

## **Respite Care**

**Definition:** Care and supervision provided to those participants unable to care for themselves. Services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part Respite Care provided in a facility approved by the State that is not a private residence. Respite may be used on a regular basis to provide relief to caregivers or in response to a family emergency or crisis.

### **Respite Options:**

***Participant-Directed Respite*** is provided by a worker chosen by the participant and/or his/her representative. The participant or representative is the respite worker's employer. Participant-directed employers and workers must receive training through the SC Respite Coalition prior to starting services. Participant-directed respite is provided in 15-minute units.

***Agency-Directed Respite*** is provided by a SC Department of Health and Human Services (SCDHHS) enrolled personal care provider or an OIDD contracted provider. A list of providers for agency-directed respite can be found on the OIDD website. Agency-directed Respite is provided in 15-minute units.

***Group Respite*** is provided to multiple participants living in the same household. Respite can be participant-directed or can be provided through an agency. Respite can be provided to 2 or 3 participants at the same time who live in the same household and are enrolled in the same waiver. Respite is provided in 15-minute units.

***Institutional Respite*** is provided daily in a SCDHHS contracted nursing facility (NF) or an Intermediate Care Facility for the Intellectually Disabled (ICF/IID). Institutional Respite may be provided in an OIDD Regional Center or in a community based ICF/IID that has been approved by the State and that is not a private residence. The unit of service is one day when the participant is present in the facility at midnight.

Respite Care (excluding Institutional Respite) will be provided in the following location(s):

- Participant's home or place of residence, or other residence selected by the participant/representative.
- SCDSS Licensed Foster Home
- Group home (i.e., CTH I or II)
- Licensed Respite Care facility
- Licensed Community Residential Care Facility (SCDHEC, SCDHHS)

### **One unit of Respite = 15 minutes**

**Respite** can be provided, in 15-minute units, for up to sixteen (16) hours in a calendar day in a variety of settings. Sixteen (16) hours per day assumes eight (8) hours of sleep time. A caregiver may provide respite to only one participant during any given time frame, with the exception of group respite, and have only one caregiver providing services during any time frame. No overlapping time is permitted, regardless of where services are provided or number of caregivers providing services.

A caregiver may only provide a maximum of 40 hours (160 units) of services per week. This includes all time for all participants and programs.

For children under the age of 12, the waiver will only fund care that is directly related to the child's disability. The caregiver is responsible for care equal to that of parents of non-disabled children.

For children in Foster Care, the Waiver Case Manager must receive approval from the DSS worker before Respite can be provided. The approval must be documented in case notes.

A Respite caregiver and Personal Care Aide cannot render services at the same time. Respite services and Personal Care services are not interchangeable.

**Institutional Respite** will be provided in the following location(s):

- Medicaid-certified ICF/IID (OIDD, SCDPH)
- Medicaid Certified Nursing Facility contracted with SCDHHS for Institutional Respite

**One unit of institutional respite = one day.**

Institutional Respite is provided in daily unit increments. See specific procedures for institutional respite later in this chapter.

**Service Limits:** *Respite* is limited to the amount determined by OIDD assessment and the participant's Community Support Waiver cost cap. Respite services must be authorized monthly. Unused units from one month cannot be banked (i.e., held in reserve) for use during a later month.

### **Providers:**

**Participant-directed respite** is provided by workers selected by the participant or the participant's designated responsible party/employer. Participant-directed respite workers and participant-directed employers must receive training through the SC Respite Coalition.

**Agency-based respite** is provided by agencies contracted with SCDHHS to provide Personal Care II services and OIDD contracted Providers. A list of available providers should be given to the participant/family and a choice of provider must be offered.

A list of DHHS enrolled providers and OIDD contracted providers can be found on the OIDD website. DHHS Enrolled Providers: <https://app.ddsn.sc.gov/public/ndp/landing.do?providerType=M>  
OIDD Contracted Providers: <https://app.ddsn.sc.gov/public/directory/landing.do#>

Respite Care cannot be provided by a person who is legally responsible for the participant. Please refer to Department Directive 735-02-DD. However, family members may be paid to provide Respite in certain circumstances. Family members/relatives wishing to receive payment for Respite Care rendered must complete the Statement of Legal Responsibility for Respite Services acknowledging that they are not a primary caregiver of the participant and that they are not legally responsible for the participant, prior to the authorization of services. The Statement of Legal Responsibility for Respite Services should be maintained in the participant's file.

### **Home Supports Caregiver Certification**

For participants who receive respite through an OIDD qualified provider, the Home Supports Caregiver Certification must be completed. The form and guidance can be found in business tools – forms.

**Conflict Free Case Management:**

To honor choice and prevent conflicts of interest, providers of Waiver Case Management services must not provide any other waiver service to the same person. When there is a conflict, the WCM will help the participant understand why a conflict exists and offer a choice of either another WCM provider or another waiver service provider. The Case Manager must then transition the participant to the chosen provider within 60 days.

**Arranging for and Authorizing Services:** Once it is determined that Respite Care is needed, the need for the service and the amount and frequency of the service must be documented in the participant's Support Plan. Completion of the OIDD Respite Assessment is required prior to authorizing the service (except in emergency/crisis situations) and annually face to face for the duration of the service to be included with the Case Management Annual Assessment and as changes/updates are requested.

The OIDD Respite Assessment is designed to supplement the Case Management Assessment in providing detailed information regarding the participant's difficulty of care and to determine the caregiver's stress level and identify other information related to the need for Respite. The information gathered from the assessment will help the Waiver Case Manager/Early Interventionist determine how many units of Respite are appropriate to meet the needs of the participant and his/her caregiver.

Once the frequency has been determined, the Waiver Case Manager will request approval to the OIDD Waiver Administration Division. The participant must be given a choice of providers, and the offering of choice must be documented. In the case of an emergency or crisis, choice may not be an option. The Waiver Case Manager should clearly document this in the participant's file.

Upon approval by the Waiver Administration Division, an electronic authorization must be completed and submitted to the chosen provider. Ongoing Respite services must be authorized annually at the time of the Support Plan, and as changes are made to the service throughout the plan year.

**Participant-directed respite**

If the participant/family chooses the participant-directed respite option, the WCM will refer the participant/family and their chosen respite worker to the SC Respite Coalition. The intake form can be obtained from the SC Respite Coalition.

**SC Respite Coalition**

Columbia area: (803) 935-5027

Toll Free: (866) 345-6786

Email: [info@screspitecoalition.org](mailto:info@screspitecoalition.org)

<https://www.screspitecoalition.org/>

***Employer Pre-Screening Tool*** (For participant-directed respite only): If after initial discussions, the participant wants to proceed with the participant-directed option for respite, the Employer Pre-Screening Tool must be completed by the WCM for any participant/representative interested in serving as the employer/responsible party. The Pre-Screening Tool is completed to assure that the participant/representative has no communication or cognitive deficits that will interfere with direction. See *Employer Pre-Screening Tool* located in Business Tools – Forms – CS Waiver.

The WCM is responsible for ensuring that the participant/responsible party understand the pros and cons of this service. Participant-Directed Respite requires the participant/responsible party to be an "Employer" of a "Worker" and maintain all paperwork and requirements needed to perform this task.

Once the employer and worker have completed the initial process through the SC Respite Coalition, the SC Respite Coalition will refer the employer and worker to the fiscal agent. The fiscal agent will provide forms needed for the employer and worker receive payroll services.

The WCM should ensure all steps have been completed prior to authorizing services. To initiate the participant-directed service following approval of the plan from the Waiver Administration Division, an electronic authorization via Therap must be issued to the fiscal agent. The authorization must include the name of the Employer of Record and the name of the worker(s) in the comments section (do not use the shared comments section). If the Employer of Record or worker changes, a new authorization must be issued with the name of the new Employer of Record and/or the new worker's information. The WCM must provide a copy of the service authorization to the employer. The employer will then develop a schedule with the worker based on the amount of service authorized. Services must be authorized annually at the time the participant's plan is completed, and as changes are made to the service throughout the plan year.

### **Institutional Respite**

Prior to requesting Regional Center institutional respite, all other respite resources must be exhausted. Respite resources include but are not limited to; natural supports, waiver funded in-home supports and/or respite in a residential facility operated by OIDD contracted residential providers. Evidence that all other resources have been exhausted must be provided or available in the record.

To request Regional Center institutional respite, the WCM must complete the ***Request for Institutional Respite*** form (located in business tools-forms-CS Waiver) and send via SComm ***DDSN, Residential Request/Residential Service Request***. The subject of this SComm must include the person's **last name, first name (Request for Regional Center Institutional Respite)**. Approval of Regional Center Institutional Respite is contingent upon availability and need.

The Residential Review Committee will review the request to ensure other resources have been attempted and the request is appropriate. If the request is accepted, the WCM will be informed via SComm and information will be forwarded to Tiffany Carter, Regional Center Administrative Coordinator. To inquire about the status of the request, Case Managers may contact Tiffany Carter by email at [tiffany.carter@ddsn.sc.gov](mailto:tiffany.carter@ddsn.sc.gov).

If the request is approved and availability has been confirmed, the Regional Center Administrative Coordinator will complete the bottom portion of the first page of the Request for Institutional Respite form and will send to the WCM and the OIDD, Residential Request SComm box. The WCM will then submit a plan change. The WCM will prepare an Admissions Packet and submit to the appropriate staff at the Regional Center prior to the identified admission date.

The admissions packet must include:

- Request for Institutional Respite
- Medication Administration Schedule
- Psychological Evaluation
- Behavior Support Information (if applicable)
- Support Plan

- Nutritional Information
- Physical (completed within 30 days prior to start of Respite)
- Tuberculosis Test (2 step)
- Social History

The participant should bring, at the minimum, the following items when reporting to an ICF/IID or nursing home for Respite Care:

- Medications in their original containers
- Spending money
- Medicaid Card
- Clothing
- Toiletries
- Durable Medical Equipment and Supplies ( e.g., diapers, wipes, etc.)

In cases of an emergency/crisis, some of this information may not be present initially, but should still be obtained and forwarded to the Regional Center Placement Coordinator or the Provider Residential Director.

**Under extreme circumstances, when the anticipated duration of Institutional Respite is not known, the service should be authorized for forty-five (45) days.**

If the participant is receiving Institutional Respite in a OIDD Regional Center, a staffing must be held within 30 days of beginning services. The OIDD Regional Center Staff will coordinate this meeting. The Waiver Case Manager, District Office OIDD Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff must be present at the staffing. Discussions will be held regarding to the participant's progress and a decision will be made as to whether the participant will continue to receive Institutional Respite.

**If the staffing team recommends that the participant be admitted to the Regional Center, the following steps must be completed:**

- For participants who reside at home with family (not in a community residential setting), the Waiver Case Manager must initiate the Request for Residential Services. (Please refer to *Directive 700-09-DD Determining Need for Residential Services* for procedures and forms).
- If Regional Center Placement is approved, the Waiver Case Manager will be notified via SComm.
- Regional Center staff will complete an ICF/IID Level of Care if the participant has **ever** been admitted to an ICF/IID. If the participant is a new admission, the ICF/IID Level of Care will be completed by the Consumer Assessment Team. The Regional Center Staff will be responsible for submitting this packet to the Eligibility Division.
- Upon notification that the participant has met ICF/IID Level of Care, the Claims and Collections Officer will notify the Waiver Case Manager and the appropriate District Waiver Coordinator that the participant is ready to be admitted to the Regional Center.
- The Waiver Case Manager will complete the Notice of Disenrollment within two (2) working days and end the authorization for Institutional Respite Care.

- The Waiver Case Manager will terminate all other waiver services.
- The Claims and Collections Officer/Person Completing DHHS Form 181 will check the Waiver Tracking System to ensure that the participant has been disenrolled from the Waiver before proceeding with admission of the participant to the ICF/IID and completing DHHS Form 181. A copy of DHHS Form 181 form will be forwarded to the Waiver Enrollments Coordinator. If the Claims and Collections Officer notes that the participant continues to remain enrolled in the, he/she will notify the appropriate District Waiver Coordinator.

**If the staffing team recommends that the participant continue to receive Institutional Respite at an OIDD Regional Center, the following steps must be taken:**

- Another staffing must be held within 30 days of the initial staffing. The OIDD Regional Center Staff will coordinate this second meeting. The Waiver Case Manager, District Office OIDD Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff **must** be present at the staffing. Discussions will be held again regarding the participant's progress, and a decision will be made as to whether the participant will continue to receive Institutional Respite or if the team recommends admission to an ICF/IID.
  - If it is decided that the participant will continue to receive Institutional Respite, the Waiver Case Manager must request approval of the additional units from the OIDD Waiver Administration Division. Upon approval, a new electronic authorization must be completed and submitted to the institutional respite provider.
  - If the team recommends that the participant be admitted to an ICF/IID, the procedures outlined above must be followed.

Depending on the circumstances surrounding the need for Institutional Respite, multiple staffings may result in a decision that Institutional Respite Care continue for an extended period. The above steps must be followed, and a staffing must be held at least every 30 days. OIDD Central Office must be notified as outlined above.

Note: While a participant is receiving Institutional Respite, he/she may continue to receive Assistive Technology (medical supplies) through the Waiver. Various Day Services can also be funded through the waiver if ICF staff will agree to accommodate the participant in transport to and from the Day Facility. All other waiver services, except Waiver Case Management, must be suspended or terminated.

**Monitoring the Services:** The Waiver Case Manager must monitor the service for effectiveness, usefulness, and participant satisfaction. Monitoring may be completed with the participant, representative, service providers, or other relevant entities. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. OIDD recommends that the Waiver Case Manager monitors this service when it begins and as changes are made.

Monitoring must be conducted as frequently as necessary to ensure:

- the health, safety, and well-being of the participant.
- the service adequately addresses the needs of the participant.

- the service is being furnished by the chosen provider in accordance with the authorization, relevant policies, and quality expectations.
- the participant/representative is satisfied with their chosen provider/s.

Some questions to consider during monitoring include:

- Is the participant receiving Respite Care as authorized?
- Does the provider show up on time and stay the scheduled amount of time?
- Does the provider show the participant courtesy and respect?
- Is the participant satisfied with the current respite provider?
- Does the caregiver feel that he/she is receiving enough relief from providing for the participant's care?
- Does the service need to continue at the current amount/frequency?
- Is there need for additional Respite to be requested at this time?
- Is the participant pleased with the care being provided, or is assistance needed in obtaining a new caregiver?

**Reduction, Suspension, or Termination of Services:** If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the participant or his/her legal guardian including the details regarding the change(s) in service, allowance for reconsideration, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See **Chapter 8** for specific details and procedures regarding written notification and the reconsideration process.