shall have a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24-hour basis.

(7) The access agency shall establish a grievance procedure for home care clients who are aggrieved by adverse decisions of the access agency. The procedure shall specify that a decision shall be made by the access agency within 15 calendar days after a grievance is received from a client and sooner in the case of an emergency. The procedure shall also outline steps for requesting a fair hearing by the department or other funding source in the event that the issue is not resolved within the access agency.

(8) The access agency shall have the capacity to provide or arrange necessary services for individuals who are non-English speaking, hearing impaired or who have other special needs.

(i) **Requirements of an Assisted Living Service Agency.**

(1) The ALSA shall ensure the selection of qualified staff and comply with the requirements set forth in section 19-13-D105 of the Regulations of Connecticut State Agencies.

(A) The ALSA staff shall be employed by a licensed assisted living service agency. The staff shall be responsible for annual re-evaluation, development of plans of care, arrangement and delivery of core services, oversight of the delivery of core services and shall provide ongoing monitoring of clients.

(B) The ALSA staff that provide direct client services shall have additional qualifications as specified in section 17b-342-1(h)(1)(B)(i) to (vii) of the Regulations of Connecticut State Agencies.

(2) The ALSA shall ensure that all staff are appropriately trained and supervised.

(A) The ALSA shall provide or arrange for orientation and ongoing training for staff in all applicable department requirements, including training in the use of the assessment tool.

(B) The ALSA shall provide or arrange for appropriate supervision and clinical consultation for staff during normal business hours and after hours if needed to respond to client emergencies.

(3) The ALSA shall have additional responsibilities as specified in subsection 17b-342-1(h)(3)of the Regulations of Connecticut State Agencies.

(4) The ALSA shall provide required reports to the department, including but not limited to, reports on specific data collection. Reports shall be submitted to the department no later than the fifteenth day of every month. The reports shall include data from the preceding month.

(5) The ALSA shall establish a written bill of client rights and responsibilities, which shall be provided to each person at the time of admission to the program as specified in section 17b-342-1(h)(4)of the Regulations of Connecticut State Agencies.

(6) All ALSAs serving participants in the Connecticut Home Care Program shall be located within the State of Connecticut and be accessible to the public.

(7) The ALSA shall have a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24 hour basis.

(8) The ALSA shall establish a grievance and appeal procedure for clients who are aggrieved by adverse decisions of the ALSA. The procedure shall specify that a decision shall be made by the ALSA within 15 calendar days after a grievance is received from a client and sooner in the case of an emergency. The procedure shall also outline steps for requesting a fair hearing by the department or other funding source in the event that the issue is not resolved within the ALSA.

(9) The ALSA shall have the capacity to provide or arrange necessary services for individuals who are non-English speaking, hearing impaired or who have other special needs.

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