Adult Foster Home (AFH) Documentation Standards Training

Frequently Asked Questions (FAQs)

Q: Some individuals under age 21 are placed in AFHs. Are they being qualified under something different than 1915(i) criteria?

A: Yes. Individuals under age 21 qualify for AFH placement in other ways.

Individually-Based Limitations (IBLs)

Q: What kind of assistance can an individual expect to receive from a Community Mental Health Program (CMHP) with IBLs?

A: 1915(i) Home and Community-Based Services (HCBS) or Assertive Community Treatment (ACT) offer a variety of services that can support individuals with health and safety needs. Oregon Administrative Rule (OAR) 410-173-0040 describes the requirements to implement an IBL if needed to support the individual in their current setting.

In addition to providing outpatient services for additional supports, CMHPs can provide structure to support IBLs, follow OARs, and refine the assessment. These can ensure all current information is accurate in the individual's treatment plan. The treatment plan identifies assessed needs and providers responsible to deliver needed services and supports, including any IBLs to support the health and safety of the individual and those they interact with.

Form CH-003 must be filled out to help drive the need for an IBL. The individual or their legal representative must agree to all IBLs in writing. IBLs must be discontinued upon direction from the individual or legal representative.

Q: How do providers engage the CMHP to assist on the IBL?

A: Providers should complete Comagine Health's form CH-003: Individually Based Limitation. Providers may also call the individual's case manager and ask them for a new assessment. Provide all the documents such as the daily progress notes and incident reports. The provider can also request the Residential Specialist in the area can come out to observe the individual.
Providers should work with Comagine to update the Person-Centered Service Plan (PCSP) to address the risk factors around health and safety and allow the entire treatment team to come together to support all individuals.

Mental Health Assessment Level of Service Inventory (LSI)

Q: What is the process for an individual that qualifies for an exceptional needs rate? What documentation is needed?

A: When an individual has documented needs outside of what the LSI captures, providers must identify what the exceptional needs are beyond what is already being covered. Provider documentation, identified in OARs 410-120-1360, 410-172-0620 and 410-173-0045 must adequately capture the reason for this request. OHA's Rate Review Committee (RRC) requires these supporting documents: daily progress notes including frequency and duration of services or supports provided, and incident reports. The RRC Request form can be accessed from the Rates Standardization website.

Q: Do you have to receive a denial by the IQA before going to the RRC?

A: No. The RRC only reviews provider documentation to support an individual with necessary supports that the LSI does not capture. These supports include medical complexities and forensic risk areas. The IQA has a process in place giving the provider ten (10) business days to review the LSI and established rate, schedule a discussion with the IQA and OHA (as necessary), and submit supporting documentation that may result in a change to the LSI score. If the areas in question are outside of what the LSI captures, the provider may submit an exceptional needs request to the RRC. The Exceptional Needs request form can be found on OHA's rate standardization website.

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)

Q: What are the options for providers when the assessed ADL and/or IADL needs conflict with what the individual reports?

A: The Individual's team plays an advocacy role in providing supporting information for assessments. Providers must document services and supports that have been provided to the individual. The documentation must specify the type and method of service or support provided, the frequency at which it is being provided and the length of time to provide the service or support.

Q: Is there an electronic form for documentation?

A: No, OHA has not developed a standard electronic form to document the services and supports. This does not mean a provider cannot use an electronic documentation template, if the documentation meets the standards described in OAR. Applicable OARs include: 410-120-1360, 410-172-0620 and 410-173-0045.

Q: What does the IQA require in a face-to-face assessment?

A: The individual should be present for much of the face-to-face. The assessment requires capturing an individual's needs around their barriers and goals, making sure to identify all their needs. The assessor will conduct a conversation that elicits information associated to each line item of the LSI.

The LSI is a clinical assessment tool used by the IQA clinician to determine services and supports the individual needs at the placement setting. The assessment process is done in a conversation with the individual. The conversation format encourages the individual to tell their experience, unlike a question/answer interview. This allows the clinician to evaluate the individual's overall mental status and provide a more detailed assessment outcome.

Q: Why are assessments like the LSI and LOCUS used for functional needs?

A: States must provide an independent assessment and have a standardized method for capturing this information. The LSI and LOCUS are the tools approved by the Centers for Medicare & Medicaid Services (CMS) to fulfill these requirements. The assessors review submitted documentation in advance of the assessment and validate the documentation through discussion and observation of the individual and the setting. The purpose of the functional needs assessment is to connect the individual to the appropriate services and supports that best meet their needs.

Q: When the face-to-face assessments (LSI, LOCUS) are complete, when does the AFH and/or provider receive the documentation?

A: The documents are sent out in one packet with the PCSP within 30 calendar days after the face to face has been completed. There may be exceptions due to waiting on nursing delegations, updated documentation, or other unforeseen specific circumstances. During this time there should be correspondence between the provider and Comagine.

Q: What is the timeframe for payments between the 30-day placement waiting period and second care plan completed by provider?

A: Once the IQA has received the completed assessment and signed PCSP, a letter will be completed and sent to the individual, their legal representative (if applicable), and the provider with the rate and date a provider may bill for services provided. The signatures on the PCSP are part of the process and required to meet the requirements established in OAR 410-173-0025. The initial residential care plan needs to be completed within 24 hours of admission. The final residential care plan must be completed within 30 days of admission and align with the individual person-centered service plan.

Payment Support

Q: What should providers do if they are not receiving payment?

A: Providers should contact Provider Services for support with payments by reaching out by email or phone. Contact email and phone number:

Email: dmap.providerservices@oha.oregon.gov Call: 1-800-336-6016

Related Rules: 309-040-0305(8) & (46) & (79); 410-120-1360(2)(a); 410-172-0620; 410-173-0045