

# Information Memorandum Transmittal Aging and People with Disabilities



Jane-ellen Weidanz

***Authorized signature***

**Number:** APD-IM-22-007

**Issue date:** 1/26/2022

**Topic:** Long Term Care

**Due date:**

**Subject:** AFH Hospital Discharge Incentive Payment

**Applies to (check all that apply):**

- |                                                                         |                                                                                          |
|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> All DHS employees                              | <input checked="" type="checkbox"/> County Mental Health Directors                       |
| <input checked="" type="checkbox"/> Area Agencies on Aging: Type B      | <input type="checkbox"/> Health Services                                                 |
| <input checked="" type="checkbox"/> Aging and People with Disabilities  | <input checked="" type="checkbox"/> Office of Developmental Disabilities Services (ODDS) |
| <input type="checkbox"/> Self Sufficiency Programs                      | <input type="checkbox"/> ODDS Children's Intensive In Home Services                      |
| <input checked="" type="checkbox"/> County DD program managers          | <input type="checkbox"/> Stabilization and Crisis Unit (SACU)                            |
| <input checked="" type="checkbox"/> Support Service Brokerage Directors | <input type="checkbox"/> Other ( <i>please specify</i> ):                                |
| <input type="checkbox"/> ODDS Children's Residential Services           |                                                                                          |
| <input type="checkbox"/> Child Welfare Programs                         |                                                                                          |

**Message:** Due to the ongoing hospital capacity concerns, ODHS and OHA have entered into a letter of agreement with SEIU, representing Adult Foster Homes, to provide an incentive of \$10,000 to those that admit individuals directly from hospitals. This is available to AFHs licensed through APD, Office of Developmental Disabilities Services, the Oregon Health Authority and Multnomah County.

For each new direct-from-hospital-admission (excluding boarders and emergency department), an AFH will receive \$3,500 ten days after admission and \$6,500 after the individual has been in the AFH for 90 days. These payments are independent of the rate and independent of payer source including Medicaid, PACE, private pay and other providers. The individual must be admitted between 1/20/2022 and 3/31/2022.

AFHs will not receive the incentive payment if the individual is being readmitted or if the AFH begins involuntary discharge procedures within 90 days of admission. AFHs with restrictions on admission are not eligible for the incentive payment. AFHs must still screen to ensure they can meet the needs of the individual.

Payments will be issued from APD Central Office. ODHS and OHA will communicate directly with AFHs about the incentive payment and the process for requesting payment. Local offices will not be responsible for approving or processing these payments.

For Medicaid eligible individuals who are enrolled in APD or ODDS services, the entry criteria still apply in order for the case management entity to authorize funded Medicaid service payments.

Please see the associated [Provider Alert](#) and Letter of Agreement for more information.

*If you have any questions about this information, contact:*

Contact(s): HCBS.Oregon@dhsoha.state.or.us	
Phone:	Fax:
Email:	

**Letter of Agreement**  
**Adult Foster Home – Hospital Decompression Incentive**

This Agreement is made by and between the State of Oregon, hereinafter referred to as “the State”, through the Department of Administrative Services (DAS), the Oregon Department of Human Services, (ODHS) and the Oregon Health Authority (OHA) hereinafter known as “the State” and the Service Employees International Union (SEIU) Local 503, OPEU hereinafter referred to as “the Union” and jointly hereafter referred to as “the Parties”.

The Parties acknowledge the capacity crisis which currently exists with Oregon hospitals and the increasing number of individuals facing discharge delays. OHA-ODHS has determined to partner with Adult Foster Home Providers and to establish an incentive to Providers who admit new individuals to their Adult Foster Home directly from a hospital.

Accordingly, the Parties agree as follows:

1. For any individual admitted directly from a hospital to an Adult Foster Home for residency between January 20, 2022 and March 31, 2022, a payment of \$3,500 will be issued within ten (10) days of notification by the Adult Foster Home. An additional \$6,500 will be paid within ten (10) days 90 days after the date of admission. Re-admissions are excluded.
2. This payment is independent of the Provider’s regular rate as provided for in the Parties’ Collective Bargaining Agreement or the rate that the Adult Foster Home charges private pay individuals.
3. The Provider may not involuntarily discharge the individual within 90 days.
4. Individual must be discharging from a hospital from an admitted status (no EDs). The incentive payment applies to all licensing types (Aging and People with Disabilities (APD), Office of Developmental Disabilities Services (ODDS) and Behavioral Health Services (BH)) and is eligible for all individuals, regardless of payer status (Medicaid/Medicare/Private/LTC insurance).
5. Reimbursements are to be submitted by the Provider upon admission and on or after the 91<sup>st</sup> day following the date of admission for each resident admitted. The State will provide the form for the reimbursement submission for this incentive payment.
6. Payments will be processed within ten (10) business days from the date of reimbursement submission. The payment will be sent via US Mail in the form of a paper check.
7. ODHS will work collaboratively with SEIU to ensure the admitting Adult Foster Home Providers, as defined above, receive the incentive payment(s) accurately and timely.
8. The Adult Foster Provider will follow all licensing and compliance requirements including the discharge processes as defined in administrative rules.

State of Oregon / SEIU Local 503

January 20, 2022

- 9. For Adult Foster Homes licensed by the Office of Developmental Disabilities Services, individuals admitted must meet program criteria and must continue to meet program criteria.
- 10. Adult Foster Homes must be eligible to admit residents.


This Letter of Agreement is effective upon final signature below and shall expire on July 31, 2022.

For the State:

  
 \_\_\_\_\_  
 Nadja Gulley, State Labor Relations Manager  
 Department of Administrative Services, LRU

1/20/22  
 \_\_\_\_\_  
 Date

For the Union:

DocuSigned by:  
  
 \_\_\_\_\_  
31E64146737A445  
 Melissa Unger, Executive Director  
 SEIU Local, 503, OPEU

1/24/2022  
 \_\_\_\_\_  
 Date

# ADULT FOSTER HOME INCENTIVE PAYMENT FORM

Per a Letter of Agreement signed January 20, 2022, between SEIU and the Oregon Department of Administrative Service on behalf of the Oregon Department of Human Services and the Oregon Health Authority, an incentive payment will be made to any adult foster home provider that admits a new individual to their adult foster home directly from a hospital. The incentive payment is independent of the provider's regular rate, whether Medicaid or private payment. The AFH provider must screen the individual to determine if they can meet the individual's care needs. Once accepted, the AFH provider may not involuntarily discharge the individual for at least 90 days from the date of admission to the AFH.

Individual Needing Placement Information																	
Name:	Date of Birth:																
<input type="checkbox"/> Individual has Medicaid    Medicaid Number <input type="checkbox"/> Private Pay <input type="checkbox"/> Individual has other Insurance? Type: <input type="checkbox"/> Other:																	
Date of Admission to Hospital:	Date of Discharge to AFH:																
Hospital:																	
Individual's Previous Living Situation : Select One: If Other, explain:																	
Did the individual agree to foster home placement? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
If the individual is unable to agree to foster home placement, was a legal representative involved? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
If no to both questions, who made the decision?																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 2px;">Male <input type="checkbox"/></td> <td style="width: 33%; padding: 2px;">Female <input type="checkbox"/></td> <td style="width: 34%;"></td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> American Indian and Alaska Native</td> <td style="padding: 2px;"><input type="checkbox"/> Native Hawaiian and Pacific Islander</td> <td></td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Asian</td> <td style="padding: 2px;"><input type="checkbox"/> Middle Eastern or Northern African</td> <td></td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Black/African American</td> <td style="padding: 2px;"><input type="checkbox"/> White</td> <td></td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Latinx/Hispanic</td> <td style="padding: 2px;"><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>			Male <input type="checkbox"/>	Female <input type="checkbox"/>		<input type="checkbox"/> American Indian and Alaska Native	<input type="checkbox"/> Native Hawaiian and Pacific Islander		<input type="checkbox"/> Asian	<input type="checkbox"/> Middle Eastern or Northern African		<input type="checkbox"/> Black/African American	<input type="checkbox"/> White		<input type="checkbox"/> Latinx/Hispanic	<input type="checkbox"/> Other _____	
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<b>What language or languages spoken?:</b> Is there difficulty communicating or being understood by others? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list: Does the patient have other Disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list:																	
Adult Foster Home Information																	
Tax ID:	Medicaid Number:	License Number															
Provider Name:		Name of Home:															
Phone:	Email:																
Address:																	

By signing this form, you attest that the following is true:

- A screening of the individual is complete and I am willing and able to provide the needed level of care.
- This individual is being discharged from a hospital after an admission to that hospital.
- This individual was not a resident of your home prior to admitting to the hospital.
- You will continue to serve this individual for at least 90 days from the date of admit to your home.
- You will follow all licensing and compliance requirements including the discharge process as defined in administrative rules.

**Email the completed form to: [HCBS.Oregon@dhsosha.state.or.us](mailto:HCBS.Oregon@dhsosha.state.or.us)**

Signature of Provider

Date

Printed Name

**Adult foster home licensee or provider will be required to refund the payment amount if admission is found to not qualify for the incentive. Adult foster home incentive payments are subject to audit at the discretion of the Department.**

DHS/APD Use Only	For OFS
<b>Date Received:</b> <b>Date Initial Payment:</b> <b>Date Final Payment:</b> <b>Reviewed and Approved By:</b>	<b>Amount Authorized:</b> <b>PCA: 39093</b> <b>Index: 33930</b> <b>AOBJ: 7927</b> <b>MMIS Reason Code: 3008</b>